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Ministry of Health
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Hansard Reporting and Interpretation Services
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STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Thursday 27 March 2008

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The committee met at 0939 in committee room 1, following a closed session.

2007 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.12, outbreak preparedness and management.

The Chair (Mr. Norman W. Sterling): Good morning. My name is Norman Sterling. I am the Chair of the public accounts committee. This morning we are dealing with consideration of section 3.12 of the 2007 annual report of the Auditor General, which deals with outbreak preparedness and management. The Ministry of Health and Long-Term Care is the primary ministry responsible for this area and we have today with us Mr. Ron Sapsford, the deputy minister, and several other people from the Ministry of Health. So I'm going to turn it over to you, Mr. Deputy Minister. You might want to introduce the people sitting with you at the table. As well, I understand you have some remarks which you have provided us with a copy of, so I turn it over to you at this point in time.

Mr. Ron Sapsford: Thank you, Mr. Chair. I'd like to introduce members of my staff who are with me today. On my left is Allison Stuart, who is acting as the assistant deputy minister of the public health division, and on my right, Dr. David Williams, who is the chief medical officer of health for Ontario.

On behalf of the Ministry of Health and Long-Term Care, I want to thank the standing committee on public accounts for giving me this opportunity to discuss some of the key issues raised in the Auditor General's 2007 report on outbreak preparedness and management.

Let me begin by saying that the ministry fully supports and appreciates the input of the Auditor General. Pandemic planning is a complex, evolving process that is continuously being refined and improved with each version of the plan. The audit report's insights have already begun to inform the ministry's way forward in protecting the health of Ontarians. I am pleased today to update you on the ministry's progress since last year's audit was conducted.

The ministry was very much encouraged by the Auditor General's references to the great strides that Ontario has made since the SARS outbreak in 2003. SARS was a wake-up call for all of us. The ministry, as well as the health care system, learned many hard-earned lessons. Our experience with SARS underscored the need for developing increasingly vigilant best practices in infection prevention and control, as well as outbreak preparedness.

In particular, we thank the auditor for acknowledging the ministry's considerable achievements, including its pandemic plan, the stockpile of antiviral drugs and medical equipment and the creation of regional infection control networks. The ministry has also funded 137 additional infection control practitioners in acute-care hospitals; created 180 communicable disease positions in local health units; established the Ontario Agency for Health Protection and Promotion; developed infection-control guidelines in hospital construction and renovations planning and design; and implemented a hospital-based hand hygiene program for health care workers.

Indeed, these measures have helped make Ontario better prepared than we were five years ago to deal with outbreaks of infectious disease. In the area of pandemic planning, the province is now recognized both nationally and internationally as a leader in this field.

However, we do not live in a perfect universe. As I've said, pandemic planning is an evolving process, never finished. We know more today than we did yesterday and less than we will know tomorrow. Our challenge as a ministry is to continually question our assumptions, update best practices and welcome input that will allow us to build and sustain a comprehensive defensive and response system to protect the life of every Ontarian.

I now want to address the major points addressed in the auditor's report. As I cite them, I will give you an update on the initiatives under way or planned to resolve these perceived gaps.

The Auditor General's report raised concerns on whether all of the players in the health system know exactly what to do in planning for and during a pandemic. It noted that a ministry survey found that one third of public health units had yet to complete a pandemic plan. I'd like to report that a significant amount of work has been done in this particular area.

As the auditor noted, clear roles and responsibilities are crucial if Ontario is to be able to respond effectively to a health crisis. Outbreak preparedness and management, particularly in the context of pandemic planning, is

a shared responsibility. The relevant legislation, the ministry emergency response plan and the Ontario health plan for an influenza pandemic together establish the roles, responsibilities, structures and procedures for Ontario's pandemic planning.

The Emergency Management and Civil Protection Act sets out the responsibilities of ministries and municipalities for emergency planning and preparedness.

The Health Protection and Promotion Act establishes key responsibilities for health protection. It also sets out the roles for the chief medical officer of health, local boards of health and medical officers.

The Occupational Health and Safety Act reflects the critical role of the Ministry of Labour during an emergency, and this legislation cannot be suspended.

Provincial emergency plans establish the Premier and cabinet as the executive authority in a provincial emergency like a pandemic. Emergency Management Ontario, part of the Ministry of Community Safety and Correctional Services, has the primary responsibility for coordinating the province's emergency response.

The Ministry of Health and Long-Term Care, through an order in council, is the responsible ministry for leading preparedness and response activities in the areas of human health, disease and epidemics, and health services during an emergency. The chief medical officer of health leads the health response by providing direction to the health sector.

Following SARS, the ministry created the emergency management unit to lead the ministry's responsibilities for health emergency preparedness and response.

Local public health units are responsible for developing community plans in partnership with local health providers. And boards of health are required to conduct activities to support the identification and management of various community outbreaks.

Hospitals and long-term-care homes have responsibility for emergency plans for their own organizations.

At the federal level, the Public Health Agency of Canada and Public Safety Canada both have roles in preparation for, and in response to, a pandemic.

The Ontario health plan for an influenza pandemic is the linchpin in the province's preparedness and management strategy. The plan describes how Ontario's health system will respond to an influenza pandemic and puts measures in place to ensure the health system will be there for Ontarians at a time when they need it most. It clearly sets out roles and responsibilities for all parties and contains checklists and targeted fact sheets, which are made available for health workers.

We know we can never rest on the laurels of the status quo. We renew our commitment to protecting lives by releasing new versions of this plan, based on the best available clinical information and the changes in the province's health system landscape. Over the past four years, the ministry has released four iterations of the influenza pandemic plan, and the fifth release will be available this summer.

Nearly 400 individuals and organizations were involved in the development of the plan and it was practised during an exercise with over 200 stakeholders. Another exercise, a test of the plan, is ready for this fall, again to test the readiness.

The ministry has made its pandemic plan public and there has been an increasing number of visits to this section of the ministry's website—www.health.gov.on.ca/pandemic. In January of this year alone, Ontario's pandemic planning and emergency preparedness online resources received almost 34,000 visits. Further, the monthly Pandemic Planner newsletter, which highlights best practices in the province and planning progress, is accessed by and distributed to over 2,900 organizations and professionals across Canada.

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As to public health units' preparedness, the ministry's September 2007 quarterly survey to assess preparedness on the part of public health units showed that 70% of public health units have pandemic plans in place. The remaining units are expected to complete their plans by the end of 2008. To support this, the ministry's emergency management unit is working with health units to develop a best-practices template and tools.

The second point: The Auditor General's report noted that the ministry has developed a critical care triage tool, the first of its kind, to help guide difficult clinical decisions during an influenza pandemic. The auditor's report expressed concern that the tool had neither been tested nor submitted for public consultation.

The ministry has supported the auditor's recommendation for public consultation on the critical care triage tool. Such public consultations are now under way. This process will improve the public's understanding, as well as give the ministry valuable input as to how the tool is received by Ontarians.

A pilot study by health care professionals is also in progress to test the best method of gauging the critical care tool's efficacy, and results are expected later this spring.

It's also important for the committee to note that the critical care triage tool has been identified as a promising practice by the Center for Infectious Disease Research and Policy at the University of Minnesota, which peer reviews practices that can enhance public health preparedness. It is also noteworthy that British Columbia has adapted Ontario's critical care triage tool for inclusion in their own pandemic plan.

Managing a surge in demand for critical care capacity during a crisis is also being addressed by the ministry. This requires a coordinated system of communication and regional partnerships. A pilot project in surge capacity planning and management for critical care is under way in the Champlain local health integration network. This test will inform the future rollout of a province-wide system for search capacity development.

It's also worth mentioning that, in 2003, the ministry created the emergency medical assistance team, or EMAT, a 56-bed acute care mobile field unit that can be

deployed anywhere in the province within 24 hours when local providers are overwhelmed due to an emergency.

The next point: The auditor also noted that public health units either did not have operational plans for setting up flu centres or were undecided whether to create them. In 2006, the pandemic plan set forth a strategy for public health units to establish plans for influenza assessment centres to ensure that hospitals and other primary care providers were able to offer a range of service for treating individuals.

A recent survey of health units confirms that a majority is already working on flu centre planning. The decision of location for flu centres is made at the local level as they are in the best position to know their own community needs.

The next point: The auditor expressed concern that about one third of public health units were without full-time medical officers of health. As well, the report noted that close to 100 public health division and laboratory positions were vacant within the ministry.

I couldn't agree more that filling these vacant positions is a high priority. To address the growing demand for health professionals, the ministry established HealthForceOntario in 2006. The public health division has been working closely with HealthForceOntario to meet the specific demands for public health professionals. The government has allocated funding for five new positions through the physician re-entry program for physicians interested in pursuing specialized education to be a medical officer of health. As well, the ministry has enhanced funding for the medical officer of health in training program. These efforts have resulted in two acting medical officers of health applying for bursaries to pursue their master's degrees in public health.

The Auditor General's report noted that the ministry had not yet collected $17 million from the federal government for its share of the cost of the antiviral stockpile. As per the auditor's recommendation, the ministry has worked diligently to get the funds owed to it for the federal cost-share portion of the antiviral stockpile. An agreement is expected to be in place by March 31 this year—and, I might add, recovery of the funds.

The report also raised concerns that the ministry will not be able to correct deficiencies in its current disease surveillance information system before transferring the existing information to a newer system in 2008. The ministry has worked hard to improve its disease surveillance information system—this is the integrated public health information system, or, as we call it, IPHIS—since its implementation in 2005.

IPHIS is the software application that supports the processes used by public health experts both in the ministry and health units to track and respond to cases, contacts and outbreaks of infectious disease that occur across the province. It is Ontario's infectious disease reporting, case, contact and outbreak management application and is the most robust software of its kind in the country.

IPHIS uses a central database providing near real-time reporting and data sharing to reduce the time it takes to recognize and efficiently manage threats to public health. IPHIS allows public health to link cases and contacts to exposures, which supports coordinated surveillance and outbreak management across the province.

Further, a new surveillance solution that is part of the public health division's surveillance operational plan for a pandemic is expected to be completed this fall. This solution will supplement the surveillance data reporting currently done through IPHIS in the event of an epidemic.

The ministry is also leading a cutting-edge form of surveillance called syndromic surveillance, which uses nontraditional and real-time sources to identify infectious disease clusters quicker than through normal channels.

Finally, the next generation of the surveillance system is called Panorama. This is a pan-Canadian public health surveillance solution. Ontario is playing a leadership role in its development and implementation. This system will improve reporting and the capability to manage large outbreaks across the country. Panorama is jointly supported by all Canadian jurisdictions and Canada Health Infoway, and builds on the current IPHIS. It will be implemented in three releases during 2009 and 2010, and Ontario is one of the first provinces to be implementing the new system.

At this point, I'd like to turn to an area where I must respectfully note that the ministry is not in agreement with the Auditor General's recommendations. The report expressed worry that in the event of an infectious disease outbreak, the availability of sites where a significant number of people could be quarantined or isolated for an extended time was limited. The ministry does not believe that a quarantine strategy will be effective in slowing the spread of an influenza pandemic. During a pandemic, the virus will be community-based, and quarantine is not likely to be effective beyond the very early stages of the appearance of the virus.

It is also important to note that the Ontario health plan for an influenza pandemic includes a description of voluntary isolation. People with influenza-like symptoms will be asked to isolate themselves and avoid contact with others. In addition, depending upon the severity of the virus, the pandemic plan also includes provisions for asking healthy individuals who have come into contact with others exhibiting influenza-like symptoms to voluntarily quarantine themselves at home until the incubation period is over.

However, the ministry will be developing quarantine guidelines for infectious disease outbreaks other than a pandemic.

Having ready access to health care volunteers during an emergency is essential. But again, in contrast to the auditor, the ministry does not believe that keeping a database of volunteers is effective. It is difficult to maintain a current database of this nature. Instead, the

ministry will further engage the health regulatory colleges to identify strategies for how their members can volunteer during emergency situations. An overwhelming number of health care workers want to help during a crisis, as we experienced after the Asian tsunami and Hurricane Katrina.

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Planning for a pandemic involves much more than enacting legislation and developing a plan. It also requires making sure the health system has the right tools it needs to continue delivering care to Ontarians during a crisis.

To prepare the health system and protect the health of the residents of the province, the ministry is carrying out an ambitious stockpiling program, including enough antiviral medications to treat 25% of Ontario's population during an influenza pandemic. Antiviral medications are used to treat illness associated with viral infections brought about by an influenza pandemic.

Secondly, we are acquiring 55 million N95 respirators for health care workers in close contact with patients during an influenza pandemic. Ontario is one of the few Canadian jurisdictions to stockpile this type of respirator in such quantities. Over 60% of this stockpile is expected to be in place by the end of this month.

The ministry is also in the process of completing its stockpile of other necessary medical equipment for use during a pandemic or other health emergencies, such as masks, gowns, gloves and other supplies.

The costly legacy of SARS, including the tragedy of lives lost and shattered, inspired many to work tirelessly to make Ontario better prepared and to continue its leadership role in pandemic planning. But our work as a ministry is not done.

We must continue to advance our preparedness and management system, adopt best practices and work in partnership with stakeholders and local communities to ensure the province can effectively respond to any health crisis.

We must also continue to promote infection control to help Ontarians stay healthy. A healthier population will be more resilient during health emergencies.

In closing, I'd like to thank the Auditor General for providing the ministry with valuable guidance to support us in continuing to build improvements into our system of outbreak management and response to pandemics.

The Chair (Mr. Norman W. Sterling): Thank you very much. Ms. Gélinas?

M^me^ France Gélinas: Thank you, Ron, for your update. It was very useful. I would like to start with the first Auditor General's recommendation, which has to do with health units. My first question will be general in nature. The Auditor General noted that the ministry's survey found that one third of public health units had yet to complete a pandemic plan. My first question will be, where in the province are those not already generally located? I'm talking about geographical areas or rural versus urban, bigger versus smaller, that kind of issue.

Ms. Allison Stuart: The distribution is scattered, but in really broad strokes it would be fair to say that more rural or smaller health units are finding it more difficult to complete their planning. Having said that, it's important that we are encouraged by knowing that every single health unit in the province is working on their plan, and by the end of 2008, even those health units that don't have a complete plan expect to have a plan completed.

M^me^ France Gélinas: Okay, and you feel confident that that will happen?

Ms. Allison Stuart: I do. We have staff within the ministry who have been and will continue to work closely with those health units that are having some difficulties in completing their plans. There's also the ability, and it's one of the joys of working in health emergency management—there is incredible generosity of spirit, and people share plans and strategies and so on with each other.

M^me^ France Gélinas: Continuing with this idea that it is mainly the smaller health units that usually have less resources; I'm familiar with the one in the north because this is where I'm from, where you find quite a few of the smaller health units with a smaller resource base that are having a tough time meeting the requirement of the ministry for their mandatory program, and then when those get added on, it overwhelms them.

Was there—and I realize that this is a little bit outside of this morning—any thought given to a redistribution of the health unit catchment area?

Mr. Ron Sapsford: The catchment areas themselves, no. The designation of the geography for health units was not considered as a way to accommodate that. I think it's fair to say that smaller units have a more difficult time, as Allison has indicated, but at the same time, the ministry is supporting those health units. Quite frankly, as the larger health units go through the process, the planning for subsequent health units becomes easier because we use the experience from one unit to help the other. All of the health units, though, received additional staff positions over the past few years specifically to address the needs of pandemic planning. There's a variability in how quickly people work across the province, but we're doing our best to ensure that the work is completed during this year.

M^me^ France Gélinas: Okay. You have talked about—and I agree with you—that this is evolving, and you will be releasing the fifth version of your plan this summer, I think you said. How widely distributed is it and do you have any idea about this net that you cast with your plan—how many people read it? Do you have any idea?

Mr. Ron Sapsford: Well, it's public. As soon as we're finished the subsequent draft, it's made public; it's put onto the ministry's website, which is publicly accessible. It's distributed widely in the health care system. Certainly, the health care system is well aware of the drafts, so professional associations, colleges—it's broadly distributed and made available, partly because each subsequent draft provides more detail. It gives, in different areas of the plan, more information. Sometimes, better tools are included in it, and the responsibility of

local providers is then to keep their plans updated and in pace.

In some cases, there are still outstanding questions around pandemic planning. Some of those questions are discussed initially at the federal-provincial level. Before we can update our plans, sometimes we have to go through that discussion with the federal public health agency and then, consequently, update our own plans. But it's very widely circulated. The website hits for the last month are quite extensive and we're well aware that it's consulted not only here in Ontario but across the country and, I would venture to say, internationally as well.

Ms. Allison Stuart: If I could just add to that, we average 200 speeches and presentations per year on the pandemic plan. This is both to the health sector and also increasingly beyond the health sector as other organizations understand that the pandemic will affect them as well. The plan itself is widely used across Canada. We do look at everybody else's work and we do see it internationally as well. We have been invited to other jurisdictions to actually present on our pandemic plan. We keep it on our website, along with the fact sheets, because one of the lessons learned during SARS was that some people felt that the information wasn't as transparent as it could have been. So we make sure that that's available.

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The Pandemic Planner that goes out each month is, again, widely distributed and then distributed again, in that we know that in some areas the person receiving it passes it on to their distribution list. We also have a booklet which was created that describes the pandemic plan, and that's available, as well as a booklet for the public. There are two kinds: one for the health worker as well as another for the public at large.

M^me^ France Gélinas: I'd like to come back to the smaller health units. I am also aware that they are the ones that have a hard time putting their pandemic plan together—I wasn't surprised by your answer. Aside from being small, what are some of the hurdles that keep them from getting their plan?

Ms. Allison Stuart: In terms of some of their challenges, one is certainly geography. While there are smaller health units, they may cover a large geographic area, as you well know. How to best address those challenges really involves some different kinds of thinking and decision-making. So that would be one. Also, access to the rest of the health sector is not necessarily as robust as it would be just down the street here.

M^me^ France Gélinas: I would agree and concur in your answer that the smaller health units—the ones in the north covering a huge geographical area—don't have the resources because they're small. There are also very few people to partner with, in order to put a plan together. Although I agree with what Mr. Sapsford said regarding learning from the best practices of others, some of those best practices are really hard to translate into rural northern Ontario, covering a wide geographical area.

Is there any plan to help them out, so that the people in northern Ontario are just as well protected as those in the rest of Ontario?

Ms. Allison Stuart: There has been extensive work done through the Ontario Hospital Association for supporting small hospitals and rural hospitals. They've got a kit that has gone out to all those sites. Many of the strategies in the kit are ones that are relevant to that local response.

As indicated previously, the emergency management unit within the Ministry of Health and Long-Term Care public health division has plans to be initiated over the summer—right now, we're really focused on getting that fifth plan out—to reach out to the specific issues of each of the health units that have not yet had a plan, to see how we may be able to be of assistance, and if not directly provide service, at least be able to broker some assistance for them.

Dr. David Williams: I would also add that we have started the regional infection control networks. That was another enhancement.

M^me^ France Gélinas: That's through hospitals?

Dr. David Williams: In hospitals, public health—these are with coordinators resourced and meeting the networks that have been enhanced since SARS, which can assist in facilitating those discussions and networking.

As you know, in the north, having just come from there, they have the sense of lots of networks—we know each other very well and connect. That's one advantage that the south sometimes has a little more trouble with. But geography—you are correct—and wide diversity is a challenge that needs to be overcome.

M^me^ France Gélinas: Does every public health unit have a hospital in its catchment area?

Dr. David Williams: Yes.

M^me^ France Gélinas: Every one does?

Mr. Ron Sapsford: Every health unit area would have more than one.

M^me^ France Gélinas: I'm thinking South Porcupine and stuff—I forget the name of the health unit there. Anyway, they all do.

What you've just described, through the small hospital network, would be available to each and every one of the health units. Then, is there something similar happening for—there are lots of communities in the north that don't have hospitals. From Foleyet to Gogama to Shining Tree, I could rhyme off hundreds of communities that are 200 kilometres away from the closest hospital. How are those being looked after?

Ms. Allison Stuart: The existing pandemic plan has a chapter for long-term communities, which was developed in conjunction with—

M^me^ France Gélinas: For what kinds of communities?

Ms. Allison Stuart: Sorry, long-term-care sites. It was developed in conjunction with long-term-care operators

and staff, so as to be really relevant to their needs. That has been in place now for two years. There's work under way now to do some further refinements to that, based on feedback from the long-term-care field.

M^me^ France Gélinas: I was aware of this through institutions such as hospitals and long-term-care facilities. When you look at the riding I cover, a lot of the time the only health services available are primary care. You'll have a nursing station or a solo physician—that kind of small community; I have 23 of them in my riding. I'm just curious: Is there a way to engage primary care in pandemic planning?

Mr. Ron Sapsford: I think the references to flu centres, assessment and vaccine in the auditor's report are really the answer to your question, because in communities that don't have institutional services, it really revolves around how we do the primary care part of it. This is the piece of work that needs to be completed in many communities, and that involves engaging family physicians in their various forms, because in case of an outbreak, first access will be to family physicians. Rather than simply letting those resources be overwhelmed, this discussion is needed around, how do we deal with flu assessment, and is there a different way that we can organize that? So part of what the health units have to do is engage those local physicians in discussions around, "If there is a pandemic outbreak, how are we together going to respond?" That is partly what takes the time, because those discussions and relationships have to be developed and agreement sought and consensus achieved and then documented in the plan as part of the approach.

Ms. Allison Stuart: In addition, at the provincial level we have a working group of primary care providers who are looking at refining and defining exactly what their roles will be. Frankly, it's easier to organize a big hospital than individual practitioners who are out doing their day-to-day work. This group has come together and has been working over the winter to look at what their roles need to be. They include nurse practitioners and primary care providers, including individuals from the north, and they're developing some further strategies to make sure we can continue to offer primary care to the people in the province.

We also have a group, which is actually meeting next week, that is looking at some additional options we might develop and provide to support response to early treatment.

M^me^ France Gélinas: Okay.

Dr. David Williams: I'd also add, from the local standpoint, having been in the north, that we would often ask the medical officer of health. We would often go to the communities where the physicians were and do in-service and discussions and connect with them—for example, CHC staff in Long Lac, etc.—and set up how they would like to connect and coordinate. We would be available with our staff and public health nurses to give updates on the plans to the staff at those facilities and keep them connected with us.

M^me^ France Gélinas: Thank you for your answer. I have a feeling that the 30% of health units that were having a tough time were the smaller health units and the health units located in the north and in rural areas of Ontario. I realize that the challenges in those areas are greater, because you have no facilities such as hospitals and long-term care. You're basically dealing with primary care, which means a lot of individuals, etc. I would encourage you to really focus—and I'm happy; I didn't know about the group of primary care providers looking at pandemics—but I would really encourage you, at the end of 2008, when everybody will be on time and on target, to really focus attention as to how we do this in areas that only have primary care as their access to the health care system. Those will be mainly in northern and rural Ontario. This is also where the smaller health units are located.

Thank you. Those were my questions for now.

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The Chair (Mr. Norman W. Sterling): I'll go to Mr. Zimmer now.

Mr. David Zimmer: I have just two short questions. When you read through the report, it's apparent, and also from your remarks, Deputy, that there's been some very sophisticated work and planning done, and all of that sort of stuff, to deal with this issue. But I am struck by how it developed that a third of the local health units were sort of allowed to fall behind; that is, not get their plans up. It seems to me there's a disconnect between some of the very sophisticated work done in most areas, except in that area—the third of the units that have fallen behind. As sort of a lessons-learned exercise, how did that happen? How were they allowed to drift behind?

Ms. Allison Stuart: I would characterize it differently. Each public health unit took on the responsibility of providing leadership for pandemic planning at the local level. Each community proceeds at a pace that makes sense for that community in terms of the various pieces that need to be brought together. For some, it's more challenging than others. Sometimes it's more challenging because of the lack of resources and sometimes it's more challenging because of the overwhelming number of resources and having to coordinate and organize them. So we've been well pleased with the movement forward on the part of all health units because, and I need to say this again, a health unit not having a completed plan does not mean that they're not working on the planning and moving forward. And they have committed that they will be complete this year.

Mr. David Zimmer: When you look at the two thirds that have moved ahead, what are they doing right? Or what are the characteristics that have enabled them to get on with the job vis-à-vis the characteristics of those folks who have fallen behind?

Ms. Allison Stuart: I don't think I could answer that question.

Mr. David Zimmer: My second question: The report, with the Auditor General's report and the other information that we have, goes into substantial detail about

managing the disease outbreak or the infectious disease outbreak. Perhaps it's not the responsibility of the ministry, but what do we do to manage the panic aspect of an outbreak? It seems to me that there are technical and medical and all of those things in place. How does the Ministry of Health address, or who do you work with, in terms of managing the emotional or the public panic that inevitably sets in at an outbreak? How does the panic piece affect the planning for the containment of the disease part of the issue?

Mr. Ron Sapsford: I'll start and maybe Dr. Williams can add to it. I think the first and most important thing is having the right information and having the communication capacity and the communication tools available for public communication. That clearly becomes a combination of the clinical information: What is the disease, how is it spread, what are the circumstances, its severity? In many cases, you don't know the answers to those questions until you're faced with a particular virus and a particular outbreak. So ensuring that we've got the appropriate communication capacity and known process, who needs to be communicated with and how: That, clearly, was a lesson that was learned from SARS.

The second is that the structure and process that the government as a whole have set up subsequently is meant to address some of those public concerns. Now, when an emergency is declared, the role of the Premier and cabinet, the various ministries in terms of their role and responsibilities, right down to individual positions, such as the chief medical officer, who communicates on what set of questions people communicate and how that communication is to be formed and then how it is to be given in an orderly fashion so that there are clear and consistent messages to the public—how the communication is created and who communicates are all part of the overall provincial emergency plan.

The specifics of the fear or reactions, to a large extent, are going to depend directly on what the virus is that we're confronted with, and clearly that falls into the clinical domain, in terms of how one responds to it and what specific actions are required as a result of it.

Dr. David Williams: I agree. The key thing is that there's a basic triad we talk about, with risk assessment, risk management and risk communication, and you have to work at all three at the same time and then integrate those together. We've made great strides to improve on those tools. For example, the IPHIS tool itself improves the surveillance knowledge base.

Right now, the public is bombarded by lots of commentary from everywhere and they're looking for clear information that's consistent, correct, that has some validity and, certainly, speaks with some authority. So part of our challenge is, first, to quickly gather that information and make sure our surveillance data is timely, correct and accurate; the messaging is consistent, working closely with communications at local levels as well as centrally—that means we have to communicate well within to make sure we are all on the same page at the same time—and then to be able to say what we're doing to manage at the same time. When you do that communication with the public to deal with their apprehensions, one is to remove the myths, to identify what those are quickly, to get the clear information and data out, what you do know and don't know, as well as what you're doing at that time to handle it and what your next steps are so the public has a sense that the issue is well at hand. We're trying to work with different strategies, if you will, at the ministry and throughout the local health units—working together.

Mr. David Zimmer: Just one brief follow-up: Coming back to the one third of the units that don't have their plan up to steam, what would happen if an epidemic broke out next week in one of those units? Is there a plan for the ministry or someone else to step in and take over, given that they don't have a plan in place? What happens if something breaks out in France's riding?

Mr. Ron Sapsford: That would have to be addressed as part of the overall provincial plan. Part of the responsibility of the ministry during an outbreak, where there are insufficient preparations, is that we would have to step in; the chief medical officer always has the statutory authority to do that in the event of an inadequate response. We would have to marshal resources to apply them to that particular problem.

The Chair (Mr. Norman W. Sterling): Mr. Ouellette?

Mr. Jerry J. Ouellette: Thank you for your presentation. You just have to look at the SARS outbreak or what took place with the new millennium and people buying generators and what happened at those times: People have a tendency to go back within about a month and just "not in my backyard," and I know that shows an I Am Legend or Andromeda Strain kind of mindset of what the expectation would be.

I may be dating myself, but can you just do a Coles Notes version, a walkthrough, of what would happen, say, in the community of Thunder Bay if there's an outbreak there? What would be the process and what would be the determining factors? Walk us through exactly what the expectation would be.

Mr. Ron Sapsford: I'll let Dr. Williams do that for you. The only point I want make is that SARS is not pandemic flu. They're very, very different.

Mr. Jerry J. Ouellette: I'm talking more about the actual reaction of the community in the short term.

Mr. Ron Sapsford: My only point is, generally, there's a common reaction to all of these things, where in fact the response needs to be tailored to what infectious carrier we're dealing with, but I'll let Dr. Williams speak to that.

Dr. David Williams: It is a good question, because all the time there are outbreaks in the province, in Thunder Bay and in smaller communities, and the advantage of the IPHIS tool that we put together is that Ontario retooled the tool and made it into an outbreak module, which means it's live-time case reporting. That means they will then assign outbreak numbers when it goes

above a certain level, and there are clear definitions of what those are.

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Mr. Jerry J. Ouellette: So what would it be in, say, a community like Thunder Bay, just to use it as an example?

Dr. David Williams: It depends on the disease. If you're talking about generals—as the deputy said, if you're not talking SARS, but other ones, because you start off sometimes with syndromic-type outbreaks, so you have an outbreak of a whole bunch of respiratory diseases that are showing up in emergency departments above the normal background—MOHs will address that; they have the extra staff that were added and they have their IPHIS reporting systems. They notify us if they have an outbreak on the go or if they suspect one. They don't have to have definite proof; they just have to have a suspicion of one.

Mr. Jerry J. Ouellette: At what kind of level do they decide that notification is necessary?

Dr. David Williams: For example, if you have a case like measles, we say any more than one case. With another disease, you need a larger cluster, so there are different definitions of different reportable diseases that will provoke an outbreak definition, because the background number is sometimes zero and if you have a case, then you have a concern. An outbreak means that you have clusters in time and place that indicate that there is some transmission going on within the community. There's normal, or it's above a background incidental case. So they will provoke or incur that in the IPHIS system and they will notify. When we identify that, we can then notify the medical officer of health or internal communications that there is an outbreak going on in some setting and they're aware of that.

Then, at that time, we assess to say, "How are they doing on it? Do they need any further assistance from us centrally or from other health units around?" if they were getting into a more expanded one. So you may start with a small one and it expands up. Perhaps another health unit starts to kick in with a report, and then you start to see that you have more than just a single city or a single little outbreak. That's when it starts to ramp up into a larger situation where the province takes on much more of a coordinating role, ensuring that the resources are there, the backup of epidemiological resources to support them, and, at times, acquiring some assistance from other sectors as well. So it's an ongoing, live-time assessment of each one to say, "Is it being handled well? Are all the cases being looked after? Is a medical officer of health, first, from his or her perspective, satisfied that it is going okay, and are we satisfied, or am I satisfied from the evaluation of my staff, that it is being handled in a timely fashion, or do we have to have some further information or more resources put into the issue?"

Mr. Jerry J. Ouellette: In the presentation, on page 6, you mention the Emergency Management Ontario part of the Ministry of Community Safety and Correctional Services. I know that in the region of Durham, they have training for nuclear emergencies, and the police officers and emergency services are trained on a regular basis. Is there training out there for these individuals to know what their role would be at the time of a pandemic taking place in the community?

Ms. Allison Stuart: I'll be happy to answer that. There are exercises undertaken with great frequency. Probably there isn't a month that goes by that there isn't an exercise somewhere in the province that brings together all the parties in terms of, how would they respond in a pandemic? In addition, from a health perspective—just back to the exercise in Durham around a nuclear event—health is involved in that exercise because we've recognized that there's usually a health component to most emergencies, so we stay involved with exercise response.

Mr. Jerry J. Ouellette: So I'm hearing that you're training them on a regular basis to keep them informed of their role. At what point do they become involved in the process for managing a pandemic? Again to use the case of Thunder Bay, just to keep the community, when would they be notified and when would they know? We're going to lead up to the point of, what about the distribution of vaccinations? What is the decision-making process for individuals and where does the process take place, and not only that, but the extent of that? For example, if policing, fire, ambulance and emergency services are part of that, are their family members included in that process, because these individuals are expected, or the health care sector, to be working with these individuals who may be contaminated at the time, and then taking it home. That causes concern for those individuals working in that area. Can you kind of give us a breakdown of how that would be expected to unfold?

Mr. Ron Sapsford: Okay. In the case of a pandemic outbreak, that would result in, one would anticipate, the declaration of a provincial emergency. In that case, through cabinet, there is a central coordinating body which is the responsibility of—corrections.

Ms. Allison Stuart: Oh, MCS.

Mr. Ron Sapsford: Yes, MCS. And the deputy minister there is in charge of coordination of that. That group brings together, then, all the representative ministries that need to be involved in alerting their own sectors: municipal affairs, the OPP, the different parts of the government. Subsequently, they work with their local contacts at the municipal level for fire, police and so forth through the chief medical officer in terms of direction to the health care system and in support of the Ministry of Health to bring the health part of the plan into place.

So the overall provincial emergency plan includes invoking each sector of the government's responsibility and then linking to the local level.

On the question of vaccination, I'll let Dr. Williams answer. But the vaccine production and distribution of that is initially a federal responsibility, so the provinces will respond in terms of vaccination, its availability and distribution as a result of federal decision-making. Then

it's our responsibility beyond that point. But I'll let Dr. Williams talk about vaccination.

Dr. David Williams: If I'm clear—for some aspects around pandemic I'll let Allison comment too—is this vaccination in pandemic or vaccination if it's required in any other outbreaks? Which were you actually—

Mr. Jerry J. Ouellette: Well, just in the pandemic process right now.

Dr. David Williams: Right. We have our annual vaccination program, because a pandemic is an influenza. We have that going on on a regular basis, so health units are heavily involved and so are local providers in giving annual vaccination programs, for use too in Ontario through the universal influenza vaccination program. That has prompted us, and we've grown and matured through that to be able to vaccinate a large percentage of the population within a very short period of time in our annual campaign. So that has ramped up the system to be able to cope with that, both in the primary care office as well as through health units, with mass vaccination clinics when they operate that.

When the vaccine is available, and there are timelines, as the deputy has alluded to, and the federal government has it available to bring out and bring forward, then there is—actually, we've had some exercises, and Allison will probably talk about that, where we've tested through the provision of our annual influenza vaccination program how well we are equipped to be able to move quickly and carry out mass vaccination programs, what the glitches are that we would run into and that we'd have to address. So there actually have been exercises ongoing as we continue to nudge and look at that, as we gain further information from the vaccine manufacturers on how quickly they would have it available, what the restrictions are on that or restrictions we'd have to accommodate to, as well as other things around the mechanical aspects, the supplies and equipment, to carry out a vaccination program at that level. Allison has more to offer.

Ms. Allison Stuart: Just a reminder that the vaccine in a pandemic will not be ready for four to six months after the actual virus has been identified. We're lucky in Canada in that there is a home-grown developer of the vaccine in Quebec. They are committed to getting the vaccine out as quickly as possible, and there are negotiations always ongoing around how quickly. That will then come to the province, and then there's a distribution to the health units.

As Dr. Williams has mentioned, he referenced that in the fall we used the annual seasonal flu vaccine as an opportunity to test, at the provincial level, what we would do if we were trying to get vaccine out in a hurry, as we would in a pandemic and which we're not having to do with such urgency in a seasonal flu vaccine program. As well, we are inviting selected health units to use their annual campaigns to get people vaccinated as opportunities to test the system. We use those as exercises, put wrinkles into the process, so that they could challenge and test themselves in terms of their ability to respond. That material is now being collated and shared with all the health units so they can learn from it.

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Mr. Jerry J. Ouellette: Okay. Any of us who have kids who go to school know that when anybody at school gets something, it goes right through the entire school. What work is being done with the school boards so that they're informed on the process, and how are they brought into this to make sure that one of the key areas of distribution of any disease could be addressed?

Ms. Allison Stuart: One of the public health measures that has been used historically to respond to other outbreaks, but specifically to a pandemic, is to close down those settings where there are a lot of people. As you've identified, schools have a lot of people, and they're not necessarily following all the rules of good hygiene. There are processes in place describing different circumstances and whether or not closing of schools would make a difference. The Ministry of Education has been involved in developing those frames of reference and then will further develop how they choose to proceed with their own pandemic planning. That work is under way, because we've spoken to many, many school boards.

Mr. Jerry J. Ouellette: I know that as a parent we sign off on the iodine pills in order for the schools to administer them in the event of an emergency. Are there sign-off sheets that are required? I know that there is a debate whether vaccinations should be or should not be allowed. Some people want them, some people don't. Do we have any processes in place to make sure that those can be taken account of in advance of anything happening?

Ms. Allison Stuart: The way we are approaching vaccines is if people turn up, they're implying consent. We do have educational material that's always available. Once we have information about the specifics of the vaccine—we won't have a long-term history of the impacts of the particular vaccine in a pandemic because it's new. But people will not be expected to sign individual consent forms in a pandemic.

Mr. Jerry J. Ouellette: Okay. What happens in the case of—the reason I chose Thunder Bay is because it's kind of isolated; I think it has the third-most-serviced airport in Ontario. What happens with infrastructure like train stations, airports, the trucking industry in those areas?

Mr. Ron Sapsford: Your question is what happens. Well, it's hard to—

Mr. Jerry J. Ouellette: I'm talking a pandemic, so all of a sudden you get fears from other jurisdictions saying, "Wait, any flights coming in or coming out." Have you addressed and looked at this issue or discussed it with those authorities?

Mr. Ron Sapsford: Yes. In terms of health's responsibility, we would see the priorities in those cases as distribution of things like vaccines and antivirals, and we're nearly finished a distribution plan which doesn't

rely on those modes of transportation so that we can assure delivery. That is part of our particular plan.

It's really difficult to estimate, though, the impact on infrastructure because it depends upon the size of the outbreak, the virulence of the disease, its transmissibility, and those are all epidemiological estimates. If it's a very huge and large outbreak, up to 30% of the population over the six- or eight-month period—this isn't all at once—it's going to have an impact. It's a question of an estimate of how many people at any one time will not be available to work or will be sick. That's part of the difficulty in the planning itself because you don't know how large you're estimating, you don't know what size or shape it is.

I think, based on the best epidemiology that we've got, the whole population will not be sick all at the same time. It won't happen everywhere all at the same time. As Dr. Williams has said, an outbreak tends to cluster, and then ebb and flow. So at one particular time it may be Thunder Bay for a period of several weeks, and then it will ebb out and normalcy return, but it may then spread to another part of the province. That's why it's important that every part of the province be ready. They each need a plan based on their own characteristics, and then the notion that the province will supplement resources as an outbreak continues and moves.

Mr. Jerry J. Ouellette: What work has been done with the Ministry of Agriculture or the Ministry of Natural Resources for transmission? Obviously we hear a lot in the news about the now-infamous bird flu virus that's taking place around the world. What's happening, or what relations are being taken into consideration to address that specific strain or impact?

Dr. David Williams: Over the last two years, we have been meeting regularly with those sectors. The chief veterinary officer and myself chair a committee that has a number of other subcommittees that work with it so that we will have a response if there's—

Mr. Jerry J. Ouellette: Who's on those subcommittees or what ministries are represented?

Dr. David Williams: We have the Ministry of Natural Resources, OMAFRA—agriculture and food—and public health as well to look at that, and representatives from the federal level. That would give us some insight and information on that in the laboratory services.

There are various subcommittees, including some other ones that look at wild bird surveillance tools. We've been doing some in conjunction with that organization as well to monitor, in conjunction with the federal surveillance program. We have that response planned to look at these test cases: If there's an avian case, how would we walk that through? Allison and myself have been involved with some conferences at the federal level to see that we work in conjunction with all their planning because when that occurs there are federal agencies that come in and start—CFI has a very prominent role to play; we've had meetings with them as well, working on information sharing, how we would then team up to work on that. There's been a fair amount over the last two years, of course, as you noted, with all the interest in it; a contingency plan on how we would respond, including in-service and discussions at meetings with the medical officer of health, and sharing of experiences with some who have the same thing out in Saskatchewan and British Colombia and what they experienced in their outbreaks of suspected avian.

Ms. Allison Stuart: If I could just add to that, the Ministry of Agriculture, Food and Rural Affairs has an avian plan, so if there is an outbreak, they have a plan in place. We have a complementary plan to deal with the human impacts of an avian influenza outbreak so that we're supportive of each other. We have a GIS system, whereby we can get, in the case of an avian flu outbreak, a picture of the province and where all the farms are that have whatever the vulnerable animal population is, as well as relating it to where wetlands are—so where the wild birds are landing and if there are farms around it etc. We've worked really closely to try and have a seamless response.

Mr. Jerry J. Ouellette: Okay. That's the majority of my questions for now, Chair. Thank you very much.

The Chair (Mr. Norman W. Sterling): Can I just ask a couple of basic questions? The antiviral drug we are purchasing now costs about $25. Sort of doing rough math, it's about $25 a person; is it? Seventy-three million—three million is a quarter of the population, so it would be about 25 bucks a person?

Ms. Allison Stuart: It's actually $23.33 for a treatment course.

The Chair (Mr. Norman W. Sterling): A treatment course, so that might be one or two or whatever number of—

Ms. Allison Stuart: That's actually 10 pills over the space of five days.

The Chair (Mr. Norman W. Sterling): And what is the shelf life of the drug?

Ms. Allison Stuart: I know where you're going. Five years.

The Chair (Mr. Norman W. Sterling): So the government is continually purchasing this in order to keep the drug enough in advance in terms of the manufacturing etc.?

Ms. Allison Stuart: None of our drug is out of date, but we will be approaching a time when our drug will be out of date. We're working with Public Health Agency Canada and Health Canada in terms of looking at whether the shelf life can be reviewed in terms of keeping it longer or whatever. That would obviously be a science decision, not a bureaucratic decision.

The Chair (Mr. Norman W. Sterling): Can a person purchase this privately?

Ms. Allison Stuart: Yes.

The Chair (Mr. Norman W. Sterling): Do they do that from the drug company, or do they do that from the government of Ontario?

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Ms. Allison Stuart: They would need to have a prescription from their physician, and then they could get

it filled at a drugstore, either paying themselves or through their insurance plans or whatever.

The Chair (Mr. Norman W. Sterling): If something happens and there is some identification that there is a problem, would a mother, let's say, in the west part of Ottawa, the area I represent, be able to go on the website and view what her options are for her family—small children, medium-sized children, older children, husband, mother—whom she should contact in that area, the phone number, the location of where those particular services would be?

Ms. Allison Stuart: I have to give a somewhat cautious response here, but that's the end point that we're aiming for at this stage. One of the reasons why we're looking at the flu centre is that we will be able to say, "Don't go to your family physician if you have the following symptoms; go to the flu centre," which then allows the family physician to carry on with regular business and ensures an expedited response for the individual or their family members with symptoms.

Also, in some of the material—I think it's this one—we do give advice in terms of how to respond. We also have further advice on our website and are developing it further, and that will include the ability to look at symptoms. Depending on which symptoms you tick off, you'll get a pop-up response that says, "For this, do whatever."

The Chair (Mr. Norman W. Sterling): We're all MPPs sitting in this room talking to you today. When a constituent doesn't get a service, sometimes they come to us and say, "I didn't get this service. I was turned down." I guess the number one question is, is your proposed critical care triage tool a public document now?

Ms. Allison Stuart: The triage tool has been public for two years. It's been in two different iterations of the pandemic plan. It got some particular exposure when there was an article written about it for the Canadian Medical Association Journal and it was picked up by some of the media. We're doing some limited public consultation on the proposed triage tool right now. We've completed one group, and we'll have another one coming up, to get a public response, and we're getting interesting feedback from the public in terms of how they want to know about it, when they want to know about it, that sort of thing.

The Chair (Mr. Norman W. Sterling): So if a constituent of ours gets a "no" answer to treatment or the vaccine or whatever, what are his or her remedies?

Ms. Allison Stuart: One of the messages that we have to work very hard to ensure that the public hears is that if you're not a candidate for critical care in a hospital, that does not mean you're not a candidate for treatment. It just means you won't be getting the critical care aspects of treatment. So there will always be treatment available.

For most people in a pandemic—and Dr. Williams will kick me under the table or nod if I get this wrong, but I think I have it right—the flu will be a flu. You'll feel miserable for a period of time and then you'll get better. That's how most people respond. For those people who don't respond that way, there will be the ability to access treatment, whether it's through a flu centre, whether someone's ill enough that they must go to an emergency department or whatever.

The plan, in terms of the vaccines—and this is a national plan—is that there will be enough vaccine for everyone. It won't all come at the same time, but there will be enough vaccine for everyone.

The Chair (Mr. Norman W. Sterling): Regardless of the treatment that the person is seeking, and they are told no because of the critical care triage, is there an appeal process? Who has the final word? Is that defined? In other words, do we go to the medical officer of health for our particular area and say, "My constituent has been denied"—and maybe rightly so. There have to be decisions and we may support that, but notwithstanding that, we still have to advise as to the remedy.

Mr. Ron Sapsford: The purpose of developing the tool is as a clinical tool. The decision-making around who gets critical care or intensive care is still a physician's decision. The purpose of the tool is to help clarify the clinical criteria that physicians in, shall I say, a more equitable way will use in coming to those medical decisions. It's not something external to the decision about who requires care and treatment and at what level. It's trying to pre-plan for, in the case of a virulent flu, the clinical indicators that one would use in making a decision about the necessity of having critical care. That's one piece of it.

The second piece of it is the surge question that was raised. It's not only about who clinically needs access to critical care, but how we expand the capacity of an institution to provide that level of care in the case of a pandemic: what human resources, what other kinds of supply resources, where in a facility that expanded capacity would be developed, what impact that would have on things like admission policy under those circumstances. That's the other piece that we're testing in the Champlain part of the province. And then based on those results, the intention would be to move that across the province. It's essentially a clinical decision.

The Chair (Mr. Norman W. Sterling): But there is no appeal for this? Essentially the answer to the constituent is, "Go to another hospital."

Mr. Ron Sapsford: "Get a second opinion," like I hear you saying.

The Chair (Mr. Norman W. Sterling): I'm assuming that will happen and things will just pile up.

Mr. Ron Sapsford: Yes.

The Chair (Mr. Norman W. Sterling): Okay. Further questions.

M^me^ France Gélinas: I would like to ask a few questions about the second key issue that was identified in the report. That was concern that the tool—we're talking about the triage tool—had neither been tested nor submitted for public consultation. As I was listening to your answer, I think I got that you have completed public consultation with one group and intend to start another one. Was I right? This is what you said?

Ms. Allison Stuart: Yes. We're doing some limited public consultation. The process that we've used is quite intensive in that we have people come in for a day, because you can't really just phone somebody at dinnertime and ask them what they think; you really have to do a lot of education around it. The public consultation is still under way. There has been extensive consultation through the process of developing the tool with the critical care sector. The next step is to take it beyond the critical care sector.

We are also doing a study right now where in one critical care unit, after the fact, they're looking at applying the triage tool and seeing whether it matches up with what really happens to people, and that's another way of measuring its success. Clearly, when you're talking about life and death in a critical care unit, you're not going to be trying out the tool directly on people. That's sort of our proxy for doing that.

M^me^ France Gélinas: Could you just expand a little bit? I'm guessing people come to Toronto for a full day for those consultations. How are they chosen? What happens?

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Ms. Allison Stuart: I can speak to a bit of it, in terms of the process. Our first consultation was in North Bay, actually. We brought people together. The people were selected at random to reflect the population. They came in for a day. First, they were asked some questions and they filled in a questionnaire. Then they were given some orientation to pandemic and what it was all about and so on and so forth. They worked in small groups and were asked to answer questions. There wasn't a right or wrong answer; it was just "What do you think?" There was some further work done with the larger group, in terms of explaining the triage tool and how it was developed and so on, then breaking out into smaller groups, answering some more questions and then bringing it back to the larger group again.

M^me^ France Gélinas: So you have done one of those and you intend to do one more?

Ms. Allison Stuart: Yes.

M^me^ France Gélinas: Where will it be held?

Ms. Allison Stuart: It will be done in the GTA.

M^me^ France Gélinas: I don't know if you were there, but were there any representatives from the First Nations and the francophone population in North Bay?

Ms. Allison Stuart: Yes.

M^me^ France Gélinas: Are there some preliminary results that you could share with us? Do you know what came out of those consultations?

Ms. Allison Stuart: Not at this time. It would only be my personal recall.

M^me^ France Gélinas: You also said, "A pilot study by health care professionals is also in progress to test the best method of gauging the critical care tool's efficacy. Results are expected later." I'm just reading from your document. Could you give this committee a little more detail as to how this is done?

Ms. Allison Stuart: Sure. What's happening is that after people have been admitted to the critical care unit and are discharged one way or the other, their file is brought to two people who survey the file and say, "If we saw this person as being a potential candidate for admission to critical care and we applied the triage tool, would they be admitted, would they not be admitted," and then compare it to the outcome—did this person survive, did they die, those sorts of things.

M^me^ France Gélinas: I'm not familiar with that type of research, but is this how other jurisdictions test? Basically, a tool assists you in making a decision. It wouldn't take away the judgment by a professional. Am I right?

Ms. Allison Stuart: Part of the discussion that's under way right now among the professionals is whether a professional who is not involved with the care of the patient should look at what is presented or whether the person who is caring for the patient should do that. Now, before a patient gets into most critical care units in the province, the patient is assessed by the critical care team as to whether it's an appropriate place for them. So it would be similar to that process.

M^me^ France Gélinas: The last one you talked about was a pilot project in surge capacity planning that's going on in the Champlain LHIN. Has anything come out of this yet that you can share with the committee?

Ms. Allison Stuart: That one is not really a test. It really is, how do we develop surge capacity for something other than a pandemic; if there's another kind of event, like a train derailment, how do we develop, how do we want to do it in our area? They've been developing those mechanisms within that LHIN and it will, at the appropriate time, be shared with others.

M^me^ France Gélinas: I forgot to ask a question when we were talking about the health unit. I know that there are some First Nations communities that receive services directly from the federal government, usually through a nursing station etc. Are those also mandated to report back for the IPHIS tool, or are those populations not included?

Dr. David Williams: We have worked out a relationship both with Health Canada and the First Nations and Inuit health branch so that when the reportable diseases come back—because they'll usually use our laboratory systems in Ontario, and the laboratories are required to report to the medical officer of health in their jurisdiction—we transfer that information to the counterpart in the First Nations community and then they take action on that, and we have an arrangement as to whether we will incorporate that into our IPHIS report or if they would like to report them in aggregate to us. There are arrangements to work with the various First Nations health care providers, because some have self-government status and some have it, as you said, through the federal government, as well. So there are varied arrangements depending on the provider.

M^me^ France Gélinas: Are they part of the health unit's pandemic planning exercise?

Dr. David Williams: They are invited to be part of that. I know that in the northwest there were representatives on the planning committee who became involved with that. Certainly, it's a major concern to have them present at the table to address their unique concerns and issues, in conjunction with the federal officers who have jurisdiction in that area.

Ms. Allison Stuart: I'd just add that we do have a chapter in our pandemic plan for First Nations communities. It was developed in conjunction with First Nations communities and was signed off by the First Nations communities and is being used in other jurisdictions now.

M^me^ France Gélinas: There are some First Nations communities that get their services from the Ontario government, and to me that was kind of a given. I just wasn't sure about the First Nations and Inuit who get their health services directly from the federal government. Those are also included in that chapter?

Ms. Allison Stuart: Yes. And there is a commitment in place that antivirals for treatment purposes and vaccines will be made available through the Ontario supplies.

The Chair (Mr. Norman W. Sterling): Do we have further questions?

Mrs. Laura Albanese: What has been done to ensure that there will be enough health workers in the case of an outbreak?

Mr. Ron Sapsford: There have been a number of things put into place. Initially, concern around the care of workers who are providing care to people who are ill—so the stockpiling of protective equipment, such as the N95 masks, gloves, gowns, that are specifically directed at health care workers. The principles in the Occupational Health and Safety Act are also being incorporated so that maximum protection can be provided for health workers.

Again, I think it's important to recognize that if this is a pandemic influenza, health workers will become ill, not specifically from their work environments, but simply because this is a disease that's spread in the community—so the notion that their child comes home from school and that's how they contract the disease, not by providing care on a hospital ward. It's important to recognize that health care workers are just other members of the population in the face of pandemic.

There are still some outstanding questions that need to be addressed: the use of antivirals for prophylaxis. Our stockpile is related to the treatment of people who are actually ill. There is still the question, and it's on the federal-provincial table, about the use of antivirals as a preventive measure. This is principally a scientific question, and there is no unanimity on the view. Nevertheless, there's a policy question that needs to be addressed. That would be another aspect of it.

I think in this province, particularly, the heightened sensitivity of our health care community as a result of SARS has increased the level of vigilance, not only in the ministry, but also in health care facilities. Certainly, the professional associations, the colleges of our health care professions, are all well aware and concerned. So the level of co-operation and diligence that different health care association groups are providing to this question of health workers' safety has been very helpful for the ministry in establishing the broad policy outlines for the pandemic plan.

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The hand-washing program that we've developed, the development of the pandemic networks across the province—all of these initiatives are directed at health care workers and their health and safety as well.

Finally, there's the question that was raised about volunteers, recognizing that health care workers will get sick and the question of, how does one maintain service? So the notion of being able to, in a cautious and prudent way, move health workers to areas of need is another area that we're looking at to support health care workers. There are legal, regulatory and liability issues involved in those kinds of questions, but we have engaged in that debate with the colleges initially because, to a degree, this is a question of licence, availability and appropriateness.

As well, we are looking at scopes of practice, and in the face of a pandemic there is quite a rigid set of rules about who can do what to whom and when: In terms of medical treatment in the face of pandemic, are there any of those regulatory or policy barriers that need to be relaxed a little bit, simply because of the volume of care and service that would need to be provided, particularly in areas like vaccination, which to a large extent is a pretty straightforward procedure? Are there ways that we can maximize the use of all health professions in those particular circumstances? That's a piece of work as well that we're undertaking with the colleges.

Mr. Jerry J. Ouellette: Just one quick question. You had mentioned, when the Chair asked you about the shelf life of vaccinations, that it was five years. Every year, they inform us that there's a new strain out so we need a new vaccine. How does that play into the goods that are on the shelf waiting, as new strains come out every year?

Mr. Ron Sapsford: We're, first of all, talking about two different things. The annual flu cycle does not fall within the definition of pandemic. So I'll let Dr. Williams talk about the vaccine piece.

Dr. David Williams: Just to be clear, though, you're mixing up the antiviral versus the vaccine. It's the antiviral that has the five-year shelf life. It has a broad spectrum approach for all, and it's being assessed all the time to say, "Are there any resistant strains coming forward for that particular drug?" So that's why they picked the one in particular that we've stockpiled. And we have another portion, which Allison can talk to. We have two types. That's different from the vaccination.

The vaccination—annually, of course, they project which ones are going to be circulating in the next upcoming year. They monitor that, as they come in, in cases to see the content of the vaccine that's prescribed by WHO. The vaccine manufacturers put it together and we carry out the program in the fall. Then, as cases come

forward: "Is it a good match? Are there any strains that are coming that are different from that?"

Mr. Jerry J. Ouellette: Right. So the antiviral, though, will affect all strains?

Dr. David Williams: There is ongoing monitoring, yes. One of the questions right at the start will be, "Is it sensitive or not?" They can do that fairly quickly. When you first identify a strain of a pandemic, as the deputy was saying, as compared to annual flu, they can do some microbiological testing, saying: "Is it sensitive to all types of antiviral drugs; these ones in particular? Are there any concerns?" That'll be one of the things that happens most quickly.

Mr. Jerry J. Ouellette: So how would we know—if we have a stockpile of 25% for five years—if we have the right stockpile?

Dr. David Williams: So far, the main one we've stockpiled has shown itself to be very robust in being effective in most of the cases that have come up for it on that one, and knowing it's going to be an H1N1, most likely, it will be sensitive to that.

At the same time, nothing is 100%, and we have to be cautious. We have to depend on asking those questions and say, "Can you ensure that it is really sensitive?" because it would be of no value if it was resistant. To do that, we want to make sure we have the other options available to us to be able to advise accordingly. But so far it's met the test. There have been some blips and questions on a few things, but that's part of the testing of the system of the monitoring and evaluation on a live-time basis.

Mr. Jerry J. Ouellette: Can you project five years from now what sort of strains may be peaking at that time?

Dr. David Williams: Knowing that the pandemic, because of what it is, will not be one that will be surging—it will be so different; that's what a pandemic is. It's a type of strain that is quite antigenically different; people's systems have not had any ability to build up some cross-protection, in the true definition.

Now there is the question—because now, unlike 1918, we're vaccinating people on a regular, annual basis. They have a degree of exposure. Do they have some partial protection? They may, but no one knows, because you're correct. When the pandemic—because it is a pandemic, we won't know that strain. All of a sudden it will start to move through the community fairly quickly and demonstrate a lack of resistance among the population. That's one of the indicators of a pandemic.

Ms. Allison Stuart: If I could just add to that, I've asked similar questions a lot of times of a lot of people. One of the responses that I found helpful was, when we talk about a pandemic, we're talking about a flu pandemic; that's what we're talking about and planning for. To this point in time, even with the year-to-year changes that go along with the virus itself, the antivirals have been effective. As Dr. Williams has said, they may not be 100% effective, not a perfect fit, but they're a good enough match to at least mitigate the impact of the illness.

The Chair (Mr. Norman W. Sterling): I was getting a little bit confused, perhaps. The antivirals, the pills that you talked about before—if something happened, I guess we would do an analysis of what the influenza is, and we would then decide whether we were going to use the pills or we weren't going to use the pills. Is that correct?

Ms. Allison Stuart: There are a couple of things: It is unlikely that the pandemic is going to start in Canada, so we will have the benefit of wherever it does start and the time lapse there, and we'll know whether the antiviral is 100% effective or something less than that.

The Chair (Mr. Norman W. Sterling): Let's say that it's not effective or something less than that; let's say that it's a very low effectiveness rate. Do we then vaccinate people with something? What's after that?

Mr. Ron Sapsford: There are two parts to this: The antiviral is really to lessen the impact of the disease; the vaccine is to vaccinate against it. We'll do both.

Once the virus is identified, the scientific community works as hard as it possibly can to make the vaccine. Then it's a question of how long it takes to produce the vaccine in sufficient quantities to distribute, and then proceed with the vaccination. The antiviral is only in the presence of the disease. I might add that you'll vaccinate everybody because you want to give people the protection against contracting the disease, because everybody won't get it all at the same time. The object is to produce the vaccine in sufficient quantity and time to inoculate those members of our population who have not contracted the disease, and hence give them protection against it. The antivirals you use only when people are sick with the disease. As Allison has said, our hope—and I have to tell you that this is our hope—is that it doesn't occur here first, because we will then know that people have contracted the disease, the pills will be given, and then the effectiveness of the pills will be known one way or the other. If, as you've suggested, Chair, they don't work for this particular strain, well then, you can't find other antivirals quickly because there's only a limited range. Then you have to wait until the vaccine itself is ready to inoculate people.

So there's that period of time between identification of a disease and the time it takes to make the vaccine where we have to be particularly vigilant, because this is the period of time when people will be getting ill, and in the face of no antiviral effectiveness, then you're simply coping with the disease with just normal clinical care and treatment of people who have the flu.

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The Chair (Mr. Norman W. Sterling): Okay. Further questions?

M^me^ France Gélinas: The first one has to do with the flu centres. The auditor said they were undecided whether to create them or not. Then in your report, you mentioned that the majority of health units are already working on flu centre planning. Are flu centres going to be mandatory in every plan of every health unit?

Ms. Allison Stuart: The flu centres are recommended. We would need to be told what the alternative arrangement will be that will fulfill the same purposes as the flu centre. By the way, Sudbury has a great plan.

M^me^ France Gélinas: I know.

Ms. Allison Stuart: A great plan.

M^me^ France Gélinas: The second one is—I forget; I think it was the fourth key issue by the auditor—that one third of public health units are without a full-time medical officer of health, and also, the vacancies in the public health division lab. How confident are you that all of these positions will be filled in the short term?

Dr. David Williams: Right now we're taking all sorts of steps to try and get those positions filled. We're in a very tight, competitive market and there are shortages across the whole country.

There are different training venues: fellowships in community medicine or for those who obtain a masters in public health. We have stipends that can be made available for those physicians who want to undertake systems of training. We're having discussions with the college on aspects around scope of practice, which is of concern right now, and transfer there; issues around licensing, because they need to be licensed in Ontario, and then those aspects that we have to go through to facilitate that from some different countries and aspects there.

Of course, we're continuing to have education sessions with students going through medical training, to help them see the light in coming to public health and to convince them of that. We've had a number of people applying to come over and take the training for a master's program, and there are various methods of taking it. They can take some part-time and full-time in going toward that status.

We have a number of people who have been applying and coming forward, so that's encouraging. But again, it is a very tight, competitive market. We're short in a number of specialties, so we're having to compete with that. We're working at different methods to fulfill that. At the same time, we have the potential to get support if we need to, to help out in certain situations.

M^me^ France Gélinas: Right now, we're almost in April 2008, end of March 2008. Is the situation better or worse than when the auditor did his report?

Dr. David Williams: We have two more who have entered the program in training, and I've met a number of the new acting ones. I was pleased at the number of new associate medical officers of health and the number of students who are coming through the university program. I'm encouraged by those who seem enthused about getting into it, but it does take some time to address. We're slightly better, but there are always people who end up retiring. It's like a revolving door in some cases to try and keep up with that.

M^me^ France Gélinas: I forget how many—are there 48 health units right now?

Dr. David Williams: Thirty-six.

M^me^ France Gélinas: It's lower, sorry. Do you know how many are presently recruiting?

Dr. David Williams: Yes. We have an active list and they notify us either when there is a medical officer of health leaving or when they are going through the recruitment process. We give them the tools and assistance on how to carry out that recruitment process. As well, they give suggested names to my office, people they would like to be considered as potential candidates. Then we review their qualifications etc.

M^me^ France Gélinas: Are things getting better?

Dr. David Williams: They are a little better than they were when the auditor a few months back—I've had some different ones resigning.

M^me^ France Gélinas: But we're not celebrating yet.

Dr. David Williams: It's moving back and forth on different ones. It's pretty well still about a third, but there are some coming up the ranks, so it's slightly better. I would say it's the picture at this time.

M^me^ France Gélinas: You've put in place some longer-term efforts to change this through what you have in your report, but basically it's still very tough?

Dr. David Williams: It's tough going. We're trying to do our best to look at any way we can to continue to improve that situation.

M^me^ France Gélinas: I was also looking at acquiring the 55 million N95 masks. You state in your report, "Over 60% of this stockpile is expected to be in place by the end of this month." Do you have a target date as to when 100% of the stockpile will be in place?

Ms. Allison Stuart: The limitations in terms of building the stockpile have in large part been due to the availability of the product. We are purchasing the equivalent of—I've got to get this right—10 years' normal use of N95 respirators. We're purchasing them in bulk, so we're having to work with the manufacturers in terms of availability. We'll continue to chip away at it until we have it done. We've done that 60-odd per cent this year, so that's very good.

M^me^ France Gélinas: Would you think you'd be at 100% by next year at this time?

Ms. Allison Stuart: I would hope so. It's a matching of resources—the resource of the N95 respirator, the funding—all coming together and then proceeding.

M^me^ France Gélinas: I have never used that term "respirator." We always called it a mask. Am I talking about the same thing?

Mr. Ron Sapsford: They're special masks. They're form fitted.

M^me^ France Gélinas: The same N95 we used during SARS?

Ms. Allison Stuart: Yes.

Mr. Ron Sapsford: Yes, that's right.

M^me^ France Gélinas: We had a really tough time getting them. We ended up getting them at Home Depot during SARS.

Mr. Ron Sapsford: As Allison has said, when we put in the massive order that we have, it's a question of the production capability and actually getting them. The

companies involved now know what our requirements are and are beginning to adjust accordingly. On this one particularly, we're also—because of this 10-year supply issue—interested at the same time in having a way to circulate a proportion of that so that we're constantly renewing it as opposed to setting it aside and letting it age. That's a part of the discussion. We're not quite through that yet, but we want to do it in a way so that it's replenishing itself as opposed to simply sticking it in storerooms. There are some complications around creating a supply in the first place that we're working through at the same time.

Ms. Allison Stuart: The N95 respirator, by legislation, must be personally fit to a person's face. Our deputy is not able to have an N95 respirator yet that fits him properly, but we're still working on it.

Mr. Ron Sapsford: I don't do masks.

Ms. Allison Stuart: The respirators we are purchasing are matched to the respirators that the field is stockpiling for their own use, because there's no point in us having a different kind which would require everybody to be fitted over again.

M^me^ France Gélinas: I remember during SARS, we had a nurse who was trained to assess you to make sure that your mask was well fitted. Will we have to go through that on an ongoing basis during a pandemic?

Mr. Ron Sapsford: For health care workers, in terms of their own planning and their own ongoing control of infectious diseases, yes, they need to know their fit, and that testing is part of the process that goes on. For those health workers who haven't had it, then yes, that's the requirement. In order to use it appropriately, it has to fit appropriately. That's an ongoing requirement.

M^me^ France Gélinas: Those are my questions. Thank you.

The Chair (Mr. Norman W. Sterling): Thank you very much. Any further questions from any members of the committee? If not, thank you very much for appearing.

Mr. Ron Sapsford: Thank you.

The Chair (Mr. Norman W. Sterling): The committee will meet in camera immediately after in terms of trying to give the researchers some indication of what might be included in our report on this hearing. Thank you very much.

The committee continued in closed session at 1130.

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