Legislative Assembly of Alberta

The 27th Legislature
First Session

Standing Committee
on
Health

Monday, November 3, 2008
5:51 p.m.

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Standing Committee on Health

Horne, Fred, Edmonton-Rutherford (PC), Chair
Pastoor, Bridget Brennan, Lethbridge-East (L), Deputy Chair

Dallas, Cal, Red Deer-South (PC)
Denis, Jonathan, Calgary-Egmont (PC)
Fawcett, Kyle, Calgary-North Hill (PC)
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Notley, Rachel, Edmonton-Strathcona (NDP)
Olson, Verlyn, QC, Wetaskiwin-Camrose (PC)
Quest, Dave, Strathcona (PC)
Sherman, Dr. Raj, Edmonton-Meadowlark (PC)
Swann, Dr. David, Calgary-Mountain View (L)
Vandermeer, Tony, Edmonton-Beverly-Clareview (PC)

* substitution for Rachel Notley

Also in Attendance

Oberle, Frank, Peace River (PC)
Rogers, George, Leduc-Beaumont-Devon (PC)
Sandhu, Peter, Edmonton-Manning (PC)
Woo-Paw, Teresa, Calgary-Mackay (PC)

Department of Health and Wellness Participants

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Gerry Predy	Acting Chief Medical Officer of Health

Support Staff

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Erin Norton	Committee Clerk
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5:51 p.m. Monday, November 3, 2008

[Mr. Horne in the chair]

The Chair: Good evening, colleagues. I'd like to call this meeting of the Standing Committee on Health to order. My name is Fred Horne. I'm chair of the committee. Seated to my right is Bridget Pastoor, the deputy chair. Before we begin, I'd just like to take a moment to go around the table and give committee members and staff an opportunity to introduce themselves as well as any members of the Assembly who are not members of the committee who have joined us this evening. I'd ask them to introduce themselves as well for the record.

Mr. Rogers.

Mr. Rogers: Well, thank you, Mr. Chairman. George Rogers, Member for Leduc-Beaumont-Devon. I'm not a member of this committee but very interested.

Dr. Sherman: Raj Sherman, Edmonton-Meadowlark. I am a member of the committee.

Mr. Vandermeer: Tony Vandermeer, Edmonton-Beverly-Clareview.

Mr. Dallas: Good evening, everyone. Cal Dallas, Red Deer-South.

Mr. Olson: Good evening. Verlyn Olson, Wetaskiwin-Camrose.

Mr. Denis: Good evening. Jonathan Denis, MLA for Calgary-Egmont.

Mrs. Kamuchik: Louise Kamuchik, Clerk Assistant, director of House services. Good evening.

Ms LeBlanc: Stephanie LeBlanc, legal research officer with the Legislative Assembly Office.

Ms Friesacher: Melanie Friesacher, communications consultant with the Legislative Assembly Office.

The Chair: We'll introduce our guests in just a moment.

Mr. Oberle.

Mr. Oberle: Thank you. Frank Oberle, not normally a member of this committee.

Mr. Quest: Dave Quest, MLA, Strathcona.

Ms Woo-Paw: Good evening. Teresa Woo-Paw, Calgary-Mackay, not a regular member of this committee.

Mr. Mason: Brian Mason, Edmonton-Highlands-Norwood. I'm sitting in for Rachel Notley.

Mr. Fawcett: Kyle Fawcett, MLA for Calgary-North Hill and member of the committee.

Mr. Sandhu: Good evening. Peter Sandhu, Edmonton-Manning, a member of this committee.

Ms Norton: Erin Norton, committee clerk.

Dr. Massolin: I'm Philip Massolin. I'm the committee research co-ordinator, Legislative Assembly Office.

The Chair: Thank you.

To our guests: we have a couple of routine items to take care of first, and then we'll formally introduce you.

Ladies and gentlemen, if I can refer you to the agenda, item 2, approval of the agenda, I'd ask for a motion to approve the agenda as circulated. Mr. Vandermeer. Any discussion, changes? Seeing none, those in favour? Opposed? That's carried. Thank you very much.

Item 3, adoption of minutes of our meeting of October 15, 2008. May I ask for a motion to approve the minutes as circulated? Mr. Quest. Any discussion, changes, additions, deletions? Seeing none, those in favour? Opposed? That's carried. Thank you very much.

We move to item 4 now. I'd like to begin by welcoming the Hon. Ron Liepert, Minister of Health and Wellness, and also Dr. Gerry Predy, acting chief medical officer of health with Alberta Health and Wellness. Thank you, gentlemen, both, on behalf of the committee for accepting our invitation to attend this evening to discuss public health issues.

Just for the record I'll remind members that Minister Liepert and Dr. Predy are here pursuant to a motion passed at our meeting of September 10, 2008. That motion entailed that they be invited to attend and respond to committee members' questions regarding the delivery of public health services in Alberta.

Just a few words, and then I'm going to invite the minister to make some opening remarks. In terms of the process for the balance of the meeting you'll all have received an e-mail from me prior to today. In consultation with the deputy chair what we've decided to do is adopt a process similar to that used in the Public Accounts Committee. That means that we will be alternating questions between opposition members of the committee and government members of the committee. We will do so until all members of the committee who wish to ask a question have had the opportunity to do that, at which time, if there's time remaining in the meeting, we'll open it up to other members of the Assembly who have joined us and give them an opportunity as well. We will ask each member to offer only one main question, followed by one supplementary question. In the interests of accommodating everyone's participation, I'll just respectfully ask at the beginning if we could be as concise as possible in both the questions and the answers so we make the most of the time that we have available this evening.

I will keep a speakers list here, assisted by the clerk and the deputy chair, and we'll move through it. We have allocated approximately an hour this evening for this portion of the meeting. We'll see where we stand at the end of the hour. Because another item that was to be on the agenda tonight has been cancelled, if our participants are willing and there is a bit of time remaining, we may ask for the option to continue for a few extra minutes. But just so everyone knows, we're working with about an hour's time frame.

Before I call on Minister Liepert, are there any questions or concerns on behalf of committee members with respect to the process? Okay. I'll thank you all in advance for your co-operation and turn it over to Minister Liepert.

Mr. Liepert: Thank you, Chair. It's our privilege to be here tonight to answer questions on – let me put it this way. I see this as a policy field committee of the Alberta Legislature. There are, I'm sure, lots of questions relative to policy, and I'm more than happy to field those questions. I will try and do my best to answer questions as they relate to the delivery of our public health initiatives in the province, but I think it would probably be most appropriate for me on those occasions to call on Dr. Predy.

I'd just like to give my thanks to Dr. Predy for his role as acting chief medical officer of health for the province. I think he's done a superb job in the time he's been here. We will be in a position, I would think, within about 30 days to have a final selection for our permanent chief medical officer of health. Those interviews are under way. We had, certainly, once we rolled out our new model for public health at the end of September, a better understanding by those who might be interested in the position as to the exact reporting process and all of the other duties that would fall under the chief medical officer of health. I don't even know whether Dr. Predy has applied, and I don't think it's appropriate to ask him if he did, but I would just like to publicly put on record that I appreciate very much the work that he has undertaken in the time that he's been acting chief medical officer of health.

I don't have any other opening comments, Mr. Chair. I think we want to try to answer as many questions in the time frame that we have, so I would turn it back to you.

The Chair: Thank you very much, Mr. Minister.

Our first question this evening is from the deputy chair.

Ms Pastoor: Thank you very much, Mr. Chair. I think I'll probably open with the question that started this off in the first place. If you don't mind – indulge me – I'm going to probably put the question and the supplementary question together. Why did the four medical officers leave all at the same time, and if salary was a factor, how did their salaries compare to others across the country? It was a peculiar coincidence that they all were worried about salaries at the same time. What was the relationship between that and the syphilis outbreak?

Mr. Liepert: Well, there's more than one question and one supplementary there.

Ms Pastoor: Yeah. Sorry.

Mr. Liepert: Let me try and recall what the questions were and answer them. First of all, the four doctors that you mentioned were all on contract. We have a number of contracted employees with the Alberta government in our department and in others. A contract has a start and an end time. When the end time is approaching, discussions obviously begin on whether new contracts should be negotiated, will be negotiated. That was the process that took place. I have made it pretty clear publicly that we were unable to negotiate contracts with the four contracted employees.

6:00

I'm not going to get into details of individual personnel. There were some extenuating circumstances with at least two of the individuals, who I won't say chose not to renew their contracts, but there were at least two of them who had other pursuits at that time. In the case of the other two we simply could not agree on a contract going forward. I'm not going to get into any other details than that because that is an issue around human resources that I'm not going to engage in public discussion around.

Could you rephrase the last part of your question?

Ms Pastoor: What was the relationship to the syphilis outbreak at that time? The understanding was that they wanted to go forward with it and were stymied, I guess, in their pursuit.

Mr. Liepert: Well, I think what you're asking is around a syphilis outbreak. You said that they wanted to go forward with it, and I think what you're referring to is a discussion around a province-wide ad campaign. At that particular time it was determined that we weren't ready to proceed with the province-wide ad campaign. I must make it clear: there have been a number of initiatives that have moved forward in public health around not only syphilis but a whole bunch of sexually transmitted diseases and a whole bunch of areas that need to be addressed.

I'm going to ask Dr. Predy to talk a little bit about some of the work that took place throughout the province at about that time. I'm going to ask him to make sure that this committee understands that dealing with the situation was more than a province-wide ad campaign.

I don't know if I've answered all of your questions, but if I didn't, then after Dr. Predy I'll come back and answer them.

Ms Pastoor: If I could just follow up on that: who made that decision? Was it a ministerial decision to not go ahead with the province-wide ad, or was it the actual public health officers?

Mr. Liepert: The decision to not proceed at that time was my decision.

Ms Pastoor: Okay. Thank you.

The Chair: Dr. Predy.

Dr. Predy: Yes. If I could just comment. First of all, the syphilis outbreak we're seeing in Alberta is not confined within the boundaries of Alberta; it's being seen across the country albeit we do have some of the highest rates in Canada. I think, as the minister said, we've put in a number initiatives, because this outbreak probably started about year 2004, over the last few years to try and deal with this. In fact, we are now seeing some progress. My day job is within the Edmonton area here, with Alberta Health Services. In fact, the outbreak did start in the Edmonton area. We've now seen a subsiding of the outbreak. So far this year, for example, in the Edmonton area we've seen 40 cases of syphilis, which is still far too high, but compared to over 90 the previous year, it is coming down. That's the good news.

We certainly recognize that a lot of the people who are getting infected are disadvantaged and don't often make contact with the health system. Locally here we've seen a lot in people who work in the sex trade. They're not easy to reach, so what we did was set up outreach teams that would go out into the inner city, into the community agencies where people are found, so we could in fact give them information directly. Our nurses on the outreach teams can actually do the testing right on the street and advise people and, in fact, even treat them there. Those were some of the things we did.

We also worked to ensure that the community agencies, the people working there, were aware of the syphilis signs and symptoms. We did work, of course, with physicians as well because, as you all know, syphilis had essentially disappeared for a long time in Alberta, so a lot of physicians didn't understand or didn't know. They weren't really looking for syphilis, had never seen it. Again, there was work to do with the professions, which we undertook.

As well, I think that the nature of the disease is such that the first symptom is usually a sore in the genital area which is painless. Often people don't really know that they have it. They don't notice it, or they think it's nothing. It goes away after a little while, but they still remain infectious. So there are characteristics of the disease that make it difficult to control as well.

Some of the work we've done is, I think, starting to pay dividends. We did some innovative things. For example, one of the things we

did was pay people to get tested because we know that often they had no incentive to be tested. They didn't really think it was important. We actually found that several people showed up and got paid to be tested. We didn't pay them a very large amount of money, just a token amount, but that still did work.

Some of the things we've done, I think, have been recognized by others across the country. The National Collaborating Centre for Infectious Diseases in Winnipeg has actually recognized the work of our outreach team as a best practice in the country and has been showcasing it and invited our team to work with them to see how we can get this kind of practice implemented across the rest of the country.

I think we have made progress. Are we there? No. We still have a long way to go to control the outbreak, but I think it is subsiding. We're on the right side, and we'll continue to do everything we can to get it under control.

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

Mr. Fawcett, followed by Mr. Mason if that's all right.

Mr. Fawcett: Thank you, Mr. Chair. I want to be clear that because this is a policy field committee, my questions will be focused on policy. We've heard that there are going to be changes to the role of the chief medical officer of health. Could you explain what these changes are and the impacts, I guess, on our health care system and to the everyday Albertan?

Mr. Liepert: Well, one of the things that we did undertake shortly after Dr. Predy came on board was for him to do a review of what the appropriate model should look like. Dr. Predy came back with a number of recommendations that, I think, for the most part, if not all, were accepted and implemented.

There has been some concern in the past about the reporting procedures that our medical officers were under. Our chief medical officer reported through an assistant deputy minister in the department. I've been very clear about it that we believe public health is an important role for our department. We believe that it has to have an interaction with the department and has to have a sense of not only input into departmental decisions but an understanding of all of the other things that are happening within Health and Wellness. But at the end of the day, it's important that the chief medical officer of health is seen to be independent, to have the ability to not have to report through a reporting line within the department. So the new role is a direct reporting to the minister and to cabinet, if necessary, but also sits at the executive level of the Department of Health and Wellness.

I'd ask Dr. Predy, since the recommendations came from your review, whether there are other things that you would like to add to the new model.

Dr. Predy: Sure. I think the reporting relationship was one aspect of the change that has been implemented.

The other aspect was to make it clear that the chief medical officer of health has a role to play not just in dealing with infectious disease threats but also looking at other aspects of health, particularly disease prevention, health promotion, and some of these other issues that in the past I think the chief medical officer of health hasn't been as directly involved in. Again, having more of an impact in a broader area of health than just infectious disease.

The Chair: Thank you, Dr. Predy.

Is there a supplementary question?

Mr. Fawcett: I think it's probably answered, so it would probably require a very short answer. Where exactly does the chief medical officer's authority derive from?

6:10

Mr. Liepert: From the Public Health Act.

The Chair: Thank you.

Mr. Mason, please, followed by Mr. Dallas.

Mr. Mason: Thanks very much, Mr. Chairman. Before I ask my questions, I'd like to table a copy of a letter from Stan Houston, a professor of medicine in infectious diseases and public health at the University of Alberta, to yourself so that all committee members can have a copy of it. If I could have somebody distribute that.

The Chair: We'll distribute that to the committee. You can proceed with your question, please.

Mr. Mason: Thanks very much, Mr. Chairman. Mr. Minister and Dr. Predy, I appreciate very much your being here this evening. The question I have arises from comments made in Dr. Houston's letter. He's commenting on the 11 cases of syphilis in newborn infants, with five deaths. He says:

> The death of a newborn from any preventable [disease] is a rare event in Alberta. Congenital syphilis in particular, is considered preventable even in developing countries with vastly fewer resources than Alberta. The number of cases of congenital syphilis that Albertans should expect, and in fact did experience for most of the past several decades, is zero.

Now, the question I have, basically, is: how did we get to the point in the province of Alberta, with all of its wealth and its modern health system, where we have such a recurrence of syphilis that we have newborn babies dying of it and apparently remedial action to deal with this epidemic was not taken in a timely way?

Mr. Liepert: Well, there's an assumption in that question that I don't necessarily support, and it was the concluding part of the question. I think that to suggest that action wasn't taken is incorrect. What we have had in the last half a dozen years in Alberta is a transient population. We've had a high degree of workers in this province, more than the average norm nationally, who would be in work camps, would be working in the oil fields, whatever the particular occupation may be. Probably in any other given situation in any other province the same results might appear. We also have had a situation where you have a lot of disposable income. A lot of not good things happen when that is the case.

I think if you looked at: has the number of people in this province, on a per capita basis, who take drugs increased? I'd say probably. Has the number of people who we are treating for alcohol and addictions increased? I'd say probably. A lot of that has to do with the fact that there's a lot of money around. I think that if you look to see whether or not the number of accidents on our highways has increased in the past number of years, they have increased dramatically because we have developed in this province over the past few years a very, I'd say, careless attitude in some ways. I think that plays into it probably more than any other factor.

I would ask Dr. Predy, who's an expert in this field, if there's anything else he has to add.

Dr. Predy: Yes. I think no one would dispute the fact that the cases of congenital syphilis are a great tragedy. In fact, I would be pleased to talk to Dr. Houston. Unfortunately, he's never contacted me. I

read about his comments in the newspaper here, but I'd be happy to hear from him about his ideas, certainly, on how we can deal with this.

We have I think taken steps to try and address this problem. One of things that is done, as you may know, is that every pregnant woman in Alberta is screened for syphilis when she shows up for prenatal care. Unfortunately, what we're seeing is that there are a number of women, for various reasons, who don't show up for prenatal care. The first time they see the health system is when they're in labour and they come into the hospital. In a number of cases of congenital syphilis those are the situations that we dealt with.

Other cases. I know of at least one case where a woman was screened early in pregnancy. Unfortunately, then her partner infected her after the screening. What we've done now is enhance the screening program for pregnant women, so not only do they get screened at their first visit, but we try to screen them again at about 28 weeks, or seven months, of pregnancy. Then we're also screening women again at delivery whenever possible. Funding has been increased to the laboratory to do these extra screenings so that we can do everything we can to try and pick up infected pregnant women because if we treat them before they deliver, we can often prevent the congenital syphilis in the infant.

Again, a lot of these women have been working in the sex trade, so they don't necessarily show up at the usual health care settings. I mentioned the outreach we were doing, working through the community agencies that might have contact with these women, trying to identify them and encourage them, if they are pregnant, to get into a doctor's office, or our outreach team can see them. We are making attempts to try and enhance what we're doing with this population, but they are a difficult to reach population. It's not an excuse; it's just a fact.

Although we've still seen cases of congenital syphilis this year, I think we're starting to get a better handle on it. As the number of overall cases decreases, I think we will see a decrease in the number of congenital cases. It isn't, certainly, a problem that we've got fully in hand yet, but I think we're on the way.

The Chair: Thank you, Dr. Predy.

A supplementary question?

Mr. Mason: Yes. Thank you, Mr. Chairman. Well, with respect to the minister, to suggest that what we're seeing in terms of the syphilis outbreak and the deaths of these newborns is just an unavoidable outcome of the boom is unacceptable to me and a real rationalization of the situation. The question that I have is: given that this is a preventable disease and has been virtually eradicated in most industrialized countries, why was this outbreak allowed to get to the point before it was effectively countered that, in fact, we had babies being born with congenital syphilis?

Mr. Liepert: Well, with all due respect to the member, I think Dr. Predy just finished answering that. You're dealing with a high degree of people who quite often don't get proper screening, don't see a doctor on a regular basis. The fact is that we have probably a higher percentage of those types of individuals here because of the boom situation. The sex trade doesn't do well if there isn't the money around to support it. You can take whatever high-road position you might want to take, hon. member, but the truth of the matter is that those are the facts.

The Chair: All right. Thank you, Minister. Thank you, Mr. Mason.

Mr. Dallas, please, followed by Ms Pastoor.

Mr. Dallas: Thanks, Mr. Chairman. Gentlemen, government policy reflects a sense that substantial programming investments need to be made in terms of prevention and wellness programming in the province. My question to begin with is relative to that investment. Are we comparing best practices to other jurisdictions? If you could identify a trend in terms of investment in prevention and wellness programming, would that trend be towards more investment in the future or a similar investment to what we've been making?

Mr. Liepert: Well, I guess it's a tough one to answer because it just makes common sense that money spent on prevention is going to save you money down the road, long term, but it's hard to quantify. You know, our funding for the whole area around public health, injury prevention, health promotion in this current year is just in excess of $150 million. That exceeds some of the budgets of some of our other departments. What is enough? It's hard to put your finger on it, but I think it's also important that you engage other providers in the system.

6:20

You know, we had a promotion this afternoon with the minister of seniors and the Premier with the seniors group here in the city around the Finding Balance campaign. It was a learning experience for me because of the statistics of the number of seniors that fall and break a bone or a hip or whatever it might be. If we can prevent those sorts of things – a lot of this is awareness and communication, but I think it needs to be targeted.

I think that too often a department of government knows that they need to communicate, make Albertans aware. So what is the first thing they do? They go out and they hire an ad agency or a public relations firm. The next thing you know, the ad agency or public relations firm comes back with this gigantic ad campaign and says: "Okay. Well, if you spend this much money and blast it out over the waves of television, you'll solve all your problems." I don't agree with that. I think you have to have a targeted approach.

I think some of the things that Dr. Predy has talked about have been the right targeted approach. Some of the things we're doing around what I just mentioned, around injury prevention, stuff like children's mental health: obviously, to me those are going to pay off long-term.

I think that sometimes we measure the wrong things. We tend to measure how many more beds we put out there for addiction treatment rather than measuring what we can do better to not need those extra beds because to prevent someone from becoming addicted is clearly way less costly not only to the system but in angst to the family than treating them after they've become addicted. You know, it's a constant struggle to try and find the right kind of approaches.

I'd ask, Dr. Predy, if there's anything you'd like to add on that that you're involved in.

Dr. Predy: Sure. I think that there are certainly some important preventive interventions that have been implemented recently. Vaccination is one of the most important preventive interventions. Most recently, with the flu season coming into play, we've increased the coverage of influenza vaccine. Free vaccine is now more widely available to wider age groups. I think that's an important piece of work.

The other thing, I think, to look at is that we do know where we have problems in the system. We have more chronic disease, largely related to risk factors like smoking, for example. We know that if you looked at something like smoking, it's not just knowledge that's important. You have to actually bring in other interventions. One

of the important things is, for example, banning smoking in public places. We now have a provincial law doing that. That, we know, does probably do more to help people quit smoking, because it makes it inconvenient for them to smoke, than a lot of the education or counselling because everybody knows that smoking is bad for them.

We have to look at other interventions when we talk about, you know, the other problem, with obesity. Recently the nutrition guidelines for children and youth were introduced. More than that, again, that's just knowledge, but that's not sufficient. You know, we've been talking to municipalities, too, about how we design communities. We know that if you design communities where people can walk to the grocery store, walk to the dry cleaners, where they don't have to get into their car to go everywhere, that's important.

Again, those are some of the challenges that we have to look at as we look at prevention because it's not just what people in health do. It's what people in other government departments do. For example, in education as well we know that people who finish high school are going to be healthier than those who don't, so again we have to look not just at the health system to keep people healthy but at broader societal, I guess, interventions as well.

Mr. Dallas: Thanks. I think you've largely answered my supplemental given the indication that there are certain types of preventative programs that are easily measured for outcomes, vaccination, I guess, being one example. Do you struggle with the metrics of measuring outcomes on the education side? Is that very difficult to quantify to Albertans, the investment that we're making there?

Mr. Liepert: That's a good question. Gerry, anything on that?

Dr. Predy: Well, I think that if we looked at health, when we look at measuring health status, generally the better educated you are, the healthier you are. It doesn't mean that if you don't have an education, you can't be healthy. I'm just talking in population terms. I think we can quantify that by looking at, you know, the health status of groups of people. For an individual, again, there are exceptions, but when we talk about groups of people generally, we know that people who do finish high school are more likely to be healthy in the longer term and live more healthy lives.

Mr. Liepert: Mr. Chair, if I could just add one brief comment. The difficulty you have with measurements is: who's making the difference? So often these programs are not necessarily just government programs. They're involving stakeholders in a wide variety of ways. I mean, take the HPV vaccine. My guess is that if you start to measure how successful that is, the success rate will depend to a large extent on whether the school districts, you know, were involved in it because it's all part of ensuring that the message is consistent.

I just happened to pick up this little thing on the desk when I was leaving. This is the Canadian Dermatology Association campaign on skin cancer screening. You know, the really successful programs probably have a multitude of avenues to try and create awareness, and that then leads to: how do you measure, and who's measuring?

The Chair: Thank you, Minister.

Ms Pastoor.

Ms Pastoor: Thank you, Mr. Chair. I don't want to belabour this too much, but I'd like to go back a bit to the syphilis problem. Certainly, the outreach is, I believe, the way to start to attack it. I think we all know that through the sex trade gossip travels quite quickly, so if you've hit two or three of them, that type of information can go and be passed. Now, whether they understand it totally is another question, but at least the gossip has travelled through. My question would be: you've done the outreach here in Edmonton; is that outreach going through the province? Have you looked at provincial numbers? Is it moving out of the area? I guess that one of the other populations that I'd be most concerned about would be the native population because sexually transmitted diseases are increasing in that particular population.

Dr. Predy: Certainly, I just highlighted some of the programs here, but similar programs are in place across the province. You know, specifically with respect to First Nations, aboriginal people, we work closely with the First Nations/Inuit health branch because they do have responsibility for public health services, particularly on reserves. There is a close working relationship there. The medical officer of health for them and for us work very closely to ensure that we do reach people in those communities.

One of the challenges there is that there is a fair bit of travel back and forth between some of the rural communities and the cities. Sometimes it creates a bit of a challenge for our people who are trying to trace the contacts and trying to follow up on people. It really depends on good co-operation with the First Nations/Inuit health branch, which I think we have.

I mentioned that I think the numbers provincially are probably – I don't have those at my fingertips, but I know that the local numbers here have gone down this year. I know that we've implemented programs across the province, but the outbreak started here, and I think it has just worked its way to some of the other centres across the province. I think we'll shortly start to see, if we haven't already seen, the numbers dropping in the other parts of the province as well.

Ms Pastoor: Thank you. My supplemental would be along the conversation you were having about education. It probably may have tied into a provincial-wide ad, which I can understand probably wouldn't have gone ahead, but I think the educational portion is very important. I did a little survey on my own. Trust me, it wasn't scientific. I spoke to someone who was 19 years old. She understood that it was sexually transmitted but that condoms would take care of it. I spoke to somebody who was 80: Henry VIII died of it, but it doesn't exist anymore. I'm not really sure that the general populace understands the disease, especially within the 19 to 25, whatever, age range, that is certainly active sexually if you want to read the statistics, or has a clue what to look for in terms of signs and symptoms or, in fact, how it can affect them for life.

6:30

Mr. Liepert: I guess I wouldn't disagree with you on that. The question is: how do you reach that highly susceptible group? That's, I guess, where we're working.

Did you want to add anything, Gerry?

Dr. Predy: I think that if you did a broad public campaign, you might create some awareness in the general public, but I think it's important to also target the people at highest risk, and they're not going to respond to a TV ad campaign or a radio ad campaign. We really have to again work with the community agencies, because a lot of these agencies do see the high-risk populations, and put the information to them in a way that they can understand. It has to be in very simple language, language that they use and understand.

We also have been trying to work at getting into places like bars.

Again, we know that one of the reasons why people engage in high-risk sexual activity is that they may not intend to do so, but if they get drunk or go on drugs, then they lose their ability to think rationally, and then they can pick up an STI.

We need to really look at how we can get into places like bars and get information to people, be sure there are condoms available, and those kinds of things. We have had some success, but I think we're again continuing to work on that area.

Ms Pastoor: What do you think about the CALM program?

The Chair: Can we come back to that?

Ms Pastoor: Yeah.

The Chair: Okay. We'll come back in the next rotation. I'm just noting that we've used a little more than half the time, and we've made it through five questions. I'd like to do at least as well in the remaining time if not a little better.

I'll go to Mr. Vandermeer, please, followed by Mr. Mason.

Mr. Vandermeer: Yes. My question would be for Dr. Predy. Is the Ministry of Health and Wellness prepared for a pandemic?

Dr. Predy: Well, I would say yes. I think one of the things about planning for a pandemic, though, is that it's not the case that you just prepare a plan and you put it on the shelf and you're ready. It's a constant, ongoing process. Certainly, the department does have a plan, has worked with other government departments – it's a government-wide plan – to ensure that we do have something in place, has worked with the health authority, again, to be sure that there are plans in place across the province.

But the most important thing, I think, is that there is a surveillance process in place so that we can monitor what's happening around the world with respect to influenza, particularly the so-called bird flu, the H5N1 flu, that we have a concern may turn into the pandemic strain, so being sure that we're kept up to date on what's happening with that strain, where it's going, whether it has mutated, all those kinds of things. Our plan is in place, but we have to be able to be sure that we are able to activate pieces of the plan as the global situation evolves. Again, we work closely with the Public Health Agency of Canada on this through the department. That's the long-winded answer to your question.

The Chair: Do you have a supplementary question, Mr. Vandermeer?

Mr. Vandermeer: Many front-line health care workers are concerned about their own personal protection. What is being done with regard to that?

Dr. Predy: Well, the department has provided funding to the health authority to purchase protective equipment, like masks and gowns and so on, for the health care workers. There's also a national initiative to look at whether or not antivirals might be an appropriate kind of intervention to provide to workers, but at this point there's no definitive answer on that, so the work there is ongoing.

Clearly, I think the important thing is to ensure that the protective equipment is there but also for ongoing education with respect to people working in the health system. We know that washing your hands is probably one of the most important things you can do, and that doesn't happen as often as it should, so there's a lot of work going on to ensure that handwashing is more prevalent. There is funding provided, again, to the health authorities to set up more handwashing stations in the hospitals, again to ensure that staff can protect themselves through that important measure as well.

The Chair: Okay. Thank you, gentlemen.

Mr. Mason, please, followed by Dr. Sherman.

Mr. Mason: Thanks very much, Mr. Chairman. I have a letter here written by John Van Aerde, the director of the division of neonatology, clinical professor of pediatrics at the faculty of medicine at the University of Alberta, and it appeared as a letter to the editor. He takes issue, Mr. Minister, with your comments that Albertans who are at high risk of syphilis have to take responsibility for their own personal health. He comments that this is a judgmental statement which lacks consideration for the newborn: "For the infant born with syphilis, the disease is not preventable, it is a fact of life." He goes on to say that one-half of the babies affected with syphilis were born to parents not in the sex trade. Finally, he says that "the message based on blame is worrisome because, in the past, it has not been a successful strategy to prevent other sexually transmitted diseases."

My question is whether or not your approach of a targeted strategy to deal with the syphilis epidemic, in fact, will make sure that people who are outside the main group associated with the disease are actually protected. In other words, if this disease is prevalent among sex trade workers, how do you know that it is not also spreading in higher income groups of the population, who may not know about it?

Mr. Liepert: Well, nobody said that it wasn't. When I say that individuals need to be more responsible for their own activity, I'm not just referring to people who are engaging in the sex trade. I think Dr. Predy mentioned a couple of examples. When you go to a bar, you may want to think about who you go home with at night. That doesn't necessarily mean that you're in the sex trade or that you're in a low-income category. Personal responsibility is all ours. We have developed a very, in my view, careless attitude around our own health in this province. You can read all the letters from whomever you want, and I'm not going to change that opinion.

Mr. Mason: Well, that, Mr. Chairman, is clear enough.

The question, really, that I have is whether or not other groups outside the ones that you are choosing to target may be at risk and need public education in order to change those behaviours. Why aren't you prepared to consider a more broadly based public awareness campaign?

Mr. Liepert: We are, and we may see something coming soon. What I did say at the outset is that I'm not about to just engage in a $2 million TV ad campaign that will run for a couple of weeks and say: "There. We've solved the problem." I don't know that you're going to hit the people we really need to hit. A lot of the work that Dr. Predy and his group have been doing is around: it may be something as simple as a poster campaign in bars; it may be a broader outreach program to people who frequent bars. I mean, nobody said that the only people we were working with was the sex trade. Clearly, no one has ever said that this is something that's confined to the sex trade. We know that's not the case. But how do you use resources to ensure that you target the highest percentage of the people that you're trying to target? That's the plan right now.

Do you want to add anything?

Dr. Predy: I think that we do track cases by geographic area, and we know that it's not just confined to one particular geographic area or

one particular neighbourhood. We do follow up with the staff that follow up with the cases. One of the, I guess, skills they have to have is to be able to engage the cases, ensuring that they get all the contacts, and they are very nonjudgmental. I can say that as a group the nurses who do that are excellent employees, and they really are nonjudgmental and are able to get good information back from people. I think we do have success that way.

Now, again, it's partly trying to ensure that people who do appear – you know, one of the challenges, as I said earlier, was that we have to get physicians onboard and other health professionals because many of them don't think of syphilis. Again, I think we've done a lot of work there to get them more onside. You know, we've had some misdiagnoses of syphilis in the past, and I think we're seeing fewer of those now. Again, some of the work that's been done, not necessarily by me but by some of the people who preceded me, is now starting to bear fruit, but it will take a while for us to get this under control.

6:40

The Chair: Okay. Thank you very much.

Dr. Sherman, followed by Ms Pastoor, please.

Dr. Sherman: Thank you, Mr. Chair. Thank you, Mr. Liepert and Dr. Predy, for appearing before the committee today. With the recent announcement you seem to have answered Dr. Stan Houston's last paragraph in strengthening the traditional public health function with the announcement of the CMOH. The next question, the next step would be: now that Health Services, Alberta Health and Wellness, has a policy dealing with public health and the delivery is under the Health Services Board – this may be a question more for Dr. Predy – what will be the role of the senior medical officer of health, the reporting relationship at the Health Services Board level, vis-à-vis who they will report to, and what will be their leadership ability to affect the delivery of public health, where currently the CMOH's job is the vision of public health?

Dr. Predy: Well, yes, I think it's a good question because we have worked closely with the department to strengthen the role of, particularly, the chief medical officer of health, and I think that will in the longer term pay dividends in terms of improving the health of the public. Now, Alberta Health Services is just in the process of setting up their organizational structure, and they've made some announcements and have identified generally where some of the public health functions will go but have not identified, I think, some of the specific roles of people in the system.

We have had some discussions with them since probably August. We did cosponsor a session where we brought in 48 people to talk about what the public health system should look like in the province. Those are people largely from within the province but a few from outside, and I think that sort of served as a launching for us to start the discussion. There have been a few meetings, but I don't think there's any final decision on how public health will be structured. Certainly, I think we've got consensus that we really want to build upon the changes that have been made within Alberta Health and Wellness and work together to create a stronger system at the delivery level as well as at the ministry level.

Dr. Sherman: My supplemental question. They say that an ounce of prevention is worth a pound of cure. Traditionally in North America health care has been concentrating on fixing the problem versus stopping it from happening in the first place. In Europe, where they don't have the luxuries of the funds and the health care facilities, a lot of their efforts are based on actual prevention. Minister, you mentioned that we spend $150 million on prevention here. In Quebec they spend a bit more. My question is: should this be strictly a health-related function or with other ministries or other communities? How do you envision funding prevention on a global level, not just from a provincial governmental level?

Mr. Liepert: Well, I would like to see a model in place where we use and aren't afraid to implement in this province best practices from wherever it might be. I think you have to be prepared to do what works. You may be able to spend half as much money and get twice as good a result. But I think this also is probably most important. As government you can do whatever you want – you can put in all the programs you want – but how do you make the average Albertan better aware of the long-term effects of not looking after their own health? You know, I go back to my days in education. I met with the Black Gold school division in the Leduc area, and they've got a very progressive superintendent who a few years ago brought in an obesity intervention program. They won a national award for this particular program, and they have dealt with some 300 students over the course of however many years it's been in play. It works. So I ask the question: well, why isn't this done elsewhere throughout the province? I mean, there are lots of examples of good things that are taking place. I think where we've fallen down is not doing a good enough job of ensuring that these good examples are deployed across the province, and I'm hopeful that with the one board we can get past these regional boundaries. I used the school example. My guess is that the reason it hasn't been that successful across the province is because it happened to be thought of by somebody else.

We've got an opportunity now with one health board across the province where if we have a best practice somewhere, we're going to move it across the province. Government can only do so much. I think government can only sort of set the agenda, and then you have to have people take personal responsibility.

The Chair: Thank you, Minister.

Ms Pastoor, please, followed by Mr. Quest.

Ms Pastoor: Thanks, Mr. Chair. That was actually a good segue into where I wanted to go in terms of province-wide standards and enforcement. Part of this is from my personal observation from my many years within the health care system. Way back when the cuts came to health, one of the first things to go was front-line cleaning staff in hospitals. I'm not sure. I just know that the MRSA numbers that come out of hospitals are really quite astounding. I sort of back it up into the lack of true cleanliness in our hospitals. I'm not sure that that was a question so much as I would appreciate a comment from Dr. Predy on that.

Dr. Predy: Well, I think you're right. At the time of the mid-90s there were some cutbacks in some of the housekeeping areas, but I think subsequent to that there was some realization that that needed to be addressed. Now, I can't comment on the cleanliness of hospitals everywhere, but certainly MRSA is related to a number of issues. We're seeing an increase in MRSA, as you referenced; however, what we're seeing is that when MRSA first emerged, it did emerge in a hospital setting, and we did see outbreaks, but now most of the new MRSA cases we're seeing are actually not acquired in the hospital. I shouldn't say most, but more and more are acquired in the community rather than in the hospital setting.

Nobody is sure exactly why this is the case. There was an outbreak, for example, in people who inject drugs in Calgary. There have been outbreaks in homeless populations. MRSA is more

prevalent in the community. We have more people who carry it, because you can carry it, so it becomes more of a problem in the hospitals, then, when people come in and carry it. It does depend on a number of factors. There are a number of factors that result in the transmission of MRSA. Some of it is just the background rate in the population. Some of it is related to good handwashing and hygiene in the hospital. But it is an issue that we continue to address.

Certainly, of the infection control standards that were released early in 2008, standards to protect against MRSA were one of the sort of pillars of that strategy that was released. You know, again, it's not a problem that's unique to this province, but it appears that MRSA, for whatever reason, is now becoming more prevalent in the community, and it's probably related in part to environmental factors and in part to a change in the actual germ itself.

Ms Pastoor: Just a very quick supplemental, then. From your comments I have to assume that you are or are not happy with the cleanliness of our hospitals. Are you considering province-wide standards with enforcement for the cleanliness of hospitals and how many staff or however? I mean, I don't know the formula that one would use. Are you happy with what you see at this point in time that is cleanliness in the hospitals?

Mr. Liepert: Are you referring to the floors or the sterilization of equipment?

Ms Pastoor: Well, actually, let's leave the sterilization out. That's a whole different kind of segment, and hopefully it's a whole different kind of staff that's been trained.

Mr. Liepert: Well, I'm not clear what you're talking about relative to cleanliness.

Ms Pastoor: Okay. Just the average, everyday walk through the hospital, going to the bathrooms, just that kind of thing. Look at the floors, look at the walls, look at the curtains, in between the beds, look at the bathrooms in the rooms: those sorts of basics.

6:50

Mr. Liepert: Well, my view is that it could be a lot better. What is the reason why it isn't? Maybe you have to ask the people who are working in the hospital.

Ms Pastoor: Yeah. Then my question would be: are we going to get provincial standards with enforcement along that line? I think, maybe more, that Dr. Predy could answer that.

Dr. Predy: Well, I think there are provincial standards around the type of cleaning and disinfection that needs to be done in hospitals. Again, I can't comment on the general cleanliness, but certainly when it comes to articles that are involved with patient care, there are standards around those, about what you can use and can't use and all those kinds of things. Again, I'm not able to comment on the general state of cleanliness in the hospitals. As the minister said, it's probably something that could be improved.

The Chair: All right. Thank you.

Mr. Quest, please, followed by Mr. Mason.

Mr. Quest: Thank you, Mr. Chair. The new Alberta infection prevention and control strategy was announced in January. The cases in High Prairie and Lloydminster-Vermilion were in October, 10 months later. I'm just wondering if you have any comments on that, why that would happen.

Mr. Liepert: I guess I wouldn't have much new that I could say relative to what hasn't already been said publicly. Let me take the Vermilion-Lloydminster situation of just last week. What we are attempting to do is create a culture within the health industry that if any person working within the health industry sees or feels that a procedure or a standard is not being met, there is a comfort level to actually report that.

In this particular case Dr. Predy might want to add to this because he was the one who received the call. This particular physician felt comfortable to call Dr. Predy and say: this is a practice that has been happening, and I'm reporting it. Had we not created that culture, it would have been very easy for that particular physician to just discontinue what he was doing, and no one would have probably been any the wiser. So we need to create a culture where employees within the health system can question standards and practices.

I guess I'll leave it at that and ask Dr. Predy to add anything he would like to add to it.

Dr. Predy: Yeah. I guess the other part of the standards was that if there are issues, breaches identified, then the process is really to report that to the medical officer of health, who can then take the action. I think that in these situations that's what's happened. Again, in the past people might have noticed something, but they might not have realized where they should report it or who they should talk to, but now we have the process in place so that people are aware that if they do see something, they should speak up and, then, of who they should talk to as well. So I think that in these cases that part of the system did work.

The Chair: Mr. Quest, do you have a supplementary question?

Mr. Quest: Well, okay. So today we wouldn't have any reason to be worried about the level of safety in our facilities, then? Good feeling about that?

Dr. Predy: Well, you know, the interventions in health care are such that there are always risks in whatever. If you're having surgery, it's not always successful because it's not like fixing a car, necessarily. I mean, I would say that our health system is as safe as any in Canada. Is it a hundred per cent safe? Is it as safe as it should be? No. I think we still have work to do. But I think people should feel comfortable that it is as safe as any other in the country.

There are some other things that we could probably improve on, but I know that one of the priorities across the province now is to improve patient safety and quality. I think there are lots of initiatives under way, not just in infection control but in other areas as well.

Mr. Liepert: I'd like to just add one brief comment. I asked for some data. We perform in this province on an annual basis – in-patient, outpatient, clinical environments, ambulatory – some 35 million procedures a year. Thirty-five million procedures a year. The only way you can ensure that those 35 million procedures a year are done safely is to have those in the system educated, ensure that they comply, and if they see something that's not in compliance, get it fixed.

The Chair: Thank you, Minister.

We have time for probably two more in the rotation, so Mr. Mason, please, followed by Mr. Olson.

Mr. Mason: Thanks very much, Mr. Chairman. Following the departure of a number of senior public health doctors earlier this

year, we attempted to contact them and find out what the circumstances might have been. We were told that because of the language in the contract that they had with Capital health or with the provincial government, they were unable to talk to us. I would like to ask a question, and that is whether or not disagreements between the department and any of these doctors over how to handle the syphilis outbreak played any role whatsoever in their departure and whether or not the minister would be prepared to let those doctors appear before the committee and speak under privilege about their views of this issue, specifically the syphilis outbreak and the reasons for their departure from Capital health or the provincial government.

Mr. Liepert: Well, I think you have got your wish, which is having Dr. Predy and me here to answer your questions, so if there's anything you want to ask me, feel free to ask it. I do not believe that it is prudent to be dragging people before this committee on a witch hunt just because you feel like you want to go on one, and I'm not going to help you in that manner. I'm going to suggest to you that if you have a question, here's your chance. Ask it.

Mr. Mason: Well, I have but haven't been getting many answers, Mr. Minister.

Mr. Liepert: Maybe not the answers you want, but I've answered fully every question you've asked.

Mr. Mason: Oh, I don't think that's true.

The Chair: Mr. Mason, did you want to ask a supplementary question?

Mr. Mason: Yeah. I'd like to ask Dr. Predy – and this is switching gears a little bit. If the practice of reusing syringes in IVs was widespread in the 1990s, why did you, on the one hand, in the case of High Prairie order a look back and a test so people could be tested in High Prairie, but the same procedure, according to your own comments, was widespread in the same period. Why aren't we treating everybody the same? Is it either that it was unnecessary in the High Prairie case, or should it also be done across the province? I can't understand this.

Mr. Liepert: I think you've had your chance to ask the question. Before Dr. Predy answers this question, I would like this member to correct his preamble. Dr. Predy never said that it was widespread. If you're prepared to change that approach to your question, he'll answer it.

Mr. Mason: Common practice is what he said.

Mr. Liepert: I told you in the House the other day, Brian, that he did not say common practice. You keep adding adjectives in front of what is said. You may not get the right answer that you deserve.

The Chair: Gentlemen, excuse me. Thank you, Minister.

I believe we have a question on the floor to Dr. Predy. Did you care to reply, Dr. Predy?

Dr. Predy: Sure. I think my comments were based upon the fact that in discussions with a number of physicians who do administer medication this way, they said that this practice had been used in the past. Now, how common it was, I can't know, and nobody can go back to the '90s. I mean, it would be a difficult task to go back there and look at it.

With the situation in High Prairie there was a risk assessment done. When it was identified, the first priority was to stop the practice, which happened. Then there was a risk assessment done. We brought in an outside consultant who had no relationship to the hospital or to the region, did the risk assessment, and based upon that risk assessment made the recommendation that the look back be done. Now, the risk assessment was based upon a number of considerations. One was the type of practice. Another was the background rate of disease in the community. Another was the time frame over which this happened. Because it was over a specific time frame, it made the look back possible.

With respect to Lloydminster, again, the same process is under way. When we found out about it, we stopped the practice, and now the risk assessment is proceeding. Once we get the results of that risk assessment, we can make a decision about what we're going to do about it, what we're going to tell the people about this issue. It is based upon that kind of a process, and we would do the same if this ever happens again.

7:00

The Chair: Thank you, Minister. Thank you, Dr. Predy.

Mr. Olson, please.

Mr. Olson: Thank you, Chair. Minister and Dr. Predy, thank you for being here to spend this time with us. Being one of the last questioners, I imagine I run the risk of some redundancy in my questions, so I'll apologize for that ahead of time.

Minister, you did mention in your opening comments that this committee is about policy, and I certainly believe that that's what we're here for, to discuss policy. I'm just interested in the way we as government approach these issues of public health. My understanding, being a neophyte, is that the definition of public health these days really is a broad definition, and as has been discussed already, we take a multidisciplinary approach. I'm interested in your thoughts, though, on what that means for government in terms of cross-ministry collaboration, what the challenges are, what initiatives are being taken. If you could just expand on that a little bit for me.

Mr. Liepert: You got an easy answer to that one?

Dr. Predy: Well, I think there are a number of areas where there has been in the past collaboration. Certainly, there has been work done across ministries on seniors' health and how that can be dealt with both from the preventive side as well as the treatment side. There was a few years ago a child health initiative, as well. More recently there was the traffic safety initiative that was mounted with Health and Transportation. Of course, I mentioned earlier the pandemic. That's a cross-ministry initiative. We know that if a pandemic comes, it's not just a Health issue because all government departments will have to maintain essential services. So there are a number of those kinds of areas, I think, where there has been work done.

Another one I can think of off the top of my head is the Water for Life strategy, where there's a look at, you know, preserving the quality of our water across the province. That initiative is rolling out jointly with Health and Environment. So there are quite a few of those that I can think of.

Mr. Liepert: I'd just make a brief comment. You know, I think the whole area of public health is so much more important today than it might have been two or three generations ago because we now live in a global world – we travel globally; we have instant communica

tion globally – and opening up the world has brought new problems with it. We have to react on the spot to things that never used to happen. If you think back to vaccinations that you received in school, you know, lifestyles of people are different today than they were in the past. There probably were sexually transmitted diseases around two, three generations ago, but certainly it didn't seem like it was an issue. With everything else that's happening in society today, the whole area of public health has taken on just an enormous role in everyday lives.

The Chair: Thanks, Minister.

Mr. Olson, we probably have time for a very brief supplementary question.

Mr. Olson: I think I'll call it good.

The Chair: Okay. Well, thank you. We have just slightly exceeded the time, and there are still a couple of things the committee needs to discuss before adjournment.

Minister and Dr. Predy, I'd like to take this opportunity on behalf of the committee to thank you very much for coming. Your response to the questions is much appreciated and will be of great assistance to the committee in its future work, I'm sure. Thank you.

Thank you to the members, who co-operated with the process that we agreed to. Your co-operation is appreciated as well.

Members, just very quickly because I know we're going to be hearing some bells ringing here shortly. Item 5 is Other Business. Is there any other business to be brought before the committee?

Seeing none, I'd just note, then, that the date of our next meeting is Tuesday, November 18, 2008, from 8 to 11 a.m. You'll recall that that is a meeting where we have agreed to hear presentations from a variety of individuals and organizations on various topics. So, again, Tuesday, November 18, from 8 to 11 a.m.

Aside from that, I guess I'll just in closing ask for a motion to adjourn. Moved by Mr. Dallas. Those in favour? Opposed, if any? Thank you very much to everyone, and thank you to the staff as well.

[The committee adjourned at 7:05 p.m.]

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