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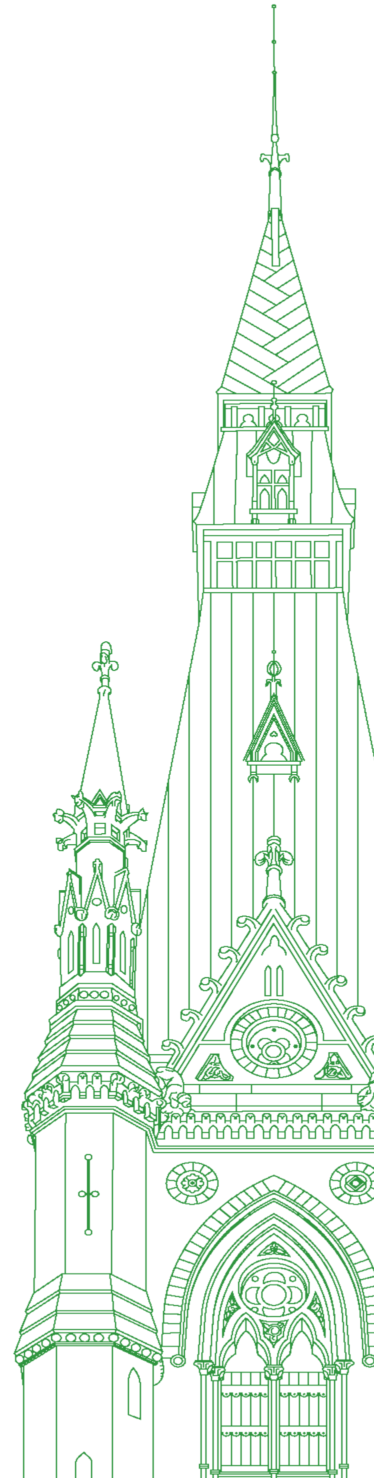

Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, March 30, 2022

● (1610)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order. Welcome to meeting number 14 of the House of Commons Standing Committee on Health.

Today we will be meeting for two hours to hear from witnesses for our study of the emergency situation facing Canadians in light of the COVID-19 pandemic. I would like to begin by thanking our witnesses for being with us today and for your patience as you waited for the delayed start of this meeting because our our votes in the House. I understand there's a fair possibility that we will be interrupted by votes again, but we very much look forward to hearing from you. Again, thank you for your patience.

Today's meeting is taking place in a hybrid format pursuant to the House order of November 25, 2021. Per the directive of the Board of Internal Economy on March 10, 2022, all those attending the meeting in person must wear a mask, except for members who are at their place during the proceedings. For the benefit of the witnesses and members please wait until I recognize you by name before speaking. For those participating by video conference please click on the microphone icon to activate your mike and mute yourself when not speaking. For those on you on Zoom you have the choice, at the bottom of your screen, of either the floor, English or French. For those in the room, you can use the earpiece and select the desired channel.

I remind you that all comments should be addressed through the chair and that you are discouraged from taking screenshots of your screen. Everything that we do here will be made available on the House of Commons website. In accordance with our routine motion, I am informing the committee that all witnesses have completed the required connection tests in advance of the meeting.

I would like now to welcome our witnesses who are with us this afternoon for two hours. Here as an individual, we're pleased to have Dr. Isaac Bogoch, associate professor of medicine, University of Toronto, and staff physician in infectious diseases, Toronto General Hospital. As an individual, we also have Dr. Emilia Liana Falcone, director, post-COVID-19 research clinic, Montreal Clinical Research Institute, and attending physician, infectious diseases, Centre Hospitalier de l'Université de Montréal.

From the Canadian Association of PPE Manufacturers, we have the president, Barry Hunt. From the Canadian Cancer Society, we have Stuart Edmonds, executive vice-president, mission, research and advocacy, and Kelly Masotti, vice-president, advocacy. From the Canadian Mental Health Association, we have Rebecca Shields, chief executive officer, York and South Simcoe Branch; and from the Neighbourhood Pharmacy Association of Canada, we have Sandra Hanna, chief executive officer.

Again, thanks to all of you for appearing today. We're going to begin opening remarks from each of you in order you are listed on the notice of meeting. As you've probably already been advised, if you could limit your opening to five minutes that will allow us more time to ask questions.

Dr. Bogoch, we're going to start with you. Welcome to the committee. You have the floor for the next five minutes.

● (1615)

Dr. Isaac Bogoch (Associate Professor of Medicine, University of Toronto, Staff Physician in Infectious Diseases, Toronto General Hospital, As an Individual): Thank you so much.

Thank you for the invitation and the opportunity to speak at this meeting of the House of Commons Standing Committee on Health.

My name is Isaac Bogoch. I'm an infectious diseases physician and scientist based out of the University of Toronto and the Toronto General Hospital. I have worked closely with various levels of government in both a formal and informal capacity during this pandemic.

As we trudge forward somewhat exhausted from the last two years, it's still appropriate to acknowledge that COVID is not going anywhere any time soon, and we will see an ongoing waxing and waning of disease activity in Canada and also in communities around the world, and this is, of course, going to be associated with morbidity and mortality, unfortunately. COVID is obviously a global issue, but I'm going to focus my talk locally.

With that in mind, how do we plan ahead so that Canadian society is not disrupted significantly by future waves or variants? Or, said another way, how do we live with COVID? By "live with COVID", I mean how do we protect all Canadians, including and especially vulnerable individuals and at-risk communities?

I'm approaching this with the understanding that we should never close businesses or schools again. We have the tools to avoid this. This involves being proactive and not getting caught flat-footed.

I see two main pillars that we should be addressing. Pillar one is building resilient health care systems, and pillar two is really fostering resilient communities and environments.

Just focusing on the first one, building a COVID-resilient health care system, this really involves proactive vaccine and therapeutics procurement and perhaps production. We saw early on that our inability to produce these products locally was a true health security threat, and now we're taking steps to remedy this, but we still need momentum on that front.

Related to vaccine and therapeutic procurement is vaccine and therapeutic rollout to the population. We have to continue to be nimble and fast with policy to be able to keep abreast of emerging evidence in real time and convert this evidence into sound policy. It also means rolling out vaccines and therapeutics in an evidence-based and equitable manner with as few barriers as possible. That might seem abstract, but a good example of this is how, in parts of the United States, they're going to roll out COVID treatments at some pharmacies. Pharmacies are present in most neighbourhoods and are staffed with knowledgeable health care professionals; they often don't require an appointment, and they're often more accessible than traditional routes for health care. COVID therapeutics at pharmacies without a prescription is just one of an infinite number of examples of how we can lower barriers to health care and provide fast, meaningful high-quality health care to populations.

The other big issue in the health care system is preparing for surge capacity. This involves outpatient care, hospital care and, of course, ICU care. We will see more variants. We will see more waves, and eventually we are going to have a real flu season coupled with COVID, and it's going to be a challenge. We can't continue to cancel scheduled surgeries every time we have a wave and our system is stretched. It's vital to have medium and long-term strategies to build more beds and to staff them, not just with doctors but also with allied health care providers. This involves meaningful investments making the health care sector a more attractive place to work, and, of course, less red tape preventing skilled health care providers who have trained in other countries and are now living in Canada from working.

Let's focus our attention now on building more resilient populations and environments. It's easy to say, hard to do. The lowest hanging fruit is normalizing mask use during COVID surges. This is a light-touch intervention, and while, of course, masking is not perfect, it still helps the individual, it helps vulnerable people, it helps the community and I think it's about as easy as it gets.

An additional strategy is further study on how we can build safer indoor spaces. This is where COVID and other respiratory viruses transmit. That, for example, includes improving indoor air quality. This involves an interdisciplinary approach with social scientists, engineers, infection specialists, building owners, building managers and others. It's not just as simple as installing HEPA filters.

Last, I think an area for improvement includes enrolling social scientists, behavioural change experts and communications experts into the larger pandemic plans. We are going to continue to see rapid scientific advancements. We're going to see variants, we're going to see waves, we're going to see a fair bit of the unknown. Policy has to be data driven and relevant, and it has to keep up with our lightning pace of discovery. Some of what's true now may not be true in the near future. We need public trust and public buy in. Behavioural scientists and communications experts can help communicate change and adaptation and communicate the unknown in an age, language, and culturally appropriate manner. I think they'd be invaluable in our future pandemic response.

● (1620)

I have several other thoughts and I'm happy to keep the conversation going during the question period. Thank you for your time.

The Chair: Thank you, Dr. Bogoch.

Next, Dr. Falcone, you have the floor. Welcome to the committee.

Dr. Emilia Liana Falcone (Director, Post-COVID-19 Research Clinic, Montreal Clinical Research Institute, Attending Physician, Infectious Diseases, Centre Hospitalier de l'Université de Montréal, As an Individual): Thank you, Mr. Chair and members of the committee, for offering me the opportunity to speak with you today. The thoughts that I will be sharing with you reflect my experiences during the COVID-19 pandemic as an infectious diseases specialist, researcher and director of the post-COVID-19 research clinic of the Montreal Clinical Research Institute. The views shared today are my own.

The COVID-19 pandemic began one year after I was recruited to the Montreal Clinical Research Institute. Prior to this recruitment, I spent eight years at the United States National Institutes of Health, completing my infectious diseases training within the National Institute of Allergy and Infectious Diseases, which is led by Dr. Anthony Fauci. During this time, I also obtained my Ph.D. at the University of Cambridge. This combined training in medicine and basic science laboratory research was essential in allowing me to anticipate, at the start of this pandemic, that there would be long-term sequelae of COVID-19. As such, I submitted a proposal for funding to CIHR in May 2020, which was unfortunately not retained. However, eight months later, I obtained sufficient funding from the Quebec government to allow for the opening of Quebec's first long COVID research clinic.

This research clinic represents a novel clinical infrastructure where every patient is enrolled in a research protocol, allowing for a comprehensive clinical evaluation, parallel data collection, human specimen biobanking, and by extension, the completion of laboratory research almost simultaneously within the same building. We are therefore able to perform translational research, which is research where we have the privilege of learning first-hand from the lived experience of patients with long COVID, and can then use this information to inform our research questions in the laboratory.

[*Translation*]

According to the World Health Organization, WHO, post-COVID-19 illness, or long COVID, is a condition that occurs in people who have had COVID-19, usually three months after the initial infection, with symptoms that last at least two months and cannot be explained by any other diagnosis. Symptoms may occur even after an acute asymptomatic infection or after initial recovery, and may fluctuate over time.

The diagnosis of long COVID is therefore complex and often requires longitudinal follow-up. In addition, the symptoms associated with long COVID are numerous, and many of them, such as fatigue and shortness of breath, overlap with other diseases. Some sequelae of long COVID can last more than two years, be extremely debilitating, and negatively impact patients' personal and professional lives, resulting in a number of patients being unable to return to work.

With a conservative estimated prevalence of 10%, the number of patients with the disease far exceeds the capacity of the specialist clinics already established in Canada, which can be costly to the Canadian health care system, as some patients may develop additional complications, while others will have to undergo several additional tests, in addition to being referred to several specialists.

[*English*]

Long COVID is a complex diagnosis to make, made even more complex by the fact that we do not yet have a full understanding of the cause of this condition. The management of long COVID is also challenging as it requires a multidisciplinary approach and we are currently lacking specific pharmacological treatment options. Without fully understanding the mechanisms that underlie the novel disease entity that is long COVID, it is challenging to identify reliable biomarkers that may either predict who will develop long COVID or help make a long COVID diagnosis. These biomarkers are especially important in the context where COVID testing by PCR is not available to all. Most importantly, the understanding of the disease mechanism is ultimately essential to identify therapeutic targets that may quicken the recovery from long COVID, especially if these treatments are administered early on in the course of the disease.

It is within this context that we need to be forward thinking and maximize our learning when faced with a new clinical entity such as long COVID or even a new infectious disease. One way to maximize this learning with a structured and efficient approach is through a translational research infrastructure that is integrated into clinical care pathways. The integration of a research clinic model, such as the one established at the Montreal Clinical Research Institute, into specialized centres across Canada would be essential for the rapid identification of diagnostic biomarkers and new therapeutic targets. This model would be even more effective if it were integrated into a network that would use standardized protocols and have an established infrastructure for real-time data sharing and integration. With this coordinated and rapid approach, we would further distinguish ourselves as a country, not only in the context of long COVID but also in the management of other complex and chronic diseases.

In addition, such an infrastructure would foster collaborations between government, industry and academia at both the national and international levels. Undoubtedly, these efforts will also allow us to be better prepared to rapidly manage the next pandemic.

● (1625)

I thank you again for the opportunity to speak to these issues, and I welcome any questions that you may have.

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

Next, we're going to hear from the Canadian Association of PPE Manufacturers.

Mr. Hunt, you have the floor for the next five minutes.

Mr. Barry Hunt (President, Canadian Association of PPE Manufacturers): Thank you, Chair and the committee, for the invitation to speak here today.

The Canadian Association of PPE Manufacturers, CAPPEM, is made up of 30 Canadian controlled private corporations, SMEs, who answered the government's call to produce PPE here in Canada.

At the start of the pandemic, Canada had no N95 manufacturers, testing labs, or national standards. Canadian hospitals only bought N95s from multinationals that sourced from foreign countries. The N95s in the national emergency strategic stockpile had expired long ago, and most had been destroyed.

When the pandemic hit, China, Taiwan, and the U.S., banned exports of N95s, and the U.S. locked Canada out of NIOSH N95 certification. When the chips are down, we simply cannot rely on multinationals or foreign countries to protect our country. CAPPEM was created to ensure that Canada would never again be vulnerable to foreign countries and multinationals for the supply of PPEs.

When COVID hit, Canada was desperate for PPE, but the multinationals could not deliver. The government response was threefold. One, compete in the world market to fly in billions of dollars of overpriced PPEs, 30% of which were found to be defective, counterfeit, or contaminated. Two, sole-sourced multi-year contracts and grants to the same two multinationals, 3M and Medicom, who could not deliver foreign N95s to Canada, when Canada needed them most. Three, a call to action to Canadian business to create a new domestic PPE industry.

SMEs make up 99% of the Canadian economy. They employ 90% of the private work force and 10 million Canadians. Canadian SMEs are the economic engine of Canada and we are here to help.

Today, we need your help. Medicom and 3M represent the 1%. Multinational manufacturers of foreign goods have been invited now by government to manufacture N95s here in Canada with plants bought and paid for by Canadian taxpayers. They were given sole-source contracts in the order of $600 million to sell N95s in competition against Canadian industry. This undermines the entire domestic Canadian PPE industry.

Despite promises made by the government to support the new PPE industry with flexible procurement, Canadian SMEs have been locked out of both federal and hospital contracts for almost two years now. Unless government reverses course, we will continue to be locked out for the next decade, and perhaps forever. The federal government says it no longer has an appetite for PPE procurement. In other words, there will be no contracts for Canadian industry. Over 100 Canadian SMEs answered the government call to action, and 70% of them are now out of the PPE business—many now bankrupt, and others on the way to bankruptcy.

The remaining CAPPEM SMEs, committed to a sustainable industry, can now produce 800 million high-quality N95s, two billion medical masks, and millions of reusable N95s every year. However, while Canadian industry is suffering from a lack of hospital contracts and promised government contracts, and now faces additional unfair competition from dumping and unfair labour practices, because the pandemic tariff exemption for PPEs has long outlived its usefulness.

SME innovation drives Canada's economic growth. There's been more innovation in Canadian PPEs in two years than in the previous 50 years worldwide. We've created new filter materials, new elastomeric N95s that look like cloth masks, and a new CSA national standard for N95s with the highest performance requirements in the world. We've also developed the world's first industry standard for bioaerosol masks to protect the general public from virulent airborne disease.

There is no stockpile today of suitable bioaerosol masks intended for the public. We believe this is a major failing in emergency preparedness. Some 14 major variants of concern have already emerged, with no signs of stopping. We need to prepare for the very real possibility that some day we may face a highly virulent strain. Canada's eight-week stockpile of N95s would be gone in eight days. We have nothing in our stockpile to provide to our eight million children.

A sustainable domestic PPE industry is absolutely the right thing for Canada. It has overwhelming public support, but it does not have the government support to make it a reality.

We were unprepared two years ago for a virulent airborne pandemic. We are still unprepared today. We heard testimony from PHAC that we are "now well situated...with N95 respirators, with domestic manufacturing in Canada." I can assure you that we are not. We need to support our domestic PPE industry now, or it won't be there when we need it.

Thank you.

● (1630)

The Chair: Thank you, Mr. Hunt.

Next, we have the Canadian Cancer Society with Mr. Edmonds and Ms. Masotti.

Dr. Stuart Edmonds (Executive Vice-President, Mission, Research and Advocacy, Canadian Cancer Society): I'm going to start, Mr. Chair.

Thank you to the members of the committee for the opportunity to present today.

My name is Dr. Stuart Edmonds. I am the executive vice-president of Mission, Research and Advocacy at the Canadian Cancer Society. With me today is Kelly Masotti, vice-president of advocacy.

With respect and gratitude I am joining you today from the traditional territory of many nations, including the Mississaugas of the Credit, the Anishinabe, the Chippewa, the Haudenosaunee and the Wendat people, which is now home to many diverse first nations, Inuit and Métis people. I also acknowledge that Toronto is covered by Treaty No. 13 and the Mississaugas of the Credit.

Two in five Canadians are expected to be diagnosed with cancer at some point during their lifetime. Cancer is the leading cause of death in Canada, accounting for 28% of all deaths.

Today, we will share with you how the COVID-19 pandemic has impacted the cancer experience of many people living in Canada, and their loved ones.

Multiple waves of COVID-19 have put a tremendous strain on Canada's health care system. To ensure that there was sufficient health system capacity during surges of COVID-19, hospitals across provinces and territories were directed to pause all their procedures deemed non-urgent, including cancer screening, diagnostics and surgeries. This has subsequently led to a growing backlog of delayed cancer screening, diagnostics and surgeries, which means people living with cancer are waiting longer to receive care.

We know that when cancer is found early, it's often easier to treat. Delays in screening and diagnosis may result in poorer patient outcomes, including an increased risk of death.

The impact of COVID-19 on cancer prevention, diagnosis and treatment will be felt for months and years to come. Studies are starting to be published on how COVID-19-related delays impact people living with cancer. A recent Ontario modelling study published in the Canadian Medical Association Journal estimated that longer wait times for cancer surgery may lead to shorter long-term survival. This study highlights the importance of maintaining timely access to cancer surgery to prevent the harmful impacts of delayed care on people living with cancer, even during times when health resources are constrained.

In CCS-led surveys between July 2020 and March 2022, people with cancer reported having their cancer care appointments postponed or disrupted. Almost half the patients reported disruptions in the first wave of the pandemic, and while disruptions dropped over time, they have increased slightly since August 2021. In our last survey, one-fifth of respondents reported disruptions to their cancer care appointments.

For many patients there is a window of opportunity for treatment. Delays in appointments and treatment may lead to missed opportunities, and the cancer may have spread.

CCS-led surveys found that people living with cancer had higher rates of anxiety during the early stages of the pandemic. The sense of anxiety was higher among caregivers, with more than three-quarters of respondents stating they were more anxious than normal.

CCS continues to hear from people affected by cancer who say they are frustrated by a lack of access to their health care teams, and although this concern has lessened over the course of the pandemic, we're still supporting them through our support programs, and we're still hearing from people who feel forgotten.

We need federal leadership. CCS was pleased to see the introduction of BillC-17 on Friday, which would provide an additional $2 billion to address immediate pandemic-related health care system pressures, particularly the backlog of surgeries, medical procedures and diagnostics. We encourage all parties to work together and pass Bill C-17 promptly. Every moment matters as has been evident by the recent CMAJ paper. Cancer is not waiting, and neither should the government.

CCS also urges the federal government to continue to make necessary investments to expand the domestic capacity of vaccines, therapeutics and other life-saving medicines. We were pleased when the government launched the biomanufacturing and life sciences strategy last July, with a commitment of $2.2 billion expected to be allocated over seven years.

One of the strategy's key investments created a $250-million new funding stream, the clinical trials fund. CCS welcomes this funding and looks forward to the details on this development and implementation of this fund. These investments are critical to keep Canada at the forefront of new innovations in health care and provide really early opportunities for Canadians to access potential game-changing new therapies and diagnostics.

I now want to turn it over to my colleague, Kelly Masotti.

● (1635)

Ms. Kelly Masotti (Vice-President, Advocacy, Canadian Cancer Society): Thank you, Stuart.

I want to acknowledge I am joining virtually from Ottawa, which is the unceded territory of the Algonquin Anishinabe Nation.

The COVID-19 pandemic has also shown us that substantial gaps persist in accessing palliative care, particularly at home or in the community. Caregivers for a loved one at home experienced a sharp increase in their duties, exacerbating the need for greater psychosocial, physical, and practical support for caregivers. As a member of the Quality End-of-life Care Coalition of Canada, we urge the government to continue to implement the framework and action plan on palliative care, including an office for palliative care to help coordinate aspects like data collection on palliative care, and to continue to invest in palliative care research.

Finally, we encourage the federal government to play a role in ensuring that Canadians are set up for success in making healthy and informed choices that make it easier to live smoke-free, keep a healthy weight, adopt a healthy diet, be physically active, be sun safe and reduce alcohol consumption. The federal government can play a strong leadership role in implementing policies and programs that will have an important population health impact.

We would also like to take the opportunity to thank the government for supporting the extension of the employment insurance sickness benefit. This extension of at least 26 weeks will change the lives of Canadians.

We look forward to continuing to work together to implement these very important recommendations for people living with cancer and living beyond cancer, including encouraging all parties to work together to pass Bill C-17 promptly, improvements to the delivery of palliative care, the implementation and the extension of the employment insurance sickness benefit and to see the clinical trials fund be implemented.

We thank you very much for your time today, and we look forward to your questions.

The Chair: Thank you, Ms. Masotti and Mr. Edmonds.

Next, from the Canadian Mental Health Association, we have Rebecca Shields. You have the floor for the next five minutes.

Ms. Rebecca Shields (Chief Executive Officer, York and South Simcoe Branch, Canadian Mental Health Association): Thank you, Mr. Chair and the committee, for the opportunity to present today—

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): I have a point of order, Chair.

The Chair: Hold on a second, Ms. Shields.

Go ahead, Mr. Barrett.

Mr. Michael Barrett: I apologize for the interruption, Ms. Shields.

Through you, Mr. Chair, the bells are ringing in the chamber for a vote. The last time we discussed this matter at committee, some members indicated that in the future they would not grant unanimous consent, because it's their absolute privilege to vote in person in the chamber, which is 100% correct. I would ask through you, Mr. Chair, if we could seek the unanimous consent of committee members to hear the opening statements of all witnesses, if time allows, and then proceed to the House to vote. I say this just in case any of our witnesses aren't able to join us following the conclusion of that vote in the chamber.

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

Colleagues, Mr. Barrett is quite right that without the consent of the committee, we're obligated to suspend the meeting. Do we have the consent of the committee to proceed to hear the remainder of the opening statements before suspending?

Some hon. members: Agreed.

The Chair: I understand there is consent in the room.

Thank you very much for that, Mr. Barrett.

Ms. Shields, please continue.

Ms. Rebecca Shields: Thank you very much.

I think we all know and all heard about the impact of the pandemic on the mental health of Canadians. I want to focus my remarks today on two specific areas where I think the federal government can help. I was very pleased to see that the federal government assigned a new Minister of Mental Health and Addictions. My remarks will be specific to some of the deliverables of that position.

Our research shows that one in five Canadians felt that they needed help with their mental health through the pandemic, but they didn't receive it, because they didn't know where to get it. They didn't think help was available, or they couldn't afford to pay for it. Beyond just building more services, I want to talk today a little bit about "how".

The first topic I want to talk about is youth services. One of the deliverables was to introduce a new fund for student mental health that will support the hiring of new mental health care counsellors, improve wait times for service, increase access overall and enable targeted supports for Black and racialized students at post-secondary institutions. This is critical. Twice the number of children and adolescents have experienced depression and anxiety since the pandemic began; 11% of all people who experience homelessness are youth; one in four youth has clinically elevated symptoms of depression; one in five has clinically elevated symptoms of anxiety; and 70% of all mental illness starts in youth at the ages of 12 to 17. However, what I'm worried about is that the government will give the money to colleges and universities to hire mental health counsellors, creating yet another silo of care that is not integrated. We all hear that the major challenge is that people don't know how to get services.

Rather than funding an already established system of care.... I want to show an example of how this works. In its wisdom, the federal government, through IRCC, funded our agency to provide holistic mental health care through settlement agencies and through welcome centres since the pandemic. Since the start of that program, we have served 292 clients. Of those, 85% experienced an improvement in their depression-related symptoms, and 89% experienced improvement in their anxiety-related symptoms and remain connected to their settlement services. Integrating care is vital, as opposed to establishing a whole new section where we have to then build relationships rather than connect them into a whole system of care.

The second area I want to talk about is the increase in substance abuse. I want to position this, though, in terms of a population perspective. COVID did not affect the genders or the populations the same. In fact, it was men who had higher rates of problematic alcohol abuse, up 28%, whereas for women it was only 18%. Men had problematic cannabis use, up 39%, and women just a little bit less. Overall, we also saw that females, especially females with children at home, had higher rates of anxiety and depression than men. They reported that men had more issues with social isolation and finance, where women had more issues with finance and caring for children. The situations are very different. "One size fits all" is not the solution. I urge the federal government, when it is designing a system of care to deal with substance abuse, to look at local solutions rather than broad public health strategies. It needs to invest in local communities where it can target populations directly.

I want to give another example of how this can work. Whether you look at OHTs or at health authorities, most of them have population-specific groups that bring together agencies who come together to deal with these issues. We have to leverage these and provide small community grants to be able to access these populations rather reach the norm through a broad scale, because COVID, as we know, impacted the mental health and the health of newcomers and minority populations far more often, or in far greater rates, than it did for white Canadians.

● (1640)

Really in summary, what I want to say is to integrate care with local existing, and do hyper-local responses.

Thank you.

The Chair: Thank you, Ms. Shields.

Finally, we have the Neighbourhood Pharmacy Association of Canada, represented by their CEO, Sandra Hanna.

You have the floor, Ms. Hanna.

Ms. Sandra Hanna (Chief Executive Officer, Neighbourhood Pharmacy Association of Canada): Thank you, Mr. Chair.

Honourable members, thank you for the opportunity to present to you today.

I am actually, first and foremost, a practising pharmacist who has had the privilege to work alongside my health system partners and governments in our collective efforts to meet the needs of Canadians as we weathered the storm of the COVID-19 pandemic over the past two years.

Today I join you as the CEO of the Neighbourhood Pharmacy Association of Canada, a not-for-profit trade association that represents leading pharmacy organizations, including chain, banner, long-term care, specialty pharmacies and grocery and mass merchandisers with pharmacies. We advance health care for Canadians by leveraging close to 11,000 pharmacies across the country in almost every Canadian community as integral community health hubs.

Pharmacies are often the first and most frequent touch point that Canadians have with the health care system, and 95% of Canadians live within five kilometres of a pharmacy. Canada's community pharmacies dispense over 750 million prescriptions annually, deliver the majority of influenza vaccinations each year, and in the past 12 months alone have administered over 18 million COVID vaccinations to Canadians, reducing the rate of illness and strain on an already overwhelmed health care system.... [*Technical difficulty—Editor*]

As we continue to navigate the steady stream of challenges caused by the pandemic, and as our federal political leaders reflect on the future needs of our health care system to support our citizens, treat those in need and protect our most vulnerable, there are even more opportunities to unlock the potential of pharmacy as a partner in communities across the country as we look to building resilient health systems.

Pharmacies and the robust supply chain that serves them have demonstrated unwavering commitment to Canadians and health systems throughout the pandemic as critical partners in the timely delivery of products and services, in mitigating supply chain challenges early on in the pandemic, and in helping Canadians to access vaccines and tests conveniently in virtually every community across the country. Without our services, medicine simply cannot get to Canadians.

Our priority is and always will be maintaining and continually improving access to prescription medicines for Canadians. While there are differences in opinion on a number of key files, including national pharmacare programs or pricing reform on patented medicines, we can all agree on one thing and it is that all Canadians should have access to the medicines they need.

Recent research demonstrates that while 82% of those surveyed support a national pharmacare plan, 70% of those supporters are opposed to a program that would replace their existing drug plans. In fact, 80% of those surveyed of those surveyed continued to be satisfied with their existing benefits. Canada's priority must be helping those who do not have coverage and those with insufficient coverage, including those with rare diseases, without disrupting the majority of Canadians who already do have drug coverage. By taking this approach we can minimize unnecessary expenses and costs to taxpayers, and allocate money to the many other critical health care priorities that we're discussing today.

The federal government can demonstrate leadership by establishing national principles to ensure an equitable approach while maintaining the integrity of existing plans. The government has previously also cited COVID-19 as a primary reason for delaying the implementation of the PMPRB's regulatory reforms. As we continue to see economies reopen, we can all agree that the pandemic is not yet behind us. Canadians deserve to pay a fair and reasonable price for their prescription drugs; however, reductions in prices have unintended downstream impacts on the professional pharmacy services that Canadians rely upon day-to-day to ensure timely access, safety, appropriateness and effectiveness of their therapies. We are concerned that the impacts of the proposed PMPRB regulations and guidelines on patient programs will be severe, and that the implementation of these regulations during an ongoing pandemic will add undo burden on pharmacists and pharmacy teams as they navigate the impact of these changes on pharmacy operations.

We have seen pharmacies offer critical supports in areas of testing and vaccination, and we know that we're just scratching the surface of pharmacy's potential to increase capacity in many public health and primary care areas. We know that there is a huge backlog of health care services, such as surgeries, chronic disease diagnoses and immunizations, that we must work together to catch up on,. This requires that every health care provider work to their full scope and capacity to improve access to care for Canadians.

With pharmacies across the country now participating in the distribution of COVID tests, and many conducting tests on site, pharmacies are uniquely situated to support the health system with disease screening and prescribing and dispensing of antivirals such as Paxlovid.

Pharmacies can also create capacity in public health as we catch up on the one in four Canadian adults, and up to 35% of children, who have missed or delayed a routine immunization due to the pandemic. Evidence demonstrates that convenience is a key driver to vaccine uptake, and the accessibility of community pharmacies provides convenience like no other.

● (1645)

There's a lot of work ahead of us, not only to alleviate the strains the COVID-19 pandemic placed on our health care system, but also to ensure that equity and equal access to services are delivered to under-represented communities from coast to coast to coast.

Neighbourhood pharmacies and our members remain committed to working with the federal government and all stakeholders to leverage the expertise of our teams to create capacity and fill gaps in care.

Thank you once again for this opportunity to speak with you today. I'd be pleased to answer any of your questions.

The Chair: Thank you very much, Ms. Hanna.

As was indicated, as a result of Mr. Barrett's point of order, we're now going to suspend.

Just for the benefit of witnesses, I want you to know that in 17 minutes, members of Parliament will be casting a vote. If they decide to go over to the chamber to cast that vote, we'll be looking at a delay beyond that 17 minutes of at least another 10 to 20 minutes.

This is a chance for you to stretch your legs, get something to drink and [*Technical difficulty—Editor*] would be to resume to take questions subject to a motion for adjournment. As of right now, we're suspended, and you have probably 25 minutes or more to yourselves.

The meeting is suspended. Thank you.

● (1645)

_____________________(Pause)_____________________

● (1730)

The Chair: I call the meeting back to order. I understand that we have quorum.

I see that our witnesses have their cameras off, but they're filing back in.

Before we begin with rounds of questions, I would like to advise the committee that we have support from the House of Commons to go 80 minutes, but that is 80 minutes beyond what the witnesses and the members committed to.

I'd be interested in hearing whether there have been any discussions in the room and whether there's any agreement as to how long folks are willing to go, subject to the availability of our witnesses. Or, do we just want to start and call for a motion for adjournment to be presented virtually at any time?

Mr. Barrett, do you want to lead off?

Mr. Michael Barrett: Just on that point, Mr. Chair, I think there were some discussions. I'm not sure that we have a concrete time. I can say that Conservative members are prepared to fulfill the 80 minutes remaining of House resources, provided that witnesses are available.

The Chair: I would suggest that we begin, and at the end of two full rounds we canvass the room.

I'm looking at the witnesses. Are you able to stick with us for an hour and maybe a little more?

I see thumbs-up all around. Thank you.

We're going to begin now with rounds of questions.

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chair, may I speak to the motion, please?

The Chair: Mr. Davies, go ahead.

Mr. Don Davies: Thank you.

I'm mindful of the fact that we are now beginning the questioning at the time that the committee meeting was supposed to end, and I appreciate the 80 minutes. I cannot stay longer than 6:30 at the absolute latest, so that's a hard exit for me.

I'm not sure how much time the witnesses have who have been waiting since 3:30 eastern, but out of respect for their time, and those of us who have other obligations to go to, I would say that there should be a hard stop at 6:30. That would give us enough time for two rounds, I would think.

The Chair: That would give us two full rounds.

Mr. Don Davies: Maybe we can agree to do two rounds or 6:30, whichever comes first.

The Chair: I'll ask for a motion to adjourn at 6:30, and hopefully that will carry the day.

Very well, we are going to begin with rounds of questions, beginning with Mr. Barrett for six minutes.

Mr. Barrett, you have the floor.

Mr. Michael Barrett: Thanks very much, Chair.

Through you, Mr. Chair, to our witnesses, I want to extend my sincere thanks for your appearance today, and also for your patience as we engage in democracy, voting in the House of Commons today. Thank you very much for your patience and for your statements today.

I want to go back to Dr. Bogoch.

It seems that you spoke quite a while ago now. You said that we can't cancel surgeries anymore, we can't be closing businesses and we can't close schools, because we have the tools to make sure that it's not necessary. I agree.

I'm wondering if you can take a moment to expand on some of the ways that we can innovate to increase capacity in our health care system.

Dr. Isaac Bogoch: Obviously, we could spend hours on this, but I'll be as brief as possible.

In terms of expanding health care, we have to be a little bit creative as well. One thing is we need more people working in health care and we need more beds. That's a solid investment over time and it's a solid investment to train individuals.

We also have very skilled health care providers in the country who are not able to work. These are internationally trained graduates and foreign medical graduates. They're involved in multiple health care professions beyond medicine, nursing and other allied health care professions, and they are not able to work because Canada has not accepted their credentials. There's a lot of red tape in Canada preventing them from working. We have way more health care providers in the country than are mobilized at this point, and they're eager to work. That's an area we can explore further.

Related to preventing shutdowns, we have the tools. We have very simple tools, like masking. Masks alone don't stop a wave, but they certainly blunt a wave. They protect vulnerable individuals. We have vaccines and we have a growing array of therapeutics that are slowly launching in out-patient settings. That's really good. Vaccines keep people out of hospital. Therapeutics can keep people out of hospital. We have to have timely and equitable access to them.

My pharmacy colleague on this call will be much better prepared to answer this than me, but pharmacies and pharmacists are in every neighbourhood. They're accessible. They can do the testing. They can do the treatment. I appreciate that there are drug interactions. Who's better to look at drug interactions than a pharmacist? They're qualified health care providers who can provide timely access to health care on the neighbourhood corner, without some of the barriers that exist with more traditional aspects of care, like seeing your primary care provider.

We can expand on all of those fronts, but we have the tools and we'll have a growing array of tools to really help prevent people getting sick and landing in hospital, such that we don't have to, for example, cancel scheduled surgeries, like we've seen in the past.

● (1735)

Mr. Michael Barrett: Thank you very much for that answer—

The Chair: Mr. Barrett, I'm sorry to interrupt.

I just got a note from the clerk that we're going to lose Ms. Shields in about 10 minutes. I wanted to alert you to that. If the next couple of questioners have questions for her, they [*Technical difficulty—Editor*].

Go ahead, sir.

Mr. Michael Barrett: Thank you, Chair.

Following up on Dr. Bogoch's point, Ms. Hanna, what are the regulatory burdens that restrict the ability of pharmacies to expand their service offerings to complement and support our overwhelmed health care system in some of the ways that Dr. Bogoch mentioned and that you mentioned in your opening remarks?

Ms. Sandra Hanna: Dr. Bogoch mentioned it, and he stole the words right out of my mouth.

Pharmacies and pharmacists are not only in every community, but we're also supplied by a very robust supply chain that allows us to have timely access to these therapies in every single community. At the moment, depending on the province.... Obviously, the jurisdictions and the provinces vary in the scope of practice and ability of pharmacists to prescribe certain products. Dr. Bogoch mentioned that these products should be available without prescription, and pharmacists can still counsel, supply, educate and ensure that these products are made available to the right patients in an equitable, accessible and safe way.

In terms of regulatory barriers, if it is not a prescribed product, it's a question of supply, of access and of its being available through the pharmacy sector, which, in many provinces right now, it is not. It is restricted to primary [*Technical difficulty—Editor*] testing or public health centres.

I think it's more of a planning question and making it accessible to the pharmacy sector to make it accessible to Canadians.

Mr. Michael Barrett: Thank you very much for that.

I have just under a minute left. We heard talk about vaccines and the availability of some of these different products.

With my remaining time, Chair, I want to provide the committee with notice of a motion. I'm not moving a motion; I'm providing notice to the committee. It's been sent to the clerk in both official languages. It reads:

> That, pursuant to Standing Order 108(2) the Committee undertake a study on the government's role in the development and procurement of the Medicago vaccine and that the Minister of Innovation and Minister of Health be invited to appear before the committee to testify.

That's also being made available now to the clerk in print in both official languages.

With my last five seconds, I want to again thank all of the witnesses for their patience, their expertise and their ongoing advocacy for the health and well-being of Canadians.

Thank you very much.

● (1740)

The Chair: Thank you, Mr. Barrett, and thanks for watching the clock.

We're going to Mr. Jowhari next for six minutes, please.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair, and thanks to all of our witnesses. We really appreciate your patience and your insight into the topic that we're talking about.

I'd like to also thank my colleague for allowing me to take his place.

Ms. Shields, you will be leaving soon, but welcome to our committee. You and I have been working very closely on the mental health front in the York Region for the past couple of years. In your opening remarks you talked about youth services and also about integrated care. First of all, I want to thank you for the work that you're doing in the York Region community as the CEO of the CMHA.

I also want you to provide us with some insight into the innovative initiatives that are currently under way by your branch, which is the mental health crisis hub. Perhaps you could kindly talk a little bit about it with the view of integrated care and the community base, as well as why this is leading in Canada and how our federal government can support you.

The Chair: The floor is yours.

Mr. Majid Jowhari: I think she's on mute.

I think Ms. Shields might have gone....

The Chair: She is still on the screen, but her camera and her mike are off.

All right. Do you have another question, Mr. Jowhari?

Mr. Majid Jowhari: No, I'll yield my time to my colleague, Dr. Powlowski.

The Chair: We have Dr. Powlowski, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Bogoch, I wanted to ask you about medical therapeutics.

In the last two years we have been on a number of committee meetings together, and you probably heard my questions about this. In Ontario, we now have two forms of therapeutics that I think are fairly readily available: Paxlovid, an antiviral, and also sotrovimab, a monoclonal antibody. Both have been shown to be quite effective in preventing hospitalization and serious illness when given early to high-risk people.

Off the top of my head, my numbers are that sotrovimab results in an 80% reduction in hospitalization, and with Paxlovid, I think the original studies were that it was 90%. Now those are probably out of date. It would seem to me that this ought to be a big part of trying to ensure that future waves don't end up shutting us down. When people who are at high risk get sick, they should be able to access these treatments, and thereby we can prevent a lot of hospitalizations, ICU admissions and deaths.

Let me start off by asking this: Are you using those forms of therapeutics very much, and are doctors in Canada using them as much as they ought to be?

Dr. Isaac Bogoch: Thank you for your question.

Yes, this is obviously a rapidly expanding area in Canada. Just to rewind for a second, earlier in the pandemic we had some very good therapeutics for hospitalized patients [*Technical difficulty—Editor*] an armamentarium of therapies for non-hospitalized patients with the whole goal to prevent people from getting sick and landing in hospital.

There have been hiccups, unfortunately. Sotrovimab, for example, and the other monoclonals don't seem to work very well against the current omicron variant. They are not being used, or not being recommended. Paxlovid is in very short supply and has a very narrow range of use. It has to be used very early on in the course of illness and has to be initiated within about four or five days of the onset of illness.

This really dovetails beautifully with our earlier conversation about getting therapeutics out quickly and in a low-barrier manner. For example, of course, we have family physicians, maybe emergency departments, maybe dedicated COVID centres, but also pharmacies and pharmacists, because they're available and they're everywhere. Pharmacists are highly qualified health care providers who can provide this quickly. They can also do the testing on site and respond to that test in real time by providing a drug that's needed in a very timely manner.

We are using these drugs. We're using them to a limited degree because we have (a) a limited supply, and (b) unfortunately omicron took the monoclonals out of our tool box, because they just don't work as well on it. There are a few others that work okay in an outpatient setting, for example, remdesivir, but again, that's an intravenous drug, so it's a bit more challenging to use. With time, we will have more access and more drugs available, and we can put those to good use.

● (1745)

Mr. Marcus Powlowski: My impression is—and this impression results from my not having enough to do as a member of Parliament, so I work Saturdays at a walk-in clinic. I see quite a few people with coughs, and nobody is doing PCR tests anymore; everybody is doing rapid testing, and everybody knows the drill. Okay, it's negative the first time, so we'll test tomorrow and the next day, and it becomes positive. They're quite familiar with it.

I don't think—and correct me if I'm wrong—that a lot of the public knows that therapeutics work or are available, so I'm a little worried that a lot of people who could be getting treated aren't getting treated because there's a lack of awareness that if you are at high risk—if you're 65, obese and have had one shot—maybe you ought to be getting Paxlovid or something.

Dr. Isaac Bogoch: For sure, 100%. I'll go back to my five minutes of time I had earlier. I think it's extremely important to enrol social scientists, communications experts, and really engaging in a culturally appropriate manner so that they're aware that vaccines are widely available and necessary and that therapeutics are increasingly available, and here's how you get them. We can go a long way. We certainly are underutilizing our social scientists and our communication experts. There are populations at risk who remain at risk, and they will have growing access to these drugs that are underutilized.

The Chair: Thank you, Dr. Bogoch and Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

Dr. Falcone, I am very pleased that you accepted our invitation. I hope that CIHR, or the Canadian Institutes of Health Research, will show as much innovation and research spirit as the Government of Quebec has done.

That said, I have nearly 15 questions to ask—we'll see what we can do in six minutes—which are divided into different categories. First, there are the risk factors, the effects of vaccination on long COVID, and the symptoms. Why do there seem to be more cases in women, for example? What about recovery and the effects of long COVID? There were fewer NAATs, or nucleic acid amplification tests. Is this related to the effects of long COVID? Anyway, I'll start.

Are there any particular risk factors that might accentuate the possibility of developing long COVID?

I am aware that in eight months you may not have been able to get all the answers to the questions I have today. Please feel free to tell me so.

Dr. Emilia Liana Falcone: Thank you very much for these very interesting questions. In fact, we have some preliminary answers to these questions.

First of all, in terms of risk factors, there is certainly a link with the severity of the acute illness. So if it's more severe, you're more likely to have long-term complications. That said, even patients with less severe disease or even an asymptomatic infection can develop long COVID.

With regard to other risk factors, we certainly see more women. We also see an association with type 2 diabetes, as well as [*Technical difficulty—Editor*]. One study showed an association with a history of asthma, a history of mental health problems, as well as several comorbidities prior to infection.

In more recent papers, which are more basic in nature, we see associations with certain autoantibodies— we're getting into the research area—with viremia, that is, the presence of an elevated SARS-CoV-2 viral load in the blood, as well as with reactivation of EBV, the Epstein-Barr virus. These are examples.

There is a team, in Germany, that has developed a tool to calculate risk that involves using some clinical data, which I've already told you about, combined with total blood immunoglobulin measurements.

That's the state of the art on risk factors.

● (1750)

Mr. Luc Thériault: I see.

We know that the Omicron and BA.2 variants are less virulent and more contagious. Could this have an effect on the prevalence of long COVID?

Can we assume that there will be an increase? Have you seen an increase in relation to these variants that are more contagious but less virulent, or is it more the virulence, at the beginning, that determines whether one will develop long COVID?

Dr. Emilia Liana Falcone: That's an excellent question.

Here you have to consider two factors: the virulence and contagiousness, of course, of the variant, but also the vaccination status of the host, since vaccination also decreases the risk of having long COVID. The majority of studies on this subject are not peer-reviewed. However, the data seem to suggest that there is about a 50% reduction in the risk of getting long COVID in this context. So you have to consider that part of the equation when you're assessing this. There are many more cases, so theoretically there should be more cases of long COVID. However, in a context where the disease is less severe and the hosts are vaccinated, I would expect that there would be a lower percentage of long COVID cases. That's what we're hoping for, at least.

That said, we are already seeing patients in our clinic who have symptoms of long COVID after being infected with the Omicron variant.

Mr. Luc Thériault: In short, may we conclude that being vaccinated provides additional protection against contracting the most severe form of the disease?

Dr. Emilia Liana Falcone: Yes.

Mr. Luc Thériault: I see.

Do you think that in the long term, a fourth dose of the vaccine would be necessary to protect people from long COVID?

Dr. Emilia Liana Falcone: At the moment, the data is still incomplete. The preliminary data I've already seen about the fourth dose seems to show a very moderate benefit in this context. I think you would have to have vaccines tailored to the emerging variants to have an effect on long COVID. I say that with considerable reservations, because we still need a lot of data.

Mr. Luc Thériault: Thank you.

There are many people with long COVID who report that they continue to suffer from brain fog.

The Chair: Mr. Thériault—

Mr. Luc Thériault: Can you explain what “brain fog” means?

The Chair: Did you hear the question, Dr. Falcone?

Dr. Emilia Liana Falcone: Yes, I heard it.

The Chair: Very well.

Please answer briefly. I tried to interrupt the member, but was not successful.

Dr. Emilia Liana Falcone: It's a fairly subjective term. Literally, patients feel that their ability to process new data is slowed down. They find that their cognitive abilities are diminished. This is associated with a perception that things are fuzzy, so to speak.

The Chair: Thank you, Mr. Theriault and Dr. Falcone.

[*English*]

We'll go next to Mr. Davies, please, for six minutes.

Mr. Don Davies: Thank you, Mr. Chair.

Thank you to the witnesses for your patience and your excellent testimony.

Dr. Bogoch, two days ago on Global News, you said the following:

> I think we should be wearing masks, I really do. We are seeing a rise in cases throughout the province. There's the wastewater surveillance signals that are up in most jurisdictions, not just in Ontario, but in many parts of Canada. There's probably more COVID in the community now than there was a week and two weeks ago.

My question for you, Doctor, is, do you believe it's premature to lift mask mandates in Ontario or across the country?

Dr. Isaac Bogoch: Thank you for that question.

Yes, my personal bias and my personal opinion is that it is too soon. Just because mask mandates are lifted doesn't mean that you can't wear a mask. We can all still choose to wear a mask.

I hope that many people are choosing to wear a mask given that we are seeing more COVID now than we did a few weeks ago and that we are in the midst of a wave. Just depending on where we are, the size of the wave might be a little bit different. I think we should be wearing masks now, and I'm continuing to wear a mask in indoor settings.

● (1755)

Mr. Don Davies: Would I be right, though, Doctor, in assuming that if there were a mask mandate, that would probably result in more people wearing masks than if it were purely voluntary?

Dr. Isaac Bogoch: Yes, I certainly agree with that. We do see that mandates indeed do work.

I truly don't know what proportion of people are wearing masks now that the mandate has been lifted, but [*Technical difficulty—Editor*] than if there was a mandate. We would still see more people wearing masks if there was a mandate than if there was not.

Mr. Don Davies: I'm looking for a yes or no response to this. Would I be correct in my thesis that wearing a mask has salutary effects to some degree against the spread the prevalence of aerosolized or droplet-based illnesses?

Dr. Isaac Bogoch: Yes.

Mr. Don Davies: Thank you.

Also, the subvariant of omicron known as BA.2 appears to be more transmissible than the original strain, BA.1, and is currently fuelling outbreaks in Europe and Asia, and in fact in other places around the world.

In your view, Doctor, have we reached the endemic phase of COVID-19?

Dr. Isaac Bogoch: No, I don't think we have. Endemic means different things to different people. I don't think we're at an endemic phase. We're probably on our way, but I don't think we're there just yet.

Mr. Don Davies: Thank you.

Now, Mr. Hunt, in a December 2021 article from CBC News, you noted that Canada's PPE industry was feeling “betrayed” by the Canadian government because the government is not buying from small home-grown companies, after encouraging them to step up to deliver the critical supplies. You were quoted as saying, “What we've seen is the exact opposite: buying only from multinationals, buying only commodity products, locking health care workers out of new and innovative products, and essentially, decimating the new PPE industry.

Can you expand on that, Mr. Hunt?

Mr. Barry Hunt: Initially the government, in March 2020, made a plea to Canadian industry to stand up a new PPE industry and made a promise to the Canadian public that they would be partnering with Canadian industry to deliver solutions for COVID. I have a quote here: “With a view to longer-term support, the Government of Canada will ensure procurement flexibility to support innovation and build domestic manufacturing capacity to supply critical health supplies to Canadians.”

That has not happened. The number of federal contracts given to the Canadian PPE industry, the members of CAPPEM, the Canadian Association of PPE Manufacturers, are zero. The contracts that have been given to the two multinational companies amount to about $600 million. That amounts to essentially an active measure against the Canadian PPE industry, in that $600 million in potential market is taken away and there are essentially crumbs that are left.

Mr. Don Davies: At the same time, in December 2021, the House of Commons unanimously adopted a motion calling on the federal government to supply Canadian-made PPE in the parliamentary precinct and to the various federal departments, agencies and organizations by January 31, 2022.

At the time, Mr. Hunt, you said the following in response, “CAPPEM and its members across Canada wholeheartedly applaud yesterday's unanimous motion.”

Can you confirm that the federal government successfully implemented this motion by the January 31 deadline and indeed to date?

Mr. Barry Hunt: We received a letter from the House Speaker to confirm that they would comply by January 31, and I believe that has happened. We received a letter from the Minister of Procurement, or a designate of the minister, to suggest that they would be following the rules for federal departments and organizations.

We were very encouraged by that. However, it was also followed with a comment that they no longer need PPE, or have a demand or desire for PPE, but that if they do some time in the future, they will consider buying Canadian PPE.

Mr. Don Davies: I think in your testimony, if I have it correct, Mr. Hunt, you said that Canada's eight-week supply of N95s will be gone in eight days.

Can you explain that for us, Mr. Hunt? How can an eight-week supply be gone in eight days?

Mr. Barry Hunt: We currently supply N95s to health care, and to various federal, provincial and territorial governments through central procurement.

If we have a particularly lethal variant that comes out and we want to protect our entire populace—38 million Canadians—that's an almost hundredfold increase in the amount of PPE we would need, or N95 respirators that we would need, and there is no capacity currently to be able to support something like that.

● (1800)

The Chair: Thank you, Mr. Hunt and Mr. Davies.

You got a lot in during those six minutes, Mr. Davies.

Next we're going to go to Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Mr. Chair, and thank you, of course, to the witnesses for being here.

I'd like to start with Dr. Bogoch.

We've talked a bit about increasing mask use and things like that. Are there particular benchmarks or metrics that you think we would need to make Canadians aware of in order to increase their mask use?

Dr. Isaac Bogoch: I'd have to think about that a little more closely, but I think that would be very easy to come up with. When there is *x* burden of COVID in a particular community, it could be recommended to wear a mask at a certain point. Of course, mask-wearing would be voluntary at any point, but that's something that certainly could be modelled and discussed with an interdisciplinary team.

Mr. Stephen Ellis: This is perhaps a big ask, Dr. Bogoch, but is that something you would be willing to do a one-pager on for this committee?

Dr. Isaac Bogoch: Yes, I would be happy to help on that front.

Mr. Stephen Ellis: Thank you for that. I appreciate it.

With the change in the way we do testing these days, certainly originally the way we talked about restrictions, lockdowns, mandates, etc. was really related to case counts, Dr. Bogoch.

Is it fair to say now that we should be more focused on hospitalizations than on case counts, especially now when we're not doing as much testing and, certainly, we're doing no contact tracing?

Dr. Isaac Bogoch: Yes. I would agree with that. I think we have to look at other metrics because we don't have that accurate a daily case count.

Hospitalizations, unfortunately, and deaths are a delayed metric. We should be acting long before we see a rise in hospitalizations and deaths. I think waste water surveillance is a wonderful surveillance tool we can use. It has a low impact. You can get a good view across the country of what the COVID situation is like, and we should be acting on those signals in addition to the other metrics we have.

Mr. Stephen Ellis: Excellent.

When we talk about using rapid tests, especially on asymptomatic people, we realize that these tests are really not very sensitive at all. Does it really make any sense to continue to push using rapid tests on asymptomatic folks?

Dr. Isaac Bogoch: I think they are excellent tests when they are used in the appropriate context. They answer the question “Am I transmissible to other people right now, yes or no?”, which is slightly different from the question “Am I infected with COVID, yes or no?” Some people test negative, but they end up being positive for COVID, but the real issue is that while their test is negative, they might in fact be positive but are just not at risk, or at much lower risk of transmitting to other people at that time.

So there's still a time and a place for rapid tests. Many people might continue to use those before they have, for example, an indoor gathering or perhaps before meeting with a more vulnerable individual.

I really think we should have tremendous access to these in the community setting so people can choose and have the option to use these tests in the right places, but, of course, we need some significant access and public education on when and how to use these tests.

Mr. Stephen Ellis: Okay. That makes better sense. Thank you.

Something else you talked about was using behavioural scientists and communication experts. I think you tied that into vaccine hesitancy.

Is that the idea you had around that, Doctor?

Dr. Isaac Bogoch: Yes. I actually think of it much more broadly. We want people to make smart decisions for themselves and data-driven decisions for themselves.

The data is changing with time. Policy is going to change with time, and we have to keep 38 million people up to date and in touch with doing the right thing. There might be a time to go get a vaccine. There might be a place to go get a therapeutic. There might be a time to put your mask back on. We have to reach all 38 million of us to inform people in a proper manner, and also have the public trust and public buy-in to do that when it's the right time. That really does involve having solid communication experts and social scientists as part of the team.

Mr. Stephen Ellis: Suffice it to say—and there's no reason to respond, Doctor—that name-calling is probably not part of that buy-in in building public trust. Is that fair?

Dr. Isaac Bogoch: Yes. I agree in full.

Mr. Stephen Ellis: Thank you.

Mr. Hunt, I have a question around the stockpile, on N95s in particular. Maybe you can inform the committee, sir, what the shelf life of an N95 mask is, unused that is.

Mr. Barry Hunt: They are rated by each manufacturer. Usually it's a minimum of two years and typically up to five years.

Mr. Stephen Ellis: Is the burden for storage significant? Obviously, we need a fairly good-sized facility to do that. Does that exist in Canada?

Mr. Barry Hunt: I don't believe that just putting respirators [*Technical Difficulty—Editor*] suggested a first in-first out rotating inventory system, a vendor-managed system, similar to what is done in pharmaceutical industries, for example.

For example, if Canadian manufacturers were supplying to the health care industry so there was a constant in and out of inventory, we could actually hold inventory in each of our plants from 20 or 30 companies across the country and would have decentralized warehousing and local distribution and a constant fresh supply of PPE at all times. I really think that's probably the best path for us going forward.

Putting them in a warehouse where they are forgotten is probably the worst thing we could do.

● (1805)

The Chair: Thank you, Mr. Hunt and Dr. Ellis.

Next—

Mr. Stephen Ellis: My wife is a pharmacist. I want to say how much I love all pharmacists.

Voices: Oh, oh!

The Chair: We'll go back to Mr. Jowhari for five minutes.

Go ahead, please.

Mr. Majid Jowhari: Thank you, Mr. Chair.

Once again, thanks to all the witnesses.

I will quickly go back to Ms. Shields.

Welcome back and thank you for agreeing to stay back. I would like to focus on one of the innovative initiatives that are currently under way in your branch in York Region, which is the mental health crisis hub.

Can you give us a little bit of a background about this project, specifically with the youth services and integrated cures lens you talked about in your opening remarks, please?

Ms. Rebecca Shields: Thank you.

Our branch is leading the development of a first-in-Canada and, certainly, a first-in- Ontario, 20-bed mental health and addiction crisis hub.

For those familiar with the Centre for Addiction and Mental Health, CAMH, it's similar to the CAMH emergency model, except this is for those 12 years old and up and is integrated with community supports. It will be staffed by physicians, psychiatrists and nurses so that they will able to offload from ambulances and from police.

The difference is that, instead of simply treating it like a hospital, we are embedding community support so that each person who comes in and their families will get the services they need to stabilize the crisis, help them withdraw from any substances they need to withdraw from, and also, in the hub, to get connected to ongoing community care, because, as we know, people who are in crisis who leave hospital may not get connected to the services they need, causing them to return to the ED or worse, have mortality.

This model has been supported by the Centre for Addition and Mental Health, all three local hospitals, the police, the paramedics and primary care, because that's really important. All of them, the health and addiction partners and social services partners, have come together to design a model that not only thinks about how we take people in to de-escalate but also how we can ensure that people who leave get the services they require.

This model is something that we are sharing as we build it, because many communities are interested in it. We know that one of the main reasons that people end up returning to mental health services is that they're not connected to the right ongoing supports, particularly post-24 hours and seven days after care.

Mr. Majid Jowhari: Thank you. Can you shed some light as to the timeline of this project and where you are with the implementation and rollout of it?

Ms. Rebecca Shields: That's a great question.

Right now we are working with provincial capital funding to try to establish the capital planning requirements so that we are seen to have completed our functional plan and are waiting for final sign-off. We are hopeful that it will happen before the provincial government drops the writ, so that we get our next tranche of funding.

Mr. Majid Jowhari: What can the federal government do? I understand you're working closely with the provincial government. What can we do on the federal side to support you?

Ms. Rebecca Shields: I really believe that this is a multi-government approach. We have a lot of municipal support as well, and the federal government can also step up with supporting access and how this can support our newcomer and refugee population.

I talked about an integrated model as well. This can't be siloed. We are trying to leverage all of the people who support mental health into this hub, because people are getting services from different communities, including the federal government. They have to be at the table helping the design of this and then support the funding of it so that services are connected by having the staff necessary to do that, because it's not just about the team and the hub, but also about the team of people who are going into the hub who connect people afterwards. This hub will only be another bottleneck if we don't have the services for people after they are in crisis.

● (1810)

Mr. Majid Jowhari: Can you briefly talk about how this concept will reduce the burden on the health care services at the primary sources that we are accustomed to?

Ms. Rebecca Shields: Right now, as we know, there are many busy emergency departments receiving intake from the police, who are taking people to hospitals for care often as a first source, or people don't know where to go for care. With this 24-7 design for people to be welcomed to get the services and connected to the services they need, it supports access, supports navigation and de-escalates crisis. All three things are the major cause of people escalating or their symptoms escalating.

We know for sure that people who are connected to care are less likely to return to emergency departments. We know that people with serious and persistent mental illness need welcoming spaces to go where they are welcomed and not treated as if they are "frequent flyers", but seen as welcomed into the care they need and where they can go somewhere, even it it's just to have that socialization so that they can get the support. It will reduce the burden on hospitals in dealing with patients who would be more appropriately serviced in community, as well as supporting clients and families as young as 12 years old to get connected to care easily, quickly and in an integrated manner.

The Chair: Thank you, Ms. Shields and Mr. Jowhari.

[*Translation*]

Mr. Theriault, you have two and a half minutes.

Mr. Luc Thériault: Doctor Falcone, earlier you touched on the fact that women seem to be much more affected than men by long COVID. According to some studies, it could be as high as 80% of cases.

Can you provide some sort of preliminary explanation for this?

Dr. Emilia Liana Falcone: There are two aspects to consider, the biological and the socio-psychological one.

On the biological side, it is generally thought that there is an autoimmune aspect to long COVID, that is, the infection may trigger a process where the immune system attacks proteins or molecules that are innate, that are part of our bodies; this generates a widespread dysregulation of the inflammatory response and the immune system in general. We know that women are predisposed to this kind of attack. That's a tentative explanation regarding the biological aspect.

The other aspect, which is more related to a societal role, is that women are more likely to go to outpatient clinics. We saw this in the population of patients who had COVID-19 and were not hospitalized in the acute phase; there were many more women. There is also the aspect that women may have been exposed to a higher viral load given their work and professional or personal role. This too may be an issue in developing long COVID.

Mr. Luc Thériault: Is there a high proportion of people who recover from long COVID?

Dr. Emilia Liana Falcone: There is a relatively high proportion, yes.

There is evidence that the health status of a fairly large proportion of people will improve. Indeed, you can see an improvement in their health between four and twelve weeks after infection.

By some definitions, [*Technical difficulty—Editor*] about 20% will get better between three and six months later.

Personally, I estimate that between 15% and 20% of patients might have complications that last longer than a year. It's difficult to pinpoint exactly. Today, there are patients who still have complications who were affected by the virus more than two years ago.

The Chair: Thank you, Dr. Falcone and Mr. Theriault.

[*English*]

Next is Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thank you.

Mr. Hunt, your association stated the following in a press release:

> Federal and provincial procurement still relies on outdated tendering criteria that gives advantage to offshore producers who, in some cases, are dumping product below cost into the Canadian market.

You yourself are quoted as saying this:

> By not recognizing Canadian content or high product standards, our procurement systems are also allowing products of inferior quality into our hospitals and homes, and, far too often, those products are coming from jurisdictions with poor labor and environmental practices.

That's as you've testified today.

Mr. Hunt, how prevalent is this, and what do you suggest be done about it?

● (1815)

Mr. Barry Hunt: The first thing we need to do, really, is to eliminate the tariff exemption that was put in place in the early days of COVID. Some $19 billion worth of product, including PPE, has been purchased under that tariff exemption. That amounts to about a $3-billion subsidy for foreign goods, or lack of protection of domestic industry.

It's very prevalent still, the amount of defective or counterfeit or contaminated product that comes into this country; 99% of Health Canada's safety alerts and recalls on their website related to PPE are for products from offshore. We see this continually. We would like to see the standards updated to include the new CSA standard that just came out for Canadian N95 respirators. We would certainly like to see better standards for medical masks in procurement.

Mr. Don Davies: Dr. Bogoch, we know that vaccine effectiveness wanes over time. Efficacy is substantially reduced, it seems, about three or four months post-jab. How long after the third booster is efficacy substantially reduced? What do you think is a good long-term plan, if that's the case, given that the European Medicines Agency has stated that they don't think we can boost ad infinitum?

Dr. Isaac Bogoch: Yes, this is clearly an issue. One of the key points here, though, is that with two and, of course, three doses of a vaccine, while the efficacy wanes more significantly for protection against infection, you still see very significant protection with three doses against severe outcomes like hospitalization and death. Having said that, it also starts to wane a little bit, but not as significantly versus getting the infection in the first place.

This is speculation here—we'll let the data drive the policy—but I think we'll see two things. One, we'll probably see annual vaccines similar to what we see with influenza, and not vaccinations every four or five months. On top of that, we'll probably have more updated vaccines reflective of the circulating variant du jour. Currently, we're still using vaccines for the original virus that emerged from Wuhan, but we'll probably see some updated vaccines for omicron or other variants shortly.

Mr. Don Davies: Thank you.

The Chair: Thank you, Dr. Bogoch and Mr. Davies.

Next we'll go back to Dr. Ellis, please, for five minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): It's actually going to be me, Mr. Chair—Mr. Lake.

The Chair: Go ahead, Mr. Lake.

Hon. Mike Lake: My questions are going to be focused on Dr. Bogoch.

There's so much noise out there right now and I'm convinced, over and over again, that despite that noise, everyone wants to be healthy. No one wants to screw up their lives. We all want to thrive. It's increasingly difficult to make the best decision you can with all the noise that's out there.

I'm going to put you on the spot. What do a number of people believe that just isn't correct about COVID?

Dr. Isaac Bogoch: I think there's still some skepticism toward the utility of vaccination in some proportion of the community—not a large proportion, but some proportion of the community. There may be some thoughts on therapeutics that might be as effective, such as ivermectin or hydroxycloroquine.

However, I think your point is significant in that it raises a much larger point that we do have significant issues even in Canada—more in other places, but still here in Canada—with misinformation and disinformation amplified online that drives behaviours that aren't really associated with healthy outcomes. This is obviously a much bigger discussion than why we're here, but there has to be a coordinated effort to combat misinformation and disinformation, because it is impeding healthy outcomes.

Hon. Mike Lake: For sure. I'd love to follow up on the conversation. Please reach out to me after this, because I want to have a longer conversation with you.

Complementary to that question, where is the most common agreement amongst medical experts, even medical experts who might have differences of opinion with you on some things? Where is the most common agreement on COVID science?

Dr. Isaac Bogoch: Vaccines are extremely safe and effective.

Hon. Mike Lake: Okay.

You talked about masks. We live in a real world where some jurisdictions are removing mask mandates, and some people just don't want to wear masks and they're not going to.

Setting aside masks, as you're very clear on the science around masks, and many experts are, what other things can people do to stay safe in their homes? When they're indoors, what other advice would you have beyond just masks?

● (1820)

Dr. Isaac Bogoch: Going back to my last statement, I would say that the vast majority of people in medicine and science would say that the vaccines are safe and effective; and you have a small but very vocal group suggesting otherwise.

Getting to your more recent question, masks, of course, are helpful, but we have other tools that are also very helpful in creating safer indoor spaces.

Rapid testing, and rapid testing before going into an indoor space, is very helpful. Creating better ventilation in indoor spaces is also a helpful tool. Vaccination, of course, while not perfect in reducing the risk of infection, does lower one's risk infection, just not to the same extent as it did with earlier variants.

Those are all helpful tools to create a safer indoor space. These are multi-layered tools. No one tool is perfect, but when you add them all up, you have a synergistic effect.

Hon. Mike Lake: I'm going to try to get the most out of my time here.

Moving to testing and therapeutics, if you test and you test positive faster, it sounds as though the therapeutics have more effect, obviously, if you take them sooner. In a theoretical world where everybody testing positive tests positive right away, would everyone benefit from a therapeutic?

Dr. Isaac Bogoch: No. It really is the highest risk at this point in time. That's key, getting the high-risk individuals timely access to those therapeutics.

Hon. Mike Lake: I think there are lots of misconceptions around testing. How accurate are the rapid tests now?

Dr. Isaac Bogoch: It's hard to give a number, because the rapid tests answer the question, “Am I contagious?” and not “Am I infected?” They answer the question, “Am I contagious right now with COVID-19?”

They're actually very good at addressing that question. You might be a positive case but not contagious to others because you haven't built up enough virus in your system, and your rapid test will be negative. Again, the test answers the question, “Am I transmissible to other people?” It's very good at doing that.

Hon. Mike Lake: Is it accurate to say that the thing that registers on the test is the same thing that makes you contagious to people? Is that a simple way of thinking about it?

Dr. Isaac Bogoch: Sure. We'll go with that.

Hon. Mike Lake: Thank you. I'm now a medical expert.

Is there a value to serological testing right now?

Dr. Isaac Bogoch: You can ask 20 people and get 20 different answers.

I'm a little disappointed in serology. I think it does have some utility, but it has less utility than we thought. It's really good more in epidemiologic studies, looking at the burden of COVID in different communities and how that changes with time. It's less helpful—not not helpful, just less helpful—with meaningful clinical decisions.

The Chair: Thank you, Dr. Bogoch and Mr. Lake.

Next we have Ms. Sidhu, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Thank you to all the witnesses.

My question is for the Neighbourhood Pharmacy Association and Ms. Hanna.

For several years pharmacists have been advocating for an increased role as primary care providers, including having prescribing authority for certain conditions and medications in some remote communities. Pharmacists may already be the closest resource primary care provider. How do you see this playing a role in addressing the human resources concern in the health care system? What do you see?

Ms. Sandra Hanna: Thanks for the question.

We think it's incredibly important. As we talked about before, there are many backlogs in the system, whether in primary care, public health or immunization. As pharmacies expand their role in primary care, by prescribing whether it's for common or minor ailments.... The majority of the provinces across Canada are already prescribing for these. There are a couple provinces that are still lagging in terms of pharmacists' ability to prescribe for some of the common ailments. We're talking about things like allergic rhinitis. We're talking about things like diaper rash or cold sores, or uncomplicated bladder infections. Pharmacists are prescribing for these things in many provinces, but still a number of provinces do not give pharmacists the ability to prescribe.

Given that authority, we'll be able to help distribute the burden of care among the many providers we have in the system. If somebody's experiencing symptoms of some of these common conditions on a weekend or in an evening, they may be going to the emergency room for that. Is that the best use of our health system resources? Likely not. It's much more costly, and they can be much better dedicated to somebody with more severe concerns.

Ms. Sonia Sidhu: Thank you.

My next question is for Dr. Bogoch.

Dr. Bogoch, could you speak to the importance of waste-water surveillance in monitoring the spread of COVID-19? What trends are we seeing in waste water in recent weeks?

● (1825)

Dr. Isaac Bogoch: Thank you. That's a great question.

The waste-water surveillance is an extremely helpful tool, especially when we don't have access to widespread community testing. It gives us an early signal as to where COVID-19 might be on the rise, or actually on the decline—although unfortunately we are seeing it on the rise in many jurisdictions. It's a way to look at early signals for COVID changes over time, plus tracking the geography of where those changes are occurring.

It's proven to be an extraordinarily helpful tool, not just here in Canada, but elsewhere in the world.

Ms. Sonia Sidhu: Thank you.

The next question is for Dr. Falcone.

Dr. Falcone, you said that we need forward thinking, an efficient infrastructure and a standardized protocol for chronic disease. Can you elaborate on that?

Dr. Emilia Liana Falcone: Yes. I think that when it comes to really understanding complex diseases, we really need to arm ourselves with objective data, which is often what is lacking in these types of circumstances for the diagnosis, and then eventually for the management of these patients.

Having a structure where we have several centres involved, where we could not only harmonize our data collection, but also pool it together or integrate it would be a lot more powerful at getting at meaningful tools like diagnostic biomarkers and potentially therapeutic targets that we could put into clinical trials.

Ms. Sonia Sidhu: Thank you.

Mr. Chair, do I have more time?

The Chair: Yes, you have about a minute and a half, Ms. Sidhu.

Ms. Sonia Sidhu: Thank you.

My next question is for Dr. Edmonds.

Dr. Edmonds, in 2021, the federal government expanded caregiver benefits through the EI program. Could you share with this committee the specific impact you saw over the last year as a result of this measure?

Dr. Stuart Edmonds: I'd like to turn to my colleague to answer that one.

Ms. Kelly Masotti: Thank you for your question.

The Canadian Cancer Society pays close attention to the supports that are available for caregivers, as well as for people living with cancer. We are focusing our attention now on the need to increase the employment insurance sickness benefit.

I'd like to take the opportunity to thank the government right now, as well as all parties around the table, for supporting the extension of the employment insurance sickness benefit.

We're also taking time to pay attention to the needs of caregivers in a time when their loved one has passed away. This current government has also given additional supports for grief and bereavement.

While I know I haven't answered your question specifically, I will get back to you with a better answer. Those are two measures of supports that we have seen over the last short while that will have a long-lasting and positive impact on people living with cancer and their family members.

Thank you.

Ms. Sonia Sidhu: Thank you.

The Chair: Thank you, Ms. Masotti, and Ms. Sidhu.

Colleagues, we have now reached the 6:30 eastern time, so I'm going to ask whether it is the will of the committee to now adjourn. While we're determining whether that is the will of the committee, I will ask the witnesses to hold tight. We want to give you a proper goodbye if this is goodbye.

Is it the will of the committee to adjourn the meeting at this point?

I'm hearing from the clerk that we have a consensus in the room.

Before we adjourn, there are two things.

First of all, to the Bloc Québécois and to the Conservatives, could you suggest some more witnesses to us for the COVID study? We're running low on the witnesses from those two parties.

Mr. Michael Barrett: You could always bring these fine people back, Mr. Chair.

The Chair: I was just about to say that.

To the witnesses—

Mr. Don Davies: I have a point of order: No sucking up.

Some hon. members: Oh, oh!

The Chair: That's not a point of order, but it's really good advice.

To the witnesses who are here with us, first of all thank you so much for giving us an extra hour. There was an incredible amount of information packed into the time that we had, for which we are extremely grateful. Thanks for bearing with us. Thanks for keeping your answers concise and extremely informative. It will absolutely be of significant value to us.

Dr. Hanley, do you have a point of order?

● (1830)

Mr. Brendan Hanley (Yukon, Lib.): It's a quasi point of order. Since I didn't have a chance to ask questions, I wanted to express my appreciation, as well, both to the witnesses and to all of my colleagues for their excellent questions and answers. I think this is fascinating and great content that we've fleshed out.

Thank you.

The Chair: Thank you, Dr. Hanley. Thank you to all.

The meeting is adjourned.

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