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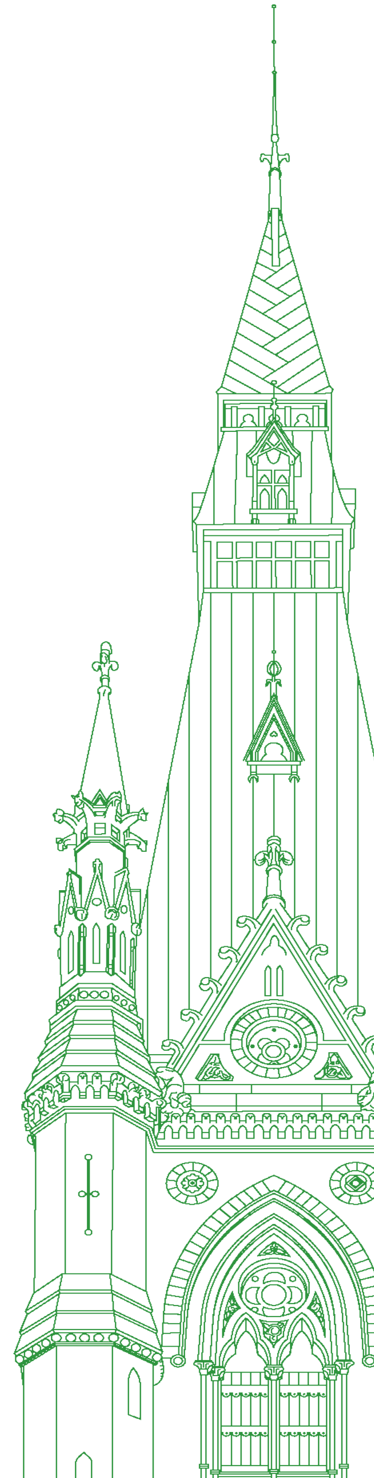

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, May 2, 2022

● (1600)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 19 of the House of Commons Standing Committee on Health.

Today, we will meet for two hours to hear from witnesses on our study of the emergency situation facing Canadians in light of the COVID-19 pandemic. Before I introduce today's witnesses, I have a few regular reminders for hybrid meetings.

Today's meeting is taking place in a hybrid format, pursuant to the House order of November 25, 2021. As per the directive of the Board of Internal Economy of March 10, 2022, all those attending the meeting in person must wear a mask, except for members who are at their place during proceedings.

I know that most, if not all, of our witnesses have been here before. You would know very well some of the standard directives.

Please wait until I recognize you by name before speaking. All of our witnesses are appearing by video conference. Click on the microphone icon to activate your mike, and mute yourself when you're not speaking. Translation is available. At the bottom of your screen, you have the choice of floor, English or French. As a reminder, please refrain from taking screenshots or photos of your screen. All proceedings today will, of course, be made available via the House of Commons website.

To the committee members, in accordance with our routine motion, I am informing you that all witnesses have completed the required connection tests in advance of the meeting.

I would now like to welcome our witnesses from the Public Health Agency of Canada who are with us this afternoon. They are Dr. Harpreet Kochhar, president; Dr. Theresa Tam, chief public health officer; Dr. Howard Njoo, deputy chief public health officer and interim vice-president, infectious diseases programs branch; Cindy Evans, vice-president, emergency management branch; Stephen Bent, acting vice-president, COVID-19 vaccine rollout task force; and Jennifer Lutfallah, vice-president, health security and regional operations branch.

Thank you all for your service. Thank you all for your presence.

Dr. Kochhar, I understand that you will be making the opening statement. If my understanding is correct, you have the floor for the next five minutes.

Welcome to the committee.

Dr. Harpreet S. Kochhar (President, Public Health Agency of Canada): Thank you, Mr. Chair.

Thank you for inviting Public Health Agency of Canada officials to provide an update on the COVID-19 pandemic.

We are pleased to be here. Joining me today are Dr. Theresa Tam, chief public health officer; and Dr. Howard Njoo, deputy chief public health officer. Also accompanying me are Ms. Cindy Evans, vice-president of emergency management; Stephen Bent, acting vice-president, vaccine rollout task force; and Ms. Jennifer Lutfallah, vice-president, health security and regional operations.

Since we last provided you with an update, there have been significant changes across the country. However one thing has stayed the same. COVID-19 is still circulating widely. Disease activity remains high in Canada, and the BA.2 sublineage now accounts for more than 90% of sequence variants. However, there are early signs that transmission may be nearing a peak in some jurisdictions.

We expect further ups and downs over the coming months, but maintaining a vaccines-plus approach can provide us with better protection going forward. This means continuing to take personal precautions like masking, improving ventilation and staying home when we have symptoms or test positive. It also means maintaining a strong core of protection against severe illness by getting up to date with COVID-19 vaccines, including booster doses. It is a crucial time to ensure that we and our loved ones are up to date on routine vaccination and catch up on any that have been missed or delayed over the pandemic. Vaccinations help keep us healthy from childhood through adolescence and into adulthood.

As of January 2022, over 74 million total doses of COVID-19 vaccines have been administered in Canada. I'm pleased that the number now stands at more than 83 million. Nationally, more than 89% of eligible Canadians, those five years of age and older, have at least one dose of a COVID-19 vaccine. Approximately 81% of the population has received two doses, and as of April 29, more than 18 million Canadians have received a booster dose.

At this time, the national advisory committee on immunization strongly recommends a first booster dose for adults aged 18 years or older, and adolescents from 12 years to 17 years of age who are at high risk of severe outcome or exposure.

In addition, NACI recommends that a first booster dose may be offered to anyone aged 12 years or older in the context of heightened epidemiological risk. NACI is also recommending that a second booster dose be rapidly deployed and prioritized for those who are expected to benefit the most, namely the residents of long-term care homes and other congregate living settings for seniors, and seniors 80 years of age or older living in the community. At this time, Canada has a sufficient supply of mRNA booster doses for all eligible Canadians.

Internationally, the outlook for COVID-19 has shifted. So too has our approach at our borders. When I last appeared, everyone coming to Canada had to be tested for COVID-19 prior to arriving at the border. However, on February 28, we expanded the options for the pre-entry test requirements, and then on April 1, we removed this requirement for fully vaccinated travellers. As of April 25, we removed the pre-entry testing requirements for unvaccinated or partially vaccinated children aged five to 11 who are accompanied by a fully vaccinated parent, step-parent, grandparent, guardian or tutor. Pre-entry tests are however still required for partially vaccinated or unvaccinated travellers aged 12 or older.

We continue to monitor our borders and assess risk, and our measures remain flexible and adaptable so that we are prepared for future scenarios.

[*Translation*]

We are at a turning point in the pandemic. We are transitioning to sustainable management. Progress may not be linear and, at the same time, we are preparing for future waves and a possible worst-case scenario.

I encourage everyone to keep their COVID-19 vaccines up-to-date, including getting a booster.

● (1605)

Be aware of the risks in your community and maintain individual protective practices, such as wearing a mask and staying home when sick.

Together, these measures will help protect us as we move forward.

[*English*]

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

We're now going to begin rounds of questions, starting with the Conservatives with Mr. Barrett, please, for six minutes.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thanks very much, Chair.

Thanks to everyone from the Public Health Agency of Canada who is here today.

Thank you, Dr. Kochhar, for your opening remarks. You spoke about the change to entry requirements that was enacted recently. I'm wondering if there is any documentation, perhaps a decision tree or established benchmarks that were used to arrive at that decision, that is being used to monitor with respect to making future decisions.

Dr. Kochhar, if such documents exist, would you be able to table them with the committee?

Dr. Harpreet S. Kochhar: We have continued to monitor the epidemiology, the vaccination rate in Canada and the available tools we have with us—for example, the availability of therapeutics like Paxlovid—and these are all taken into consideration as we relax our border measures. Those are the components that we take into consideration while we change our border posture.

Mr. Michael Barrett: Thank you doctor for that response. I'll just leave it open-ended, sir. Following your appearance today, if you or your staff find that there are documents that you believe would be helpful in informing the committee and Canadians with respect to that decision-making process and that may get into a bit more granular detail, I'd very much invite you to submit those to the committee.

Testing requirements for incoming international travel remain in place more than two years into the pandemic. This has created pretty serious bottlenecks at Canada's largest airports, including significant aircraft holds at the gate and delays offloading passengers. This worsens Canada's ability to attract tourists, which has downstream impacts on trade and investment relationships with other countries, our allies and partners.

What is the Public Health Agency of Canada doing to update or remove legacy processes at the border, including international arrival testing, to ensure that these backlogs do not occur during the peak summer tourist season and beyond? We're certainly seeing those backlogs right now.

Dr. Harpreet S. Kochhar: Mr. Chair, I invite my colleague Jennifer Lutfallah to respond, as she has been managing the border operations.

Ms. Jennifer Lutfallah (Vice President, Health Security and Regional Operations Branch, Public Health Agency of Canada): We are aware of the gate holds that have been occurring across the country. There are a number of factors that are contributing to those gate holds. In terms of your question with respect to testing, as you are aware, we have moved over to an MRT system, which has significantly decreased the number of individuals who are being tested at airports, thereby reducing the number of people within those airports. Unvaccinated individuals, as you know, continue to be tested via our border testing program.

As I understand it, there continue to be issues with respect to individuals who have not completed ArriveCAN, which has led to individuals being referred over to PHAC, thereby creating bottlenecks, if you will, within the airport.

We are working with our federal partners, as well as airport authorities and airlines, to ensure that those individuals in fact complete their ArriveCAN prior to boarding the flight, thereby reducing the volume of individuals within those airports. We're hoping that these measures, as well as others that we continue to assess with CBSA as well as Transport Canada, will get us ready for the summer period.

Mr. Michael Barrett: I thank you, Chair, and I thank the witness for the response.

In addition to slowing down people's arrivals, we've also seen the emergence of evidence that this type of arrival testing is not effective. I'm seeing that there are few countries that are actually continuing to employ arrival testing. I'll ask two question because I only have a minute and a half left.

Why is PHAC continuing to pursue this particular method? Controls are important, but why are we continuing with this one at Canada's biggest airports? Second, wastewater testing is a better early warning tool than arrival testing, so I'm wondering if PHAC is undertaking steps to expand the use of wastewater surveillance.

● (1610)

Dr. Harpreet S. Kochhar: Let me start by mentioning that the post-arrival testing is actually a very important tool for us to monitor the prevalence of COVID-19 in fully vaccinated travellers arriving, specifically to monitor new variants that might be of concern because that is how we track them, and we can take action. Also, we identify travellers for whom compliance and enforcement activities are required, so if they're not actually vaccinated, they are directed to a DQF, or they are directed to do day 1 and day 8 tests. That is an important piece for us and our programming.

Wastewater testing is a tool that we have been using in the cities, where we are using a lot of stuff. Major cities have been able to test the wastewater and give us an early warning signal about what is circulating in those communities. Accordingly, the individual choices as well as the community availability of the tools can be upped, such as making sure there is masking, for example, or making sure individuals take particular precautions around going into a cumulative setting. Wastewater continues to be a part of our tool kit as we move forward.

The Chair: Thank you, Dr. Kochhar and Mr. Barrett.

Next, we're going to hear from Ms. Sidhu for six minutes, please.

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

Thank you to all the witnesses for being here with us.

My first question is to Dr. Tam.

Dr. Tam, this pandemic has had significant impacts on mental health across the population. If we look at seniors, they are socially isolated, and youth are also impacted. How can we better address the mental health of Canadians, especially for certain vulnerable populations?

Dr. Theresa Tam (Chief Public Health Officer, Public Health Agency of Canada): Mr. Chair, I thank the member for her question.

This is an extremely important question because mental health is of course very important. The overall health of the population—even before the pandemic—is something we have to address in a more concerted manner, but the pandemic has had a really significant impact on mental health across numerous populations, not just because people are worried about the virus. It's compounded by the impact of the disruptions to our lives, our work routines, financial stress, social isolation, grief and bereavement because of the loss of loved ones, and reduced access to available services and supports.

These impacts have been particularly acute for certain groups, including frontline health workers, who've experienced worsening mental health conditions during the pandemic, racialized Canadians and others who have been impacted by the social determinants of health and inequitable access to services. I think this is a big issue, as is the concurrent, parallel and worsening opioid and other substance use overdose crisis.

The response to this has to be multi-faceted. By the way, we have had some innovation and new approaches that I believe will benefit mental health during the pandemic and in times to come, for example, the Wellness Together platform and PocketWell have allowed numerous Canadians, including youth, to have access to more real-time services through so-called “stepped care”, as part of a range of measures. I believe budget 2021 provided funding, $10 million over three years, for the Public Health Agency to support projects that would promote mental health, especially those most impacted by the pandemic.

As I said, because health workers and frontline essential service providers have been severely impacted by PTSD—that's post-traumatic stress disorder—and trauma, there was $50 million provided over two years, starting in 2021. These projects are beginning in the spring, I hope. It is spring now, so we want to be able to look at how this diverse programming can support our frontline workers who have been burnt out and impacted.

Of course, there has been a significant investment in Kids Help Phone. The capacity of distress centres has been augmented, and additional funding has been provided to the Canada suicide prevention service.

● (1615)

Ms. Sonia Sidhu: Thank you, Dr. Tam. The next question is about vaccination.

Data still shows that there are gaps in coverage for COVID-19 vaccination. Recently, the Minister of Health came to Peel to visit the medical officer of health, Dr. Lawrence Loh, and we had a conversation about how to continue encouraging Canadians to get vaccinated.

How do you think we can continue to encourage Canadians to get vaccinated against COVID-19?

Dr. Theresa Tam: Thank you for that question.

I think that vaccines remain a cornerstone of our ongoing management of COVID-19, and it is really important to continue to encourage uptake of the first two doses but also the boosters now for up-to-date vaccination.

I think there are a number of reasons why, for example, the booster rates are not as high as for the first two doses, and we need to understand better and address those issues. I'm sure that when you're on the ground in Peel, some of the local health units will talk about the different challenges experienced by different population groups.

There's certainly a lack of trust in policy-makers, public health officials and governments by certain groups that have been experiencing inequities. There's complacency, people thinking that two doses is enough, when we know that, with the arrival of the omicron variant, you need to get up to date with the booster dose when eligible. Convenience and access is still an issue for many, so local public health has been using many different measures to try to improve access through mobile clinics or getting pharmacists.... Thank you, pharmacists, for providing your support to getting vaccines into arms.

I think a lot of different information and misinformation also doesn't help. Providing credible information through health care providers is a really important component and one that the public health agency has been supporting by providing health care providers with credible information so that they can counsel their clients.

Because of the trust issue, we've been trying to enable local leaders in their communities, including faith leaders and other trusted leadership, in order to augment trust and vaccine uptake. I think you need a multi-faceted approach, as we had for the first two doses.

I remind you that if you recently had COVID, you can get a vaccine as recommended, but you wait three months before you get a booster. Omicron virus itself may not provide consistent protection against further infection, so it's also important to trust that point.

For parents, I think that the uptake in children aged five to 11 could be better. I just want to reassure parents that over three million doses have been provided to kids in Canada, and there are no safety signals. Many children have been vaccinated around the world, so we encourage parents to seek answers to their questions and get their kids vaccinated.

The Chair: Thank you, Dr. Tam and Ms. Sidhu.

[*Translation*]

Now it's Mr. Garon's turn.

Go ahead, Mr. Garon.

Mr. Jean-Denis Garon (Mirabel, BQ): Thank you very much, Mr. Chair.

I'd like to thank the witnesses for being with us.

Dr. Tam, in terms of people's reaction to vaccines, the situation has really changed. There seems to be much more confusion than before. People think that each booster will be the last. They thought the first booster would be enough, and they are often surprised that they need a third and a fourth. Today—

The Chair: Mr. Garon, I'm sorry for interrupting you.

● (1620)

[*English*]

Colleagues, the bells are ringing. We're obligated to suspend the meeting unless there is unanimous consent to proceed for a period on which we all agree. What's the pleasure of the meeting?

Mr. Michael Barrett: Mr. Chair, I would say that we would consent to complete the first round of questions.

The Chair: Okay, so that would be Mr. Garon and Mr. Davies.

Is that acceptable? Is everyone okay to continue until Don's finished his turn?

Some hon. members: Agreed.

The Chair: Thank you.

[*Translation*]

You can start over, Mr. Garon.

Mr. Jean-Denis Garon: When you talk to people, consult the media and observe people's attitudes toward vaccination, you realize that people are increasingly confused. They thought that one booster would be enough and are surprised they need a third and a fourth.

Today, we're witnessing a decline in confidence among Quebeckers and Canadians, and everyone is developing their own theory about the duration and effectiveness of vaccines, among other things.

What could be done to improve scientific communication? What is currently being done?

Wouldn't it be appropriate, for example, to tell Canadians and Quebeckers in advance how often they'll have to get a booster?

What work is the Public Health Agency of Canada doing about this type of communication?

[*English*]

Dr. Theresa Tam: Mr. Chair, maybe I will take this question.

That's a very important question. Of course, we are learning about both the virus and the vaccines over time. The duration of the protection of the vaccine, which we saw as extremely good with two doses of vaccine at the start, really shifted when the omicron variant appeared. There are changes in the virus itself.

It's really important to provide Canadians with up-to-date information as we have it. Both Health Canada, in its authorization of vaccines including boosters, and the national advisory committee on immunization will address the recommendations with the increase in knowledge.

I think that's what we've been seeing happen over time, and I think Canadians really rolled up their sleeves and got the first two doses. I think there's an increase in understanding that boosters are important, all the chief medical officers and the national advisory committee on immunization came out again strongly, given the evolving evidence, to say, “If you're 18 and over, go get boosted. Even if you've been infected, wait three months and go get boosted.” That is a much clearer message, I think, than when we were still trying to learn about the impact of omicron and the booster doses.

I think that's a very clear message and I hope all Canadians will get boosted, but we will keep learning as we go along. We're preparing for any potential re-emergence of different variants, and we have to check the effectiveness of the vaccines against those as they emerge. We cannot know that ahead of time. We also have to prepare ahead of time for a potential for a fall-winter respiratory season during which, Canadians should bear in mind, governments will likely come out to recommend additional doses as well.

I think the most important thing is to keep the communication channels open and, as I said, capacitate health care providers and other trusted leaders in providing the credible information.

[*Translation*]

Mr. Jean-Denis Garon: Thank you very much, Dr. Tam.

Let's talk about another aspect of the situation. We see summer coming, we see tourism starting up again, we see the flow of travellers starting to increase again. This is very good. We're happy for our regions and for our economy. However, we know that all the health restrictions, which are obviously a provincial responsibility, have sometimes eroded social cohesion, so we're a little more reluctant to impose new restrictions.

What are your projections on the trajectory of the pandemic? I know you don't have a crystal ball, but I'd like to know how you see the summer and fall months ahead.

[*English*]

Dr. Theresa Tam: I think that at the moment we, together with the other chief medical officers, have been characterizing this period as a transition period. We hope we're passed the extreme acute phase, the crisis phase of the pandemic, but we're on the road to a more steady state. We're not there yet, so there's unpredictability in the timing of the waves and what variants might come along.

There may be a seasonality to this virus, in that it will go up and down like influenza, but we don't know. We have to keep our surveillance and our information channels, as I said, going throughout this fall and winter season, and we'll evaluate at the other end.

However, the good news is that with the high vaccine coverage as a whole—we need the boosters, of course—there's a high level of immunity. You may have seen some of the results post-omicron wave, which mean that globally and domestically there is an increase in the population level of immunity. That is good in terms of the chances of our being able to keep society open.

Going forward, what is important is preparedness. Get prepared. Get prepared for a potential nasty variant that's going to come along and is not only highly transmissible but can cause a severe outcome. Be prepared for that scenario. I think we now stand a better chance of gaining some of that normality back.

I would say that Canadians who have learned all these different great public health measures, personal protective measures, should consider keeping going with those layers of protective measures that they can put on, not just for COVID-19 but for influenza and other respiratory viruses that are making a comeback. It's a matter of developing these personal habits to try to reduce the need for the escalation of more restrictive public health measures.

● (1625)

[*Translation*]

The Chair: Thank you, Mr. Garon.

[*English*]

Next is Mr. Davies, please, for six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Thank you to the guests for being here.

Dr. Tam, on April 12, a little over two weeks ago, you said the following:

> It depends on the location, but yes, we can say we are experiencing a sixth wave in Canada, generally speaking.... There has been a rise in COVID-19 activity everywhere.

Dr. Tam, have we reached the endemic phase of COVID-19, in your view?

Dr. Theresa Tam: In my view, no. As I just said in my last response, we are in a transition phase. An endemic period is where we have much more predictability in the pattern of this virus and can then anticipate a more regularized response, if you like. We're not there yet, so we have to be careful.

Yes, we are still experiencing that BA.2 sixth wave.

Mr. Don Davies: Thanks, Dr. Tam.

In your view, is it premature to lift federal mask mandates at present?

Dr. Theresa Tam: That is not my decision to make. I would encourage everybody, whether there is a mandate or not, to continue to wear a mask in indoor public settings when you're not with people who are in your household.

Mr. Don Davies: If I may, you're Canada's chief public health officer. If you don't know, I don't know who else to ask, so I'm going to ask you again.

Is it premature to lift federal mask mandates or not? Answer yes, no or you don't know.

Dr. Theresa Tam: At the height of a sixth wave, no, I don't think we should be lifting mask recommendations or mandates.

Mr. Don Davies: Thank you, Doctor.

Dr. Tam, PHAC's most recent epidemiology and modelling update released on April 1, a month ago, outlined both the realistic scenario for the future, defined by ongoing transmission with intermittent waves, as well as a worst-case scenario, defined by the emergence of an immune-evasive and severe virus of concern, which I think you've mentioned.

In your view, Dr. Tam, what is the likelihood of the worst-case scenario coming to fruition?

Dr. Theresa Tam: That's unpredictable, because in that scenario, you can potentially have a virus that goes somewhat under the radar, maybe developing in an immunocompromised host—

Mr. Don Davies: Dr. Tam, let me clarify my question. I know it's unpredictable, but I'm wondering....

This is your modelling. Has PHAC put a number on it or quantified it in some sense, or do you have no idea whatsoever?

I'm just trying to find out if PHAC has put some sort of projection on whatever the likelihood of that might be.

Dr. Theresa Tam: I don't think we know the probability, and that's not modelling. It's scenario planning, to clarify that particular presentation. You have to account for both of those scenarios. We don't really know, but I think it definitely could happen, and we need to plan for it.

Mr. Don Davies: Thank you.

Earlier this month, Health Canada confirmed that almost 1.5 million doses of COVID-19 vaccines held in our national inventory have expired since January. We had a problem with expired personal protective equipment early on in this pandemic.

Given that Canada has only donated 14.2 million surplus vaccine doses of the 50 million it promised to deliver to the COVAX facility by the end of this year, why were these doses allowed to expire?

● (1630)

Mr. Stephen Bent (Acting Vice-President, COVID-19 Vaccine Rollout Task Force, Public Health Agency of Canada): Mr. Chair, I would suggest that I take that question.

PHAC works very closely with provinces and territories to ensure that procurement and allocation strategies align with the requirements and demands of individual jurisdictions. When there are doses surplus to Canada's need, Canada makes every effort to make them available to countries through COVAX with sufficient shelf life.

Canada has committed to donating the equivalent of 200 million doses to the COVAX facility by the end of 2022. While the priority will be to place doses to be donated through COVAX, Canada also works for all other potential avenues, including through multilateral and, if necessary, bilateral donations to ensure that vaccines can get to those who need them most.

We are also working with the COVAX facility—

Mr. Don Davies: With respect, Mr. Bent, I have limited time. If you're not going to answer my question, I would rather you just say so.

The question I asked was why the 1.5 million doses were allowed to expire, not what arrangement you have with the provinces or COVAX.

Mr. Stephen Bent: We work very closely with Global Affairs Canada and international bodies like COVAX to make doses available as soon as we can, so that they can be used if needed by other countries. We have made doses available to COVAX, and they are in the process of identifying countries that can take them. If no suitable country is identified, the doses are retained by us until they expire.

Mr. Don Davies: Are you saying, sir, that no suitable country was identified to Canada, so we chose to let 1.5 million vaccine doses expire because we couldn't identify any country that needed them? Is that what your answer is?

Mr. Stephen Bent: I would offer that we continue to work with COVAX to identify potential countries that could take the doses, and offer as much lead time as possible.

Mr. Don Davies: Thank you.

Dr. Kochhar, you talked about being up to date, and you gave an example of the flu vaccine. I'm curious about the efficacy of a third or even a fourth booster. Help me understand this, and forgive my ignorance if I don't understand this correctly.

The mRNA vaccines were developed to respond to the spike protein on the first version of COVID-19, which was the alpha version. We have immune escape variants, which by definition are mutating away from that. We've gone through beta, delta, gamma, omicron, and there are others.

Can you help me understand how giving a booster, which boosts antibodies to recognize the original spike protein of the alpha variant, can help produce effective immunity to a virus that has significantly changed since that time?

The Chair: Dr. Tam, Mr. Davies is out of time, but could you provide a concise response? If it requires something longer, maybe respond in writing, but go ahead with a couple of brief comments, please.

Dr. Theresa Tam: Yes, I'll take that question.

Despite the change in the spike protein through different variants, up until omicron, two doses of vaccine retained really good vaccine effectiveness against the most prominent ones, even though we were monitoring for waning immunity. When omicron arrived, even though it looked significantly different from the delta and preceding variants, through our vaccine effectiveness estimates, a boost provided at least an initial protection of 60%, as a range, against infection and symptomatic disease, and over 90% vaccine effectiveness against severe disease with the third dose. That could wane over time, but that's still good news.

The Chair: Thank you, Dr. Tam.

The meeting is suspended. We'll see you after votes.

● (1630)

_____________________(Pause)_____________________

● (1710)

The Chair: I call the meeting back to order.

Thank you, everyone, and thanks to our witnesses for your patience.

We're going to continue on until probably six o'clock, unless there's a motion to adjourn that is accepted by the committee.

We have about 45 minutes, and we're going to recommence questioning. The next person to pose questions is Dr. Ellis for the Conservatives, for the next five minutes.

You have the floor, Dr. Ellis.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for your patience with the shenanigans of government—unfortunately.

That being said, I'll get right to the matter.

Dr. Tam, through the chair, I'm wondering. With respect to some of the questions that were asked previously, would it be in the interest of PHAC...? Would you submit a decision tree on who would make decisions in the Public Health Agency of Canada? We've had some difficulty understanding who makes the decisions. If you would submit that in a simple form, that would be excellent.

Secondly, would it be fair to say that it's the Prime Minister who makes the final decision with respect to federal mandates? It's a simple yes or no, ma'am.

Dr. Theresa Tam: That would be a cabinet decision.

Mr. Stephen Ellis: It's a cabinet decision. Okay, fair enough.

As I said, I'd love to see your decision tree in a page. It would be great if you would send that to us.

With respect to federal employees and mandates related to perhaps their lack of vaccine, I'm trying to understand what benchmark and metrics you might use. We've asked this question multiple times.

Let's focus specifically on those unimmunized federal employees, perhaps a federal scientist who works by himself or herself. What would be the harm in their working alone? I can't see any. Secondly, what are the benchmarks and the metrics you are going to use to allow those folks who are unimmunized to return to work?

Dr. Harpreet S. Kochhar: I'll start before I maybe pass it on to Dr. Tam.

In relation to the federal vaccination mandate, we have focused on multiple factors, as I mentioned earlier: the global and domestic epidemiological situation, vaccination coverage as well as the new variant of concern that is circulating, availability of rapid tests, as well as availability of different therapeutics. All of these things guide us to really see how far we can take it in terms of our ability to have those who are unvaccinated come to work.

Again, at this point, the federal vaccine mandate is specifically a function of Treasury Board Secretariat, and we have almost 99% coverage for the public service employees—at least.

● (1715)

Mr. Stephen Ellis: Thanks, Dr. Kochhar. I appreciate that. We've heard that multiple times.

I find it a bit contemptuous that nobody is willing to specifically release what those benchmarks are. You just said that you have them.

I'm going to be so bold as to say that there are three physicians on this committee—not to be downplaying the work of my other colleagues—but oftentimes we're told that this complicated science can't be explained. I find that hard to believe. Clearly you are using some sort of science.

Would you be so kind as to table that here to the health committee—the science you're using? You have to have some. You just said that you did. Can we see it? It's a simple yes or no. Can we see it, yes or no?

Dr. Harpreet S. Kochhar: We continue to actually use—

Mr. Stephen Ellis: Sir, I'm going to interrupt you because I don't have much left. It's a simple yes or no. Can we see the benchmarks and the metrics that you use? They cannot be that complicated. Just send me the ones on federal employee mandates for who can return to work without being immunized. Does that exist, and can we have it?

Dr. Harpreet S. Kochhar: My simple answer is that we take a number of factors into consideration—

Mr. Stephen Ellis: Right. Tell me what they are and please give me the list of them. That's all I'm asking. You know what they are because you use them, so I would like to see them.

On behalf of Canadians who, as Dr. Tam said, are lacking trust and have gained complacency, could you please give me the list of benchmarks that you're using? You have them. I know you do. You just said that you did. Could we have them here at committee, please? It's simple.

Dr. Harpreet S. Kochhar: We would take that as a remittance, Mr. Chair.

Mr. Stephen Ellis: I'm not sure what that means. Is that a yes or a no?

Dr. Harpreet S. Kochhar: We will attempt to put that together in a written format for your consideration.

Mr. Stephen Ellis: You will table that in writing to this committee.

Dr. Harpreet S. Kochhar: Yes.

Mr. Stephen Ellis: Thank you very much. Wow, that was just lovely. I really appreciate that.

I have no time left, so thank you, Mr. Chair.

The Chair: You got what you were looking for, Dr. Ellis. Thank you for that.

Mr. van Koeverden, go ahead, please, for five minutes.

Mr. Adam van Koeverden (Milton, Lib.): Thank you, Mr. Chair.

I'd love to hear from our witnesses, so I'll try to keep my question brief.

My question, for anyone who is prepared to answer, is with respect to arrival positivity rate. I'm just curious as to whether, when folks arrive at various ports of entry, that post-international travel positivity rate has at all mirrored or resembled or perhaps even predicted future increases in cases domestically here in Canada. Has our arrival testing supported the prediction of cases in Canada?

Dr. Harpreet S. Kochhar: Mr. Chair, I'll start.

In terms of the positivity rate, it has varied over time. I have the latest statistics. For example, from April 10 to 16, the test positivity rate among fully vaccinated travellers was almost 3.27% in the air mode and 2.4% in the land mode. Again, we compared that with partially vaccinated or unvaccinated travellers, for whom the test positivity rate was 2.25% in air mode and 5.8% in land mode. We continue to look at border test positivity rates, which remain considerably higher than those prior to when omicron first emerged, and that is a way for us to continue to monitor the incoming travellers for their positivity rate so that we can make adjustments to our public health measures.

● (1720)

Mr. Adam van Koeverden: Thank you, Dr. Kochhar.

If I'm understanding, what you're saying is that the incoming travellers are still testing positive for COVID-19 at a higher rate than the general population.

Ms. Jennifer Lutfallah: If I may answer, the president has provided you with the positivity rates. Those tend to mirror what we've been experiencing on a domestic level in terms of trends. During the omicron phase, we saw a fairly substantial increase with respect to positivity for those travellers who were arriving particularly at the land port of entry, so in terms of your question, the trend seems to be the same.

Mr. Adam van Koeverden: Thanks. That's what I was interested in knowing, whether the test positivity rate at the border was resembling increases domestically.

The second half of my question is with respect to the disproportionately high number of children under five who have been admitted to hospital recently. It's pretty alarming. The numbers are high. I think in the last numbers I saw, those for the “children under five” age category were the third-highest, which is shocking considering their age category involves only five years, whereas one of the other age categories was “those over 65”.

Do you have any reflections on what's necessary to ensure that the youngest and most vulnerable members of our community are protected from COVID-19?

Dr. Theresa Tam: Mr. Chair, I'll take this question.

That is correct. We are seeing some of the highest rates of infection as well as hospitalizations in the very young. The most senior populations still have the highest risks, but not surprisingly, if the younger children get sick, since they have smaller airways they can get sicker than others, as is the case with other respiratory viruses. As well, of course, as we all know, those under five are not vaccinated at this point.

I think there is good news, at least, that one manufacturer, Moderna, has submitted an application to Health Canada, so we hope that they too will benefit from vaccination as a form of protection in the future. Others—the parents, the older children, the people around them—can help protect this age group as well by taking all of those other layers of measures that I've talked about so often, such as getting vaccinated and masking, in order to reduce transmission to that age group.

The Chair: Thank you, Dr. Tam and Mr. van Koeverden.

[*Translation*]

Mr. Garon, you have the floor for two and a half minutes.

Mr. Jean-Denis Garon: Thank you.

Dr. Tam, is it fair to say that most of the new variants we're dealing with often come from developing countries, where the vaccination rate is extremely low? In that context, if that's true, are the international efforts to increase vaccination in those countries, including the Canadian effort, sufficient?

Dr. Theresa Tam: Thank you for your question.

[*English*]

I think the most important thing is the global surveillance system, as you've said. Because surveillance has improved and genomics have improved, we are able to monitor these variants.

Yes, it's quite possible for these variants to come from countries that have lower vaccination rates, but I think this virus is evolving. As we exert pressure on this virus from an immunological perspective, whether it's from the vaccine or from prior infection, the virus will continuously adapt.

It may come from a country with a higher bulk of viruses and transmission—that is true—but we have to remember that the virus can come maybe all of a sudden from a place you don't expect, including maybe from an immunocompromised host.

[*Translation*]

Mr. Jean-Denis Garon: As time is short, I basically want to know whether, as we speak, you feel that enough is being done to vaccinate all of these countries that cannot afford vaccines, unlike the G7 or G20 countries.

● (1725)

[*English*]

Dr. Theresa Tam: I think more needs to be done, and it's not just the provision of the number of vaccines. It's being able to support the vaccination of the population. There's trust and there are other issues as to why these vaccines are not being used. The supply is outpacing demand at this moment.

I know that refers back to another question previously. We need to better understand and support other countries and their populations and support the local jurisdictions in increasing vaccine uptake. It's not just a matter of supply.

[*Translation*]

The Chair: Thank you, Mr. Garon.

[*English*]

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

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

Dr. Tam, last week WHO Director General Tedros Adhanom Ghebreyesus said the following at a press conference:

> As many countries reduce testing, WHO is receiving less and less information about transmission and sequencing.
>
> This makes us increasingly blind to patterns of transmission and evolution.
>
> But this virus won't go away just because countries stop looking for it.
>
> It's still spreading, it's still changing, and it's still killing....
>
> When it comes to a deadly virus, ignorance is not bliss.
>
> WHO continues to call on all countries to maintain surveillance.

Dr. Tam, given that many provinces and territories scaled back access to PCR testing after the emergence of omicron, do you believe that Canada currently has a sufficiently robust system in place to monitor COVID-19 activity and the emergence of new variants of concern?

Dr. Theresa Tam: Thank you for the question.

I think, yes, the number of tests—and by that, I mean PCR tests—being done around the country has been reduced, but of course rapid tests have come into play. We don't have samples from those rapid tests in order to look for variants or sequencing, but there are quite a lot of samples being done every day from which we can do sequencing.

We are still sequencing at quite a high rate—at a rate at which we can detect more rare variants—but we need to keep this up. Of course, at the wastewater surveillance, we can actually, on top of doing viral copies, use metagenomics to look at variants in the wastewater.

Mr. Don Davies: Thank you, Dr. Tam.

Dr. Tam, you touched on this a bit in my last round. I'm curious about whether the protection offered by mRNA vaccine third-dose boosters is waning at a rate similar to second doses.

Dr. Theresa Tam: We of course have to observe this over time, because many people got boosted more recently. What we're seeing is that third doses do increase protection against infection or symptomatic disease and, therefore, transmission, but that does decline over time. We're just trying to plot to see how fast that waning occurs. We need a bit more time, but it does decline so you can still potentially get infected.

The vaccine effectiveness against severe disease was boosted to very high levels of over 90%. Even over time that just gradually decreases, so we need more time to figure out the duration of protection. It does seem to be quite good at the moment, but we'll certainly provide further updates as time goes on.

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

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

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

Thank you to all of the witnesses. It is wonderful to have you appearing before committee.

One of the biggest questions I frequently get in my constituency office, in my beautiful riding of Fort McMurray—Cold Lake, are questions as to when we are going to see mask and vaccine mandates for the federally regulated sectors removed. I know we've had many people ask questions about what the targets are, but I'm wondering what you think I should be telling my constituents when they call and ask those questions.

Dr. Harpreet S. Kochhar: As I mentioned earlier, for the federal vaccine mandate, for example, the Treasury Board of Canada is responsible for the policy on vaccinations for the public service. Again, all the elements of the policy and other public health aspects are being reviewed by them. This is all based on science and advice—

Mrs. Laila Goodridge: That's fantastic for the public servants, but for me in my riding, being a northern riding, we basically have to fly to get just about anywhere. There are requirements by the federal government and PHAC that require proof of vaccination.

For people who want to go to a funeral in Toronto, if they're not vaccinated, they can't go. They're really curious to know when you are going to update this, because no other allied country is requiring people to be vaccinated to travel within their own country. Are there any targets in place for that?

● (1730)

Dr. Harpreet S. Kochhar: What I can say is that we are continuously evaluating the epidemiology, the vaccination coverage and what other public health layers can provide the protection. This is an active conversation that we are having in terms of the public health advice as we move forward, so that particularly science-based decisions can be made on that.

Mrs. Laila Goodridge: That's fantastic, but just so you are all aware—and I'm going to share this—it is more than 3,600 kilometres to get from Fort McMurray or Cold Lake to Toronto. I'm going to use Toronto as an example because you are aware of that. I have numerous constituents who contact me because they want to go.... They're not typically from those communities. They're from somewhere else. Unfortunately, they'll have parents who get sick and they need to get on a plane, but because of the rules of this government, they can't go visit their parents in their dying days.

I'm asking for some compassion and understanding. Many people in rural and isolated communities have different needs from those in urban centres. They can't just get in a car and quickly get there. This is really impacting the lives of everyday Canadians in communities like my riding, and all across northern Canada.

Can you do anything special to make sure that this is being considered?

Dr. Harpreet S. Kochhar: My heart goes out to those communities who are unable to attend to the family and other aspects of their daily life. We are committed to providing that advice to get to the point where we can have an appropriate decision, based on the public health guidance, as well as the ability to still protect the population from the transmission of COVID-19. We continue to work towards that goal.

Mrs. Laila Goodridge: Could you, at the very minimum then, perhaps look at simplifying the process for people who have medical exemptions, who have been exempted by doctors, physicians? I have one constituent who is a nurse and has an anaphylactic allergy to vaccinations. The process that was required to be able to get on a plane was so onerous and time-consuming, she almost missed her father's funeral. This is someone who has served us as a nurse on the front lines throughout the entire pandemic.

These mandates are completely heartless. Can you at least look at something to perhaps provide more clarity for those with medical exemptions?

Dr. Harpreet S. Kochhar: Again, we continue to work with our colleagues, with Transport Canada, which has the mandate also in terms of domestic flights. We continue to provide that kind of advice so that the decision can be taken to appropriately support and assist any of those situations.

The Chair: Thank you, Ms. Goodridge and Dr. Kochhar.

Next we're going to go to Dr. Hanley for five minutes.

Go ahead, please.

Mr. Brendan Hanley (Yukon, Lib.): Thank you, Mr. Chair.

Is Dr. Njoo still with us? Yes.

Dr. Njoo, just to perhaps mix it up a bit and change the theme, I'm just wondering what, to your mind, are some of the infectious disease priorities that may have suffered as a result of our necessary focus on the pandemic over the last two years. Also, how is the agency looking to address some of the backlog of work in some priority areas of infectious disease?

Dr. Howard Njoo (Deputy Chief Public Health Officer and Interim Vice President, Infectious Diseases Programs Branch, Public Health Agency of Canada): Thank you very much for the question, Mr. Hanley.

I can say yes. It's not just for infectious diseases. There have been many what I would call unintended consequences and a lot of collateral damage obviously as a result of the COVID-19 pandemic in terms of people accessing health services for other infectious diseases as well as obviously for a whole host of what I would say are non-communicable diseases—mental health, etc. We all know that. The opioid crisis is also obviously a very important priority.

For infectious diseases, I would say that the ones that have probably suffered the most, which we need to get back on track, are the ones that I think are unduly, disproportionately affecting vulnerable populations, those who are marginalized, who are racialized and who are not able to have the same resources to deal with certain infectious diseases as are perhaps many of us who are more fortunate.

For example, I would point out tuberculosis. Certainly the burden has been borne unduly by, for example, indigenous populations especially in the north and by the Inuit. We continue to work with them, but obviously in terms of the effort, we have had to take away from those scarce resources to deal with COVID-19, and addressing something like tuberculosis is certainly something we need to get back on track.

There are also what I would call the sexually transmitted, blood-borne infections, such as HIV/AIDS. The global pandemic that's been long lasting certainly isn't going away, and we need to get back to addressing HIV and all the other sexually transmitted, blood-borne infections.

Finally, I would say that another priority, which we're making headway on but which is certainly something we need to pay much more attention to in the future, is antimicrobial resistance. COVID-19 is the current very real pandemic, but I would say that may become a slower-moving pandemic if we don't pay attention. You can see even the WHO has listed it among its top 10 threats as being something that's going to affect us down the road. Can you imagine living in a pre-antibiotic era, if that were to return to Canada, in which we were not able to use antimicrobials, antibiotics, in a way that we're so used to doing at the present time?

Just in a nutshell, those are some of the infectious disease issues we're looking at. Of course I could go on and on. There are also things like climate change and how climate change is affecting infectious diseases in terms of the spread and distribution of vectors. Lyme disease and others certainly have a much wider range now, and more Canadians are being affected because of climate change.

You can see that there is a wide scope, and we intend to start addressing other infectious disease threats in addition to dealing with COVID-19 at the present time.

Thank you.

● (1735)

Mr. Brendan Hanley: Thank you very much.

I'm glad you mentioned antimicrobial resistance, because it's certainly something we cannot turn our attention away from.

This is a question for, perhaps, Ms. Evans.

I notice that in budget 2022 the agency has been designated over $400 million related to surveillance and risk assessment. Given that this is Emergency Preparedness Week, I wonder if you could talk about how this funding might help to strengthen surveillance with a view to managing and responding to and preparing for potential future phases of this pandemic but also, equally as important, potentially other infectious disease threats and pandemics, as quickly as you can.

Thank you.

Ms. Cindy Evans (Vice-President, Emergency Management Branch, Public Health Agency of Canada): Thank you for the question.

You've referenced, certainly, the funding in budget 2022, which will cover a broad range of activities. We are quite pleased with respect to some of the steps we'll be taking in terms of the early warning systems we have, and we will be advancing a number of the issues that were raised in that external panel report.

Certainly more broadly within the agency, as has also been raised, there is an interest in having more integrated risk assessment. That's some work we will be able to advance through those investments that have been articulated. As well, we will be looking broadly and horizontally across our surveillance programs to further advance those.

Thank you.

The Chair: Thank you, Dr. Hanley and Ms. Evans.

Colleagues, we have now completed two full rounds of questions. I'm advised that there are some members who have other obligations they are anxious to get to, so we're in a situation where we have three options.

We can entertain a motion to adjourn now, or we can agree to continue on as we do have the room. We do have the administrative support.

A third option that you may not have considered is to continue on with what's called a reduced quorum. For those who absolutely have to leave, they can, with the assurance of knowing that we're operating under the rules of a reduced quorum, which prevents any motions from being presented except for a motion to adjourn.

I'd be interested in taking the pulse of the room as to whether you wish to wrap, to continue or to continue under a reduced quorum. We do have the resources, but we have people with scheduling challenges.

Go ahead, Mr. Barrett.

● (1740)

Mr. Michael Barrett: Thanks, Mr. Chair.

If there were unanimous consent for a reduced quorum to be in effect, I think that would satisfy the issues of Conservative members.

The Chair: Do we have agreement to continue for one further round of questions with a reduced quorum?

I have Mr. Davies.

Mr. Don Davies: Mr. Chair, before I can answer that, I'd like to get some shape around what we're talking about. The committee would go until when...? The Bloc and I have only ourselves here. We'd like to have other people to....

The Chair: My understanding is that we have support until as late as 6:30. I would suggest that we simply complete one more round of questions. That would be 24 minutes from now, if everyone stays on time.

Mr. Don Davies: How is that divided? Do you mean that each party gets six minutes?

The Chair: No. The third round would be five minutes for the Conservatives, five minutes for the Liberals, then two and a half, two and a half, five, five.

Go ahead, Mr. Lake.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): If we just do the five, five, two and a half, and two and a half, that takes us to six o'clock, which is when you said we would end anyway.

The Chair: Yes. We can operate under a reduced quorum as such.

You get the last word, Mr. Davies. Surely that's satisfactory.

Mr. Don Davies: That's delightful, Mr. Chair.

The Chair: Okay. We are now operating under a reduced quorum. No motions are allowed except for a motion to adjourn.

The next round of questions will be posed by Mr. Lake for five minutes.

Hon. Mike Lake: Thank you, Mr. Chair.

In the original line of questioning by the Liberal member, she brought up mental health. I believe it was Dr. Tam who talked about some of the government spending on mental health in the recent budget. Just for clarity, exactly how much was committed in 2020-22 for the Canadian mental health transfer in the recent budget?

Dr. Harpreet S. Kochhar: Dr. Tam, did you want to answer that?

Dr. Theresa Tam: On that, I believe I would have to consult Health Canada. That is not within the area the agency has responsibility for.

Hon. Mike Lake: Just to be clear, nobody in the Public Health Agency knows how much was committed in the Canadian mental health transfer in the recent budget. In the Public Health Agency of Canada, nobody knows the answer to that...?

Dr. Harpreet S. Kochhar: I think what we have information about is that there wasn't any specific-to-mental-health transfers, but there are mental health crisis support pieces over budget 2021 and other pieces that we have incorporated into the mental health support, for example.

Hon. Mike Lake: Just to be clear, I have the Liberal platform from a couple of months ago, from when we had an election just a few months ago. It promises $4.5 billion towards the Canadian mental health transfer. In the costing of that platform, it's very clear—this is just a couple of months ago—that it promises $250 million for 2021-22 in the Canadian mental health transfer.

Am I making a mistake in reading the budget? Is that $250 million committed? It was just promised a few months ago in an election.

Dr. Harpreet S. Kochhar: I think this would be something we'd have to discuss with our colleagues in Health Canada.

Mr. Chair, if you prefer, we can come back with a written answer on that one.

Hon. Mike Lake: That would be great.

Could I just get some clarity? There was some questions earlier about policy decisions. Would a decision like this be a decision made by Health Canada or the Public Health Agency of Canada, or would this be a decision made by the cabinet—the decision not to fund $250 million for the Canadian mental health transfer that was promised in the Liberal election platform just a few months ago?

● (1745)

Dr. Harpreet S. Kochhar: My understanding would be that this would be something that would be discussed in the cabinet. We provide advice on that.

However, I am not sure that I would be able to answer the question straightforwardly on that.

Hon. Mike Lake: Okay. I have one final question.

In your knowledge of the NDP-Liberal agreement—and perhaps the NDP member who's at the table could answer this question—I'm wondering if the NDP members of the coalition, or whatever their agreement is called, agreed to this when they made their agreement, to not include the $250 million for the Canadian mental health transfer.

Don, do you want handle it?

Mr. Don Davies: Sure. The answer is no.

Hon. Mike Lake: Thank you. I'm done.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Lake.

Next we have Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

Dr. Tam, Dr. Njoo, Don and I have been at this for a long time.

You're all public health experts. I'm not telling you this story for your knowledge but for some of the people in the committee room who aren't familiar with this story.

Every public health class probably starts out with this story of London during the 1800s. There is a cholera epidemic and Dr. Snow, this very wise doctor, decides that instead of treating people, we should prevent them from getting sick. He puts a lock on this well in the middle of London, and thereby stops this cholera epidemic.

That's used as the example of how prevention is so much better than treatment. It's a lot more efficient. It's cheaper. It's a better way of doing things.

Using public health, so far we've done an excellent job by using things like vaccinations and social distancing. I have to say, with the Public Health Agency of Canada leading us, the Canadian people have done very well. We've had a third of the death rate of the United States, and about half the death rate of countries like France, Italy and Germany, by using those public health measures. However, I think it's come at a cost. It's certainly come at a cost in terms of the national debt and in terms of mental health. It's come at a cost in terms of civil strife.

I wonder—and I'm asking you this question—whether we ought to start looking at changing direction. We've whipped the public health horse about as hard as we can whip it. Maybe we have to start changing direction, in terms of trying to place measures that prevent people from getting really sick. That means protecting the elderly with third doses or fourth doses of vaccines, if necessary.

The other thing is possibly doing better in terms of treatment. We have pretty good treatments in terms of Paxlovid and remdesivir, which really aren't being used that much. The public largely doesn't know about them, and people don't know that if you're high risk and you get sick, perhaps you should get treatment.

We've maybe come full circle. Normally public health is cheaper and a better way of addressing a problem, but perhaps we're starting to look at treatment as becoming almost the cheaper thing to do.

I'd like to ask your opinion about that. Should we be doing more in terms of treatment, protecting the really vulnerable and worrying maybe a little less about the costly public health measures?

Dr. Theresa Tam: Thank you for the question.

At this period, two-plus years into the pandemic, with vaccines in hand, even though we're still learning about it, I think there's a much better chance of getting that balance. That's what the chief medical officers across the country are trying to do. They're trying to balance the impact of the pandemic, but also trying to reduce the negative impacts of some of those measures. I think the easing of public health measures is occurring across the country, with a view that unless it's really, really necessary, you're going to rely on the least restrictive of those public health measures, like mask wearing, etc., in order to reduce the impact.

Treatments do play a role in reducing severe outcomes and preventing those with the highest risk, who may not respond as well to vaccines.... It is a complementary measure. However, vaccines remain, I think as a preventive tool, one of the most important aspects of our ongoing management of COVID-19.

● (1750)

Mr. Marcus Powlowski: I take it from what you're saying that you do believe the treatments are important. Do you have any comment as to whether we're using them as effectively as we could? Certainly my experience, as someone who occasionally still does clinical medicine, is that the vast majority of people don't seem to know about them, and certainly accessing them has not been very easy.

Dr. Theresa Tam: Yes, the broader health system is learning how to do implementation. Of course, from a federal perspective, we have done our leadership work in procuring the vaccine and leveraging partners to provide guidance on how best to use the medication.

Implementation is not easy, because you have to get the medication into people really fast and people have to get a diagnosis, but we're seeing innovation across the country. You've heard about Quebec getting it through pharmacists' being able to prescribe. Other provinces are making sure that the physicians who look after those at highest risk, for example, people who have certain types of cancers and other chronic medical conditions, know how to access those medications.

I've been encouraging members of the public who are at higher risk to find out, at the local level, how they can access the medication ahead of time, before they need it.

We will get better at it as the doses continue to arrive.

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

[*Translation*]

Mr. Garon, you have the floor for two and a half minutes.

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

Dr. Powlowski just spoke eloquently about prevention. However, to carry out prevention, you need medical staff, and to have medical staff, you need resources.

These resources have been largely taken up by COVID-19 patients in recent years. Provinces have been forced to triage because of the lack of resources and, in some cases, people have even been denied access to doctors, particularly in order to prevent chronic diseases.

Does the Public Health Agency of Canada consider the lack of provincial staffing to be a public health issue?

[*English*]

Dr. Theresa Tam: Maybe I'll start. Health Canada is playing a lead role in terms of convening provinces, territories and our ministers in talking about health human resources. Those are probably one of the top priorities of the discourse and discussion with the provinces going forward, including credentialing and getting an international medical workforce trained and recognized.

All of that is extremely important, and I just want to say that it is not just the health care workforce but also the public health workforce writ large. That is probably one of the most critical questions and challenges for the health systems in Canada.

[*Translation*]

Mr. Jean-Denis Garon: You seem to be saying that it is indeed considered a significant problem to have denied a large number of patients of care because of the mobilization of health care professionals to treat COVID-19 cases. Do you think, then, that increasing financial resources, particularly for provincial health systems, would be a way to solve this public health problem?

[*English*]

Dr. Theresa Tam: The key to addressing COVID is to take all of the measures we just talked about, including vaccinations and protection of health care workers in terms of different layers of measures. If we don't address COVID-19, the health system will not be able to get back to addressing backlogs of surgeries, etc. That is a very specific approach that needs to be undertaken so that the health care system can catch up on some of these backlogs.

As for the health transfers or the actual health human resources, I'm afraid that I'm not in the best position to be commenting on those. We could be reaching back to Health Canada and the minister for some of the plans going forward.

[*Translation*]

The Chair: Thank you, Mr. Garon.

[*English*]

Thank you, Dr. Tam.

The last MP to pose questions in this meeting will be Mr. Davies.

Go ahead, please, for the next two and a half minutes.

Mr. Don Davies: Thank you. I feel obligated to state for the record that there is no coalition government in Canada. There is a confidence and supply agreement between New Democrats and Liberals. That's just for anybody interested in accuracy.

Dr. Tam, I'm interested in your views on infection-acquired immunity. The immunologists I've spoken to and the data I've reviewed seem to show that there is at least some evidence that the durability and strength of infection-acquired immunity can rival, if not exceed in some cases, the immunization from vaccination particularly from mRNA vaccines.

I'd like to hear your views on that and maybe ask why Canadian health policy doesn't recognize in any way the impact of infection-acquired immunity.

● (1755)

Dr. Theresa Tam: I think we're just learning about immunity both from infections and from vaccines. It also depends on the variant that you're talking about.

I think there's certainly evidence that for variants prior to omicron, if you had an infection, you could have quite significant immunity. That has to be monitored in terms of how long that immunity lasts for and the quality of that immune response, but when omicron arrived, it was a game-changer.

There are many things about omicron that were a bit different. It can cause a milder illness and maybe infect only your respiratory tract before your body gets to work fighting it, and that immunity to omicron variants might be quite variable, so we're still learning about that.

What is important is that we have to understand what we call “hybrid immunity” as well. Some of the studies—and they're quite sparse at the moment—show that if you're unvaccinated and you get infected, you're more likely to get reinfected with omicron. If you are vaccinated and you're infected, you're less likely to. Your body generates more neutralizing antibodies, perhaps, but those questions remain.

I think it is not a simple question. It may be dependent on the variant as well.

Mr. Don Davies: Do I have time, Mr. Chair?

The Chair: Very briefly, yes, go ahead.

Mr. Don Davies: Last Tuesday, Moderna announced that a COVID-19 booster it's designing to target the beta variant generated a better immune response against a number of virus variants, including omicron. Does the federal government plan to procure any doses of Moderna's bivalent vaccine targeting the beta variant?

Dr. Theresa Tam: I'll start, and then Stephen Bent, who's in charge of procurement, can supplement.

I think it's very important to get the clinical trials looked at in terms of the Moderna bivalent vaccines. We're looking forward to the data—we hope over the next month—on the bivalent ancestral strain, plus an omicron strain, but the proof of concept with a beta variant strain is promising. I know that, with our contractual arrangements, we have made provisions to purchase new formulations.

I don't know if Stephen has anything else to add.

Mr. Stephen Bent: No, I would just echo Dr. Tam's comment that our current agreements with Moderna allow us to access new formulations when they're approved by the regulator.

Thank you, Mr. Chair.

The Chair: Thanks to both of you.

That concludes our questions.

To all of our witnesses here today, thanks for your patience with the late start and the late finish. We can only imagine how busy you are, so your indulgence is greatly appreciated, and your service to Canadians is also greatly appreciated. Thank you so much for being with us.

Colleagues, before we wrap, on Wednesday we're going to be continuing to hear from witnesses on the COVID study, but not all parties have provided us with witnesses, so if they don't do that fairly promptly, their spots will be taken up by those who have. From the suggestion of the analysts, it will be a split meeting, with an hour for witnesses and an hour to plan committee business and what we're going to be doing going forward.

I think that's it. We're good for Wednesday. That will apply to the meetings after Wednesday. The message is to get your witnesses in, please.

Is it the will of the committee to adjourn?

Some hon. members: Agreed.

The Chair: We're adjourned.

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