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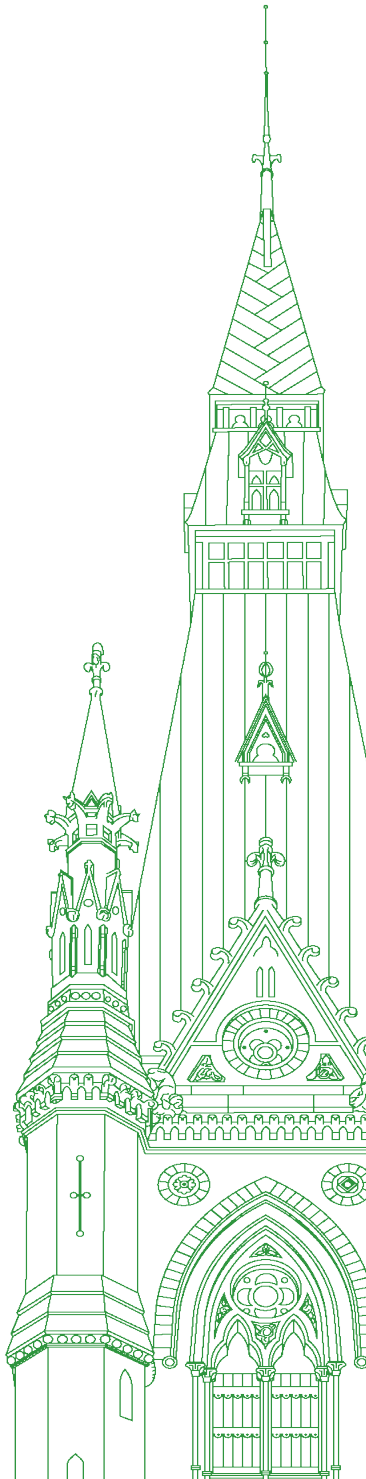

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, October 18, 2022

● (1105)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): Welcome to meeting number 35 of the House of Commons Standing Committee on Health.

Today we meet for two hours with witnesses on our study of the emergency situation facing Canadians in light of the COVID-19 pandemic.

We do have some preliminary business that we should deal with right away. As a result of the motion that was just passed in the House, we are now without our first vice-chair, and it is customary to fill that vacancy.

I trust all of the campaigning is complete, the arms have been twisted, the deals have been made, and this will all proceed expeditiously.

I now hand it over to the clerk to preside over the election of the first vice-chair.

The Clerk of the Committee (Mr. Patrick Williams): I must inform members that the clerk of the committee can only receive motions for the election of the vice-chair. The clerk cannot receive other types of motions, entertain points of order, or participate in debate.

Pursuant to Standing Order 106(2), the first vice-chair must be a member of the official opposition. I am now prepared to receive motions for the first vice-chair.

Mrs. Goodridge.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): I would like to nominate Dr. Stephen Ellis to be the first vice-chair.

The Clerk: It has been moved by Mrs. Goodridge that Mr. Ellis be elected as the first vice-chair of the committee.

Are there any further motions?

Is it the pleasure of the committee to adopt the motion?

(Motion agreed to)

The Clerk: I declare the motion carried, and Mr. Ellis duly elected as the first vice-chair of the committee.

Some hon. members: Hear, hear!

The Chair: Congratulations, Dr. Ellis.

Mr. Majid Jowhari (Richmond Hill, Lib.): It comes with privileges and rights. Let's make sure the privileges are not rights.

The Chair: That was a very efficient and effective campaign. In keeping with our further discussion, I'll do my best to look after myself, so that your vice-chair's duties won't be too onerous.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23, 2022. All of the witnesses we have before us today are familiar with the processes associated with hybrid meetings. Screenshots, or taking photos of your screen, are not permitted. The proceedings will be made available on the House of Commons website.

In accordance with our routine motion, I'm informing the committee that all witnesses have completed the required connection tests in advance of the meeting.

I will now welcome our witnesses who are with us this afternoon. From the Public Health Agency of Canada, we have Dr. Theresa Tam, chief public health officer; Dr. Howard Njoo, deputy chief public health officer; Stephen Bent, vice-president, COVID-19 vaccine rollout task force; Jennifer Lutfallah, vice-president, health security and regional operations branch; Cindy Evans, vice-president, emergency management branch. From the National Advisory Committee on Immunization, we have Matthew Tunis, executive secretary.

Thank you all for taking the time to appear today.

I understand Dr. Tam will be giving the opening statement.

Dr. Tam, you have the floor. Welcome back.

Dr. Theresa Tam (Chief Public Health Officer, Public Health Agency of Canada): Mr. Chair, thank you very much for once again inviting the Public Health Agency of Canada to provide an update on the COVID-19 situation in Canada.

I would like to acknowledge that I am speaking to you from Ottawa, the traditional unceded territory of the Algonquin Anishinabe people.

[*Translation*]

As per the public update that I gave on October 7, virus transmission is occurring across the country with regional variation. The latest data up to October 8 shows that COVID-19 disease indicators, such as weekly case counts and lab test positivity, are stable compared to the previous week. At the same time, hospitalizations are elevated or increasing in some areas, which could be an early sign of fall resurgence.

As gatherings and activities begin to move indoors because of the colder weather, COVID-19 and other respiratory infections can spread more easily. While the risks of exposure may be increasing with more virus circulating, for many, immunity from vaccination or prior infection may be waning.

● (1110)

[*English*]

This is why the National Advisory Committee on Immunization, NACI, recommends getting a COVID-19 booster dose six months after your last COVID-19 vaccine dose, or your last infection. It is important that we all stay up to date with our vaccination to maintain our protection.

In the coming weeks, seasonal influenza vaccines will be rolled out across Canada. It is good to know that influenza vaccines can be given at the same time as COVID-19 vaccines to people over five years of age.

For many people across Canada, it has been six or more months since their last vaccine dose or infection. As a result, overall population immunity may be falling and leaving us all less protected.

Only 18% of those eligible are up to date with their COVID-19 vaccination in terms of having completed their primary series or received a booster dose within the past six months, with younger Canadians reporting lower coverage relative to older-age adults.

We now have two bivalent COVID-19 vaccine booster formulations that are good options for improving protection in people aged 12 years or older. As of October 9, over 5% of eligible Canadians have received a bivalent vaccine.

Both bivalent vaccine formulations target the original virus strain and the highly infectious omicron variant. Likewise, both bivalent vaccines are expected to boost immunity against omicron variants and broaden the repertoire of our immune response to the SARS-CoV-2 virus.

Although there is a temptation to believe that infection from the current circulating variant is not so bad, it is important to remember that infection also means continued transmission of the virus, and carries with it the risk of developing post-COVID-19 condition, or long COVID. There is scientific evidence suggesting that receiving at least two doses of a COVID-19 vaccine before infection reduces the risk of post-COVID-19 condition.

The World Health Organization recently indicated that we have never been in a better position to end the pandemic, but while the end is in sight, we are not there yet.

While transitioning towards a longer-term, more sustainable approach to the pandemic, we will continue to work in collaboration with our provincial and territorial partners, indigenous communities, as well as key stakeholders.

[*Translation*]

During the transition, we will continue to monitor for and prepare for worst-case scenarios, such as the emergence of more transmissible, immune escape or more virulent variants.

The Public Health Agency of Canada's established pan-Canadian network for a wastewater surveillance program enables efficient monitoring of a community for early detection and major trends in virus activity. Clinical and wastewater genomics continue to inform public health measures, predict and monitor the circulation of COVID-19 variants in community and institutional settings, and develop short-term modelling forecasts.

[*English*]

The agency will continue to disseminate evidence and produce guidance to inform decision-making about response measures, with consideration given to the most recent evidence, the current epidemiological situation and other key factors such as health care system capacity. The agency will continue to communicate on the evolving situation to Canadians, recognizing that uncertainties remain.

In addition, the agency will support public confidence for vaccines and personal protective practices that empower Canadians to take individual and collective responsibility. The priority will continue to be protecting the health and safety of Canadians, and our path forward will continue to be based on the best available science and evidence.

Thank you. *Meegwetch*.

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

We're now going to proceed with rounds of questions, beginning with the newly-minted vice-chair of the committee, Dr. Ellis, for six minutes, please.

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

Thank you to the rest of the committee for their vociferous, yet traditional confidence in electing me the vice-chair. I really appreciate it, of course.

Thank you very much to the members of PHAC and NACI, and others who have come here today.

Certainly, the anxiety level with respect to COVID in the minds of Canadians has subsided, but of course the ever-burgeoning threat of things moving indoors and the increased risk is there.

Along that line of questioning, perhaps I'll go back, Dr. Tam, to something we've talked about multiple times before. Hopefully this time you'll be able to shed some light on this for all Canadians. If we are talking about increasing measures with respect to perhaps access and mask wearing, etc., I believe that Canadians want to know which metrics or benchmarks the Public Health Agency of Canada will be using to make those decisions.

I realize that previously you have told this committee multiple times that it's much too complicated for us to understand. I take that with great umbrage, of course, but would appreciate your comments with respect to that today.

● (1115)

Dr. Theresa Tam: Mr. Chair, thank you for the question.

Of course, many of these measures are taken at the local and provincial levels, as well, not just by the federal government. The current status of public health measures is decided more at that local level.

I think it's a combination of different assessments and metrics. First of all, we have to assess the virus—the variants that are currently circulating and their characteristics. That includes how transmissible they might be, whether they escape immunity developed through prior vaccinations or infections, and their virulence. How severe are those virus variants? Of course, there's ongoing study of host and population-level immunity, such as through the serosurveys undertaken by the COVID-19 Immunity Task Force.

The capacity of the health care system is very important. As people have seen, when hospitals, emergency rooms and other places are stressed, that needs to be taken into account in terms of whether, for example, mask wearing would help reduce some of that spread and impact on the health system. If any public health measures are put into place, they are there to buy time, as well. During any such time periods, provinces and all levels of government have to take action, including adjusting any of the recommendations and guidance required. It's also a balance between reducing transmission and its impacts and, of course, the potential negative effects of some of these measures on society.

Mr. Stephen Ellis: Thank you, Dr. Tam. I appreciate that answer. It's certainly different from before, and I hope this can improve our working relationship as we go forward. I don't think it's related to my new title, but maybe it is.

On behalf of all Canadians, in the next minute and a half, perhaps I'll ask you to speak, Dr. Tam, about variants of concern.

Dr. Theresa Tam: I think it is great that, during the pandemic, more capacity has been provided for us to monitor genomics and other characteristics of variants of concern. The Public Health Agency of Canada and, indeed, our National Microbiology Laboratory, as well as provincial, territorial and global lab works, have been monitoring the ongoing evolution of the SARS-CoV-2 virus.

The trajectory of viral evolution has changed over time. This is quite interesting. The earlier variants have multiple and often very divergent evolutionary pathways, seeing as there were no vaccines, therapeutics or broad-based population immunity to constrain the range of the mutations. More recently, however, multiple lineages descending from the omicron variant—that very transmissible variant—have begun to develop multiple identical mutations, a phenomenon we're calling “evolutionary convergence”. We have to learn more about that. You may have seen or heard about a variety of these variants, such as BA.2.75, BA.2.75.2, BA.1.1 and BA.4.6. Multitudes of BA.5 descendants have these convergent evolutionary mutations.

The very important thing about monitoring these mutations is that, when there's broad population immunity, it seems to put pressure on the virus to find advantages, such as escaping our existing immunity from infection or vaccines. This broad range of omicron descendants is now being carefully monitored.

● (1120)

Mr. Stephen Ellis: Other than that, there certainly are, potentially, other variants coming down the pipeline, of course. Communicating with other countries is essential.

Are there any other specific scary variants of concern out there, Dr. Tam, at the current time?

Dr. Theresa Tam: At the current time, there are descendants of omicron variants and subvariants, but we haven't detected any very extraordinary appearances, as yet. That is a scenario for which we're planning ahead. For example, a very distinct immune escape, where vaccines or treatments don't work and it causes severe illness, is one of the worst-case scenarios. We haven't detected one of those yet, but we need to be prepared for the potential.

The Chair: Thank you Dr. Tam.

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

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

I would like to welcome Dr. Ellis as the new vice-chair of the health committee.

I think things are looking really good with respect to COVID. Usually when school returns, that's the time for a real rapid spread of disease, and we really haven't seen that, so I find that really encouraging.

Prior to this meeting, I looked up what is of concern right now. I understand that there was a Swedish study recently looking at the BA.2.75.2 variant, which there is some concern about, even though the variants that are common in Canada right now are the BA.5 and the BA.4.

For the BA.2.75.2, which is apparently a lot worse than those without the "2" on the end, studies apparently show that it seems to escape, that it is no longer sensitive to the antibodies that are out there as a result of either the vaccine or previous infection. Now, I'm not sure what that means. Apparently, in India this has been around for at least a month. It's present in 40 different countries. I saw news reports of it in India a month ago, and yet there don't seem to be any reports of large numbers of people being hospitalized or of deaths in India.

Can you tell me what you know about that variant? There does seem to be concern about the effectiveness of the vaccine and the treatments against that variant.

Dr. Theresa Tam: Mr. Chair, thank you to the member for that question.

On BA.2.75, indeed, BA.2.75.2 is the specific sublineage that we're monitoring. It's part of the group that I mentioned in response to the last question. The BA.2.75 and its sublineages currently represent 1.1% of the sequences detected in mid-September. It has stalled recently in Canada.

However, it still needs to be monitored, because BA.2.75.2 has been growing considerably faster than other BA.2.75 sublineages that we're monitoring. The vast majority of sequences in Canada at this point are still BA.5, but BA.5 has many different variations that we are monitoring, as I've said in my last report. The member is correct, in that one of the concerns is that is it able to evade potential prior immunity or monoclonal antibody treatment.

The good news is that we do have these bivalent vaccines. They are now on board. All of the vaccines so far, actually, have good impacts on severe outcomes.

As well, we have treatments like Paxlovid. That is not a monoclonal antibody treatment, and it is available for those at the highest risk.

Mr. Marcus Powlowski: Now, from your response, the BA.2.75.2 is 1% of the cases in Canada and hasn't been increasing. Do I have that right?

Dr. Theresa Tam: Yes, its growth has been observed, but it's stalled. It's slowing.

On the contrary, BQ.1.1—I think some news media have been covering that sublineage, which is a descendant of BA.5—has a faster growth estimate at this point. It represents only 0.6% of our current sequencing that was last reported, but because of the rapid increase and acceleration—for example, in European countries—that one deserves close attention.

● (1125)

Mr. Marcus Powlowski: A number of people, including my daughter.... She asked me this yesterday. She said, "Dad, should I get the bivalent vaccine?" Can you make a case for the bivalent vaccine versus the previous vaccine?

Dr. Theresa Tam: Yes.

The National Advisory Committee on Immunization—and Dr. Matthew Tunis is here with us—made a recommendation to preferentially use the bivalent vaccine, both Moderna and Pfizer now that we have them, because it contains both the original virus strain and the omicron variant strain. That helps not only to boost your antibody level when you get the booster—if you haven't had it in the last six months, go get one—but to broaden the repertoire of your immune response.

It does more than just boost levels of antibodies. The way that these bivalent vaccines are constructed, we believe it will increase the repertoire of the immune response itself.

Mr. Marcus Powlowski: One of the frequent criticisms we initially heard about the messenger RNA vaccines was that we didn't have much experience with them and they were new. That argument is getting a little tired, in that we've been using them for over two years and, seemingly, we haven't seen any great rise in adverse effects as a result of the vaccines.

I think a lot of people, especially people with kids, and I have a bunch of kids.... When you're talking about the combination vaccine, this is a new vaccine, so what can you say to reassure us that this combination vaccine is as safe as the original vaccine?

Dr. Theresa Tam: Health Canada, of course, has a well-established process in evaluating both the safety and the immunogenicity of the vaccines. After any vaccine is launched, we will have post-implementation studies, especially on safety, but also on effectiveness.

As you've indicated, millions and millions of doses of these vaccines have been utilized globally. Just because we are adjusting one of the strains, that doesn't mean that any of the other processes would change. The manufacturing process and the way the vaccine is made have been assessed as usual.

One of the best analogies I could make is that it's a bit like changing influenza strains and updating them every year. A similar kind of concept is being used by the regulator. We know a lot about these mRNA vaccines and their safety. We're just swapping out and updating the strain itself.

The Chair: Thank you, Dr. Tam.

[*Translation*]

Mr. Garon, you have six minutes.

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

I thank all the officials for being with us today.

I will continue in the same vein as my colleague. It's always impressive to be surrounded by doctors, so I'll try to ask questions as intelligent as his.

There was a sense of fatigue among people who had had one, two or three booster doses of the vaccine. Now, with the arrival of the bivalent vaccine, there is a sense that there is a new interest among the public. People are starting to talk positively about vaccination again in the media.

Do you think this is the right time to increase vaccination and booster rates, which have lagged substantially in recent months?

Dr. Theresa Tam: Thank you very much for this question.

[*English*]

This is an incredibly timely question, because our public research and surveys have demonstrated that people are interested in an updated vaccine. People do understand that respiratory virus season is upon us, and people are going to get further and further into gathering indoors, going to school, and working on site. All of this means that there does appear to be a rising interest, which is really great.

We do have a seven-point action plan to help Canadians improve uptake. A lot of that, of course, is working with the provinces, territories, and local health units. You've seen the campaigns rolling out now. You're going to see more and more messaging going out in the next days and weeks. The momentum is gathering.

From the Public Health Agency perspective, we've launched ad campaigns. One is called “Lots of Questions”, which was launched at the end of August, and the other ad campaign is called “Take Action”. One of our key strategies is to support communities that may have lower vaccination coverage, equity-deserving communities, with multilingual formats and targeted mailouts to populations where vaccine uptake is lower and there is high community spread.

Of course, there are social media campaigns, shareables and partnering with stakeholders, including private sectors, as well as press conferences. It really does take the engines of local public health to get the campaign rolling. We're also going to start the influenza campaigns. We're encouraging people to get both if they're eligible.

● (1130)

[*Translation*]

Mr. Jean-Denis Garon: Thank you.

Although I'm very optimistic and fully intend to receive the new bivalent vaccine as early as next week, I feel that it may be losing the information battle. For example, at the time it arrived in Canada and began to be administered, Agence France-Presse was reporting comments from the World Health Organization, WHO, that there was not yet enough data to recommend vaccines against COVID-19 specifically targeting the Omicron variant.

For example, the general public is under the impression that they are being told by Health Canada to get the bivalent vaccine, while at the same time there are messages that the WHO is not recommending it because there is not enough data.

Can you explain how the general public should understand these announcements made by the WHO?

[*English*]

Dr. Theresa Tam: It is very important that we communicate clearly with Canadians. The National Advisory Committee on Immunization has been very clear: If you haven't had a booster or you haven't been infected within the last six months, please go and get your vaccine up to date.

This is after Health Canada, of course, has done its evaluation on safety on the immunogenicity data that manufacturers are able to provide and some of the clinical data, for example, from the Moderna vaccine manufacturers. All of this has been taken into account to provide the information for the recommendations.

Given that Dr. Tunis is on the panel, I'm wondering if I could pass the mike over to him to provide a bit more detail.

[*Translation*]

Mr. Jean-Denis Garon: I will clarify my question to make sure it is clear.

When the WHO states that it does not have enough data to recommend these vaccines, it is seen as a contraindication by the general public, who have not studied epidemiology or virology.

Can you explain clearly what the WHO means when it announces this publicly?

[*English*]

Dr. Matthew Tunis (Executive Secretary, National Advisory Committee on Immunization, Public Health Agency of Canada): Thank you, Dr. Tam.

Thank you, Chair, for the question and the opportunity to respond.

It's an excellent question. Part of the challenge we see here is that we have an expert advisory committee like NACI, which provides expert and evidence-based advice to provinces and territories and to the Public Health Agency of Canada, which then turn it into communication materials. What we see is a very motivated and interested media and public who like to look straight to the source to see what the advice is from the advisory committee. There's some complexity, I think, in the communication pathways there.

Something we've seen throughout the pandemic and throughout the vaccine program is that NACI has consistently given advice in real time as evidence continues to evolve. What the member may be referring to is when the bivalent vaccines were first introduced to the booster program. As Dr. Tam mentioned, NACI recommended that the bivalent vaccine could be used as a booster option and that boosters were important, particularly for the elderly and with the six-month interval, as Dr. Tam outlined. As the product environment has evolved and as the evidence has strengthened about the bivalent boosters, NACI recently recommended that bivalent vaccines are now, in fact, preferred for those in the authorized age groups, where they're available.

Again, this demonstrates an evolution of the science. The expert advice moves along as the science strengthens and evolves, and then the committee adjusts the strength of its recommendations. It is now clear that there are two good options for this bivalent product, and the committee was of the opinion that this would be preferred now. That is a strong recommendation for the bivalent product as being preferred, whereas earlier in the program it was being onboarded as one of the many important booster options.

I think this is something we'll continue to see occurring. As expert advice is evolving in real time—and we know that COVID-19 evidence and vaccine science are evolving as quickly as possible—we're all very closely reading every preprint and every publication that comes out to try to get the edge on the virus and get the edge on the best science. That's a function of the system of this medical and evidence-based advice coming through in real time as things are evolving.

As Dr. Tam mentioned, the important takeaway is that at this point, the bivalent vaccines—those boosters that are approved for several age groups—have been shown to have high levels of antibody, which we expect will result in protection against omicron and the other variants. The goal this fall of the program is to use those vaccines to try to diversify the immune response; it's not necessarily to have the closest match to exactly what is circulating today. We know that omicron variants are the most distinct from the original ancestral strain, so providing a vaccine that covers both of those allows the immune system an opportunity to establish a strong breadth of protection that we think will be important going through this winter for the program.

● (1135)

The Chair: Thank you, Dr. Tunis.

Mr. Blaikie, welcome to the committee. You have the floor for the next six minutes.

Mr. Daniel Blaikie (Elmwood—Transcona, NDP): Thank you very much, Mr. Chair.

Thank you, Mr. Tunis, for those comments.

If I understood Monsieur Garon's question, I think it's an important question because it speaks to the confidence that Canadians have. We know that it's been a difficult time in some cases with respect to trust. What we are concerned with doing around this table is trying to help build confidence in those recommendations. I took him to be asking essentially whether Health Canada has access to evidence and data that the World Health Organization is not using or whether Health Canada has the same data but different criteria for what we count as sufficient to be able to make a recommendation. We do have a curious situation in which the WHO is saying there's not enough data to make a recommendation, and we have our own national advisory council, which has done very good work throughout the pandemic, saying that they're satisfied that they do have enough evidence to make a recommendation.

Can you please help us understand the difference—whether that's a difference in the data at your disposal or it's a difference in the criteria you're using to assess the adequacy of the evidence—in terms of why we have apparently competing proclamations?

Dr. Theresa Tam: Mr. Chair, thank you for that question and further clarification.

I would just emphasize that we have to look at the point in time at which these different organizations are communicating. Right now it's not just Canada. The United States, the European regulatory agencies and indeed countries very similar to our own—which have access, of course, to the manufacturers' data and their own epidemiologic information—have all recommended the bivalent vaccines.

That may be something we need to consider. I really want to thank the committee for trying to bring this point out so that Canadians can understand. Health Canada, which is not here today, our regulator, has very strong safety and effectiveness criteria that they bring to bear. They do talk to the FDA, the European Medicines Agency and the United Kingdom, for example, and they exchange information very closely. So they do share the data and they have similar data in front of them.

Mr. Daniel Blaikie: Thank you.

Mr. Tunis, go ahead, please.

Dr. Matthew Tunis: I could add to that as well, Mr. Chair, if possible. Thank you.

We work closely with our international counterparts and we know that many countries, as well as the WHO, have an advisory committee of experts similar to Canada's. We often see these advisory committees having common threads of understanding, as Dr. Tam mentioned, but we also see areas of deviation. What's important to understand and remember is that every country has a unique context and a unique environment. In the case of the WHO, they are in fact speaking to the entire global context.

In Canada, NACI is taking the Canadian information and evidence, the Canadian supply context and the available products into consideration. The WHO has certainly not recommended against bivalent products; it is recommending that those can be included as part of the booster suite, but it is not making a distinction or a preference among the different products, whereas in Canada, based on the supply context, the availability of the products and NACI's expert assessment, the recommendation was in fact that the bivalent products could be preferred.

I think an important level-setting piece of information is that all of these countries are recommending booster programs. It's now a question of which product among the suite of available products might give the best edge, and there will be different expert assessments again as the evidence continues to evolve on that.

At the end of the day, WHO, NACI and other countries are recommending that boosters should be used as part of a fall framework, as part of a preparedness against the winter season and the strains to come. We are seeing the bivalents being recommended and used quite broadly in Canada, Germany and the U.S. There has been a preferential direction towards bivalents. I think there is actually not a large gap between the positions of NACI and the WHO on this.

Thank you.

● (1140)

Mr. Daniel Blaikie: Thank you very much for that answer. I think that was quite helpful.

What I'm hearing is that Canadian organizations are paying attention to what other international bodies are doing, but also have specific, if not privileged, information relevant to the Canadian context. When Canadians are asking themselves which body they should go to first for the best advice for themselves and their families, it's the organizations based here in Canada that have experts who are paying attention to all of the many types of statements being made on the international stage, and then adding that Canadian-specific information to issue in particular recommendations for Canadians. I thank you very much for making that case clearly.

Of course, public trust factors into that. We want people to have the maximum amount of trust in our Canadian institutions they can. One thing coming out of the SARS experience was an emphasis on the need for an independent evaluation of how the Canadian government and Canadian officials performed in that context. That's something that hasn't happened yet here in Canada in respect of the COVID-19 experience.

I'm wondering if you can speak to the importance of having a public inquiry, independent advice, not necessarily because the findings are going to be different than Health Canada's own internal processes, but because I think it helps Canadians enjoy more confidence in those findings when they know they're coming from an independent source. Could you speak to the value of that independent investigation and give some thought or express some views about the timing of such an investigation? I think that would be welcome.

Thank you.

The Chair: To the witnesses, Mr. Blaikie has well exceeded his time, but we would be interested in a brief response if that's possible.

Thank you.

Dr. Theresa Tam: Thank you, Mr. Chair.

I can't comment on the specifics of any such reviews and inquiries. All I have to say is that we've just been through the biggest pandemic of the current era. It is very important to take note of lessons learned and be as objective as we can. The inputs from a variety of experts on what went well, as well as what could be improved, are important to set us up well for our response going into the future, given that pandemics will occur again.

The Chair: Thank you, Dr. Tam.

We have Mrs. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Thank you to all the witnesses for attending today virtually. It would be lovely to see your smiling faces here in person, as I do believe it often adds to the richness of the back-and-forth dialogue to have our witnesses here in person, but alas I won't harp on that.

I'm not sure if you follow what goes on at the health committee, but I've brought up on numerous occasions—as have some of my other colleagues—concerns around the lack of pediatric formulations of over-the-counter drugs, specifically infants' Tylenol, Motrin and Advil.

This is especially concerning as we're approaching the cold and flu season, when parents are going to need more of this. What would you recommend to parents going forward, as we approach the cold and flu season in this COVID-19 era, when there is no over-the-counter pain medication available?

● (1145)

Dr. Theresa Tam: Mr. Chair, the supply of these medications isn't really in the purview of the Public Health Agency. I will say that, of course, prevention is key, and that getting up to date with vaccinations is one way of preventing certain respiratory infections.

Certainly there are other ways, for example, to soothe children and reduce fevers. That kind of information should be made readily available, including through pediatricians and the Canadian Paediatric Society. I think there's work done by Health Canada and others in the federal departments to link up with pharmacists, pediatricians and others to address the situation, and also to provide parents with sound advice.

Mrs. Laila Goodridge: Thank you. I don't think it's necessarily going to provide a lot of comfort to parents to tell them that there are other ways they could deal with their child's fever. They're probably going to end up taking them to the emergency room at two in the morning rather than providing them with the pediatric pain medication that would just solve the problem.

I think this is one of the big issues in which I see a major disconnect between the advice we get from the Public Health Agency of Canada and what we hear on the ground.

I represent a large rural riding in northern Alberta. They see your press conferences, and they don't feel heard. They don't feel like you have been on the ground in many rural and remote communities to actually understand some of the day-to-day experiences, so I would encourage you.... Have you gone outside of Ottawa to hear from people directly, to see what things are looking like on the ground in Canada?

Dr. Theresa Tam: That's an important point, and, for sure, we have different roles and responsibilities between the federal, provincial, territorial and local governments, but it is important to hear from communities, so that's a really good suggestion.

All I am saying is that I know that my colleagues in Health Canada, and indeed the minister, have been working very diligently to look at the supply situation for the medications that you've just talked about. It's just that it's not the day-to-day responsibility of the Public Health Agency, and I want you to get the best information from the right department. We can certainly reach back to our Health Canada colleagues on that front.

Mrs. Laila Goodridge: Thank you.

From that answer, can I ascertain that PHAC and you have not travelled to see what the state of the COVID response is outside of Ontario?

Dr. Theresa Tam: Of course I always work with the other chief medical officers, and it is their responsibility as well for their own communities, but we also have regional offices of the Public Health Agency that are placed across Canada. They have been our eyes and ears on the ground to the local situation, and indeed, to link with local jurisdictions in terms of public health.

We work very closely, of course, with Indigenous Services Canada because one of the key federal populations that we have to listen very carefully to is the indigenous peoples—

Mrs. Laila Goodridge: Not to interrupt, but it is just a yes-or-no question. Have you travelled outside of Ontario to see what the COVID situation is on the ground?

Dr. Theresa Tam: I have been fortunate to be able to go to Montreal, Quebec, but also to Vancouver. However, no, I have not travelled extensively, but as I said, we have many staff who are on the ground.

● (1150)

The Chair: Thank you, Mrs. Goodridge.

Next is Mr. van Koeverden, please, for five minutes.

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

Thank you to our witnesses for your appearance today and for your extraordinary work over the last couple of years, which have been one of the most important and difficult times for Canadians and certainly for the health care sector as well.

I would just like to point out that I think most Canadians recognize, Dr. Tam, what your role is as the chief medical officer of health for the Public Health Agency of Canada. You're not a politician, and travelling around from community to community to liaise with Canadians isn't part of your mandate.

I would also just like to say that, in general, Canada is in a good place today, and that's in large part due to the fact that we've had reasonable restrictions and a very high vaccination rate. There are still, tragically, 45,000 deaths in Canada as a result of COVID-19, but if we had numbers similar to the United States, that number would be triple, and that's a daunting thing. An additional 90,000 Canadians wouldn't be with us today if we had different restrictions. That goes for France, Sweden and Spain also, which would indicate that those figures would be double. By all accounts, I think Canadians have a lot of confidence in our public health care system and public health in general, and I want to thank you, on behalf of all Canadians, for the extraordinary work you've done.

I'm just having a little bit of trouble hearing myself. There is a lot of chatter going on in the room, and I think it's important that we all recognize that we have time to speak and time to listen in this room.

Dr. Tam, we have seen recently in the media that Canadians are starting to become a little bit tired of keeping up with vaccinations. There is a sense a lot of Canadians have that COVID-19 is over or that they don't need to worry about COVID-19 anymore. We're fortunate to be in that situation, due in large part to the number of Canadians who have gone out and had a vaccine.

However, it is important, as spokespeople for our communities and as elected officials, that we provide Canadians confidence and information with respect to vaccines. Could you share with this committee how we can all work with your agency and among ourselves to increase confidence among Canadians and give them all the information they need in order to go out and get vaccinated and continue this positive trend that we're all fortunate enough to be experiencing?

Dr. Theresa Tam: Mr. Chair, I want to thank the member for that question. My colleague, Mr. Stephen Bent, vice-president of the vaccine rollout task force, can supplement my answer.

My previous response describes some of our seven-point immunization action plan, which aims to boost the confidence of Canadians for the bivalent vaccines. That includes communicating with Canadians in the different ways and formats that I've outlined.

Through numerous surveys, we know that Canadians trust their health care providers, so providing information to our pediatricians, physicians, nurses and pharmacists who are on the front lines, so that they can answer questions from the public, is very important, as well as clearly communicating what is now quite a clear message from the National Advisory Committee on Immunization, which is to get a booster if you haven't had one or if you haven't had an infection in the last six months. This is actually a very clear message that all of you and others could communicate, as well.

Then it's building trust, of course, with communities that have been disadvantaged and have experienced inequities over the years and working with them so their leadership can provide the voice to their populations to take action to get a booster. We're providing funding, through grants and contributions, to specific communities to help them improve the vaccination rates.

Maybe Mr. Bent would like to add something to my response.

Mr. Stephen Bent (Vice-President, COVID-19 Vaccine Rollout Task Force, Public Health Agency of Canada): Thank you, Dr. Tam.

Mr. Brendan Hanley (Yukon, Lib.): Mr. Chair, I have a point of order.

I'm having a hard time hearing the response. There's a lot of chatter in the room. I wonder if you could address that.

Thank you.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Mr. Chair, I'll also weigh in on that. I know there are a few new members around the table. As someone who's been here for seven years...we have these handy little headsets that they can absolutely put in if they'd like to. That's free advice for the new members to listen to if they're having so much difficulty hearing.

● (1155)

Mr. Adam van Koeverden: It's still my time, Mr. Chair, and I would like to say that we all know about these. That was fairly condescending, to tell us that we have a way to listen, when—

Mr. Matt Jeneroux: It's not condescending. Come on, Adam.

Mr. Adam van Koeverden: If the witnesses were in the room, talking over them would be seen as an extraordinarily disrespectful thing to do. It's fine to talk in a group if you'd like to avail yourself of any of the other spaces in this room. If the witness was in the room, you would not be talking over the witnesses like that. It's extraordinarily rude. I noted that you were doing it while I was asking my question, as well. It's extremely distracting.

We're here to work, and we're here to listen to these witnesses. If you're not interested in listening to the witnesses, then use another part of the room.

The Chair: If we could show respect for one another and for the witnesses, that would be greatly appreciated.

Mr. Bent was about to offer an intervention.

If you could keep it brief, Mr. Bent, then we're going to retreat to our corners and move along. Thank you.

Mr. Stephen Bent: Thank you, Mr. Chair.

I would only add that this year alone we've been able to invest an additional $5.3 million in projects to reach under-reached and marginalized communities, including indigenous and racialized communities.

I would also add that in the context of vaccine confidence, we continue to work with the provinces and territories and with the regulator in terms of vaccine safety and ensuring that Canadians have the latest, most up-to-date information in terms of the overall safety and efficacy of the vaccines that we have available to us. That's a really important part of this space, as well.

Thank you.

The Chair: Thank you.

[*Translation*]

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

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

Dr. Tam, I still feel that public trust remains the most important asset for a public health agency. Such an agency gives directives to people; it does mass medicine and asks people to follow those directives.

The pandemic is obviously still with us, but we are taking stock of a number of things.

During the pandemic, many people in the public had difficulty distinguishing between politics and science. It was hard to know what specific recommendations you had made to the government and what analyses you had given them.

It was difficult to know which parts were political. It's good that there is political involvement, because politicians are elected to make decisions, especially on social cohesion. I am not here to put your agency on trial. In fact, I think it has done a good job.

I wonder what could have been done differently to increase public confidence in the scientific process that led to health measures, mandates, and vaccination, among others.

Dr. Tam, I don't want you to waste my remaining time telling me what you did. I would like you to tell me what you would have done differently and what could have been done differently.

Communication is part of the scientific process in public health. I am not asking you to play politics, but rather to tell me what should have been done differently.

[*English*]

Dr. Theresa Tam: Yes, trust is really important. I am not a politician, as you rightly pointed out. Because we're dealing with extremely complex decisions, it is ultimately the political decision-makers who make those decisions. We provide both technical information to them and, of course, communication with the Canadian public.

There's a lot to be learned, I think, about how we communicate uncertainty when we don't have every piece of data that we need and, of course, how to navigate and bring the population along as things evolve. That happened throughout the pandemic because the virus was new. We had to learn practically every day about how it's changing and what measures can be done to reduce its impact. That is very critical to future pandemic preparedness.

[*Translation*]

The Chair: Thank you, Mr. Garon.

[*English*]

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

Mr. Daniel Blaikie: Thank you very much.

I think for most people, when they think about their experience of the pandemic, there's the personal side in cases where they may have a friend or family member or themselves who got very ill and all the anxiety and worry that come with that. We talked a fair bit about vaccination already, which is of course the best way to try to prevent similar instances in the future.

The other thing I think is part and parcel of people's experience of the pandemic, even if they didn't get sick with COVID themselves, was just the extreme strain that it put on hospitals. They may have experienced that in the case of a loved one. They may have experienced it in their own case, requiring health services for something that was unrelated to COVID but where the treatment and the availability of health resources were severely impacted as a result of the level of infection and just how difficult it was for the health system.

In this moment of, relatively speaking, apparent calm, I'm wondering what we can be doing in order to try to strengthen health systems and shore up our hospitals in the event that we do see another wave or something else that comes along that requires a significant amount of health resources.

I know that provinces, of course, are responsible for that direct delivery, but in health human resources, for instance, we're going to need to train more people. Having 10 different provincial strategies that are competing and might incorporate poaching, for instance, as part of their strategy will not be helpful. Some kind of national collaboration and co-operation might help there.

I'm wondering if you could point to other areas where co-operation among provinces and with the federal government might help us develop a faster response or to be ready more quickly for events that may be coming down the line.

● (1200)

Dr. Theresa Tam: Given the nature of a pandemic and the complex public health challenges, there has to be a huge amount of collaboration between provinces, territories and the federal government. No level of government can do this alone.

In terms of the health care system pressures, on the public health side what we're trying to do is promote prevention and health promotion so that we reduce the impact on the health system. It's very important to have emergency rooms, primary health care and other systems being more resilient. Part of the solution is actually shoring up public health. You've seen in the pandemic that if vaccinations and other measures were not put in place, those very systems would be even more pressured than they were before. We need to protect our health care workers.

Those kinds of collaborations are absolutely key. Of course, we need to collaborate on monitoring and sharing of information and data to inform our collective response, while recognizing that there are different contexts, different populations and indeed different virus activities on the ground.

The Chair: Thank you, Dr. Tam.

Next is Mr. Jeneroux.

Welcome to the committee. You have the floor for the next five minutes.

Mr. Matt Jeneroux: Thank you, Mr. Chair. Despite my earlier intervention, it is a real pleasure to be here with every single one of the committee members, but also to be back at the health committee.

Dr. Tam, it's good to see you once again.

Dr. Njoo, it's been a while since our very many meetings back in early 2020 in the lead-up to the pandemic, but that's kind of where I would like to start, if we can.

There are a number of quotes here that I know have been associated with you, Dr. Tam, which I'm going to read, and then I would like you to perhaps reflect upon what we could do differently or next steps that could have perhaps been taken earlier to prevent the rapid spread at the beginning of the pandemic.

First of all, you said, “Canadians should not be concerned that they can pick up the virus from an infected individual by any casual contact, such as walking through the airport or another public place.” Dr. Tam, that was you on January 27, 2020.

“Dr. Theresa Tam said again that sealing off borders is not an effective approach to containing the virus.” That was you, Dr. Tam, on March 4, 2020.

“[P]utting a mask on an asymptomatic person is not beneficial.” Dr. Tam, that was you on March 30, 2020.

Dr. Njoo, I certainly won't miss a quote from you as well. On February 26, 2020, you stated, “We have contained the virus.”

Again, in terms of perhaps what you can do differently at the beginning of a pandemic and steps to stop the rapid spread, I would love to hear your insights based on those quotes.

Dr. Theresa Tam: Mr. Chair, I'll start.

Thank you to the member for those questions. Part of my reflection on lessons learned is that hindsight is 20/20. Information and the evolution of the understanding of the virus are changing all the time. At that point in time, at the end of January, we were very good in Canada to be able to pick up our first case. There was no discernible community transmission at that moment in time. However, as everyone could see, things were evolving fairly rapidly.

For pandemic preparedness going forward, I would suggest that we need to increase global collaboration, share information more rapidly if possible, and reduce the rapidity of transmission from the original source if we actually know where it started. However, the way this coronavirus was transmitted changed over time. At the beginning, the R value, what we call the reproduction number, wasn't that high, and then it just kept gaining more and more momentum. Then our understanding of asymptomatic transmission came into play. That's when we really stepped up the recommendations for mask wearing, when it was much better understood.

We need to have humility in the face of these viruses, for sure. I'm sure there's a lot we can do, but shoring up public health is a really important aspect of preparedness going forward.

● (1205)

Dr. Howard Njoo (Deputy Chief Public Health Officer, Public Health Agency of Canada): Mr. Chair, maybe I could add something in terms of the comment attributed to me. If I recall correctly the date, those comments were actually made at the health committee here. Certainly, if we look at the larger context, what was indicated at that time—which was, as Member Jeneroux reported, February 26—was that certainly with our efforts to date, at that point in time the virus had not obviously transmitted to a large degree. If you look at all of the comments I made, I said we continued to work closely with the provinces and territories in terms of planning for a potential worst scenario.

One of the things I did mention, I do recall, at that committee, was things that were unknown at the time, things like public health measures. I said that we were not at that point yet, but we had to start thinking about potential measures like social distancing, which at that point in time was something totally unheard of, and looking at what might need to be done in terms of schools and other maybe more restrictive public health measures.

I think you need to take the whole context of everything that was said and what we knew at the time. And certainly, as Dr. Tam says, I think we do have humility. As the science evolves, statements made or what we say and do at a certain point in time based on the state of science at that point in time certainly evolves with—

Mr. Matt Jeneroux: I'm sorry to cut you off, Dr. Njoo. I know I have about 10 seconds left. Just quickly, are the Public Health Agency of Canada and Health Canada planning to conduct a full review and report on the handling of COVID?

Dr. Theresa Tam: As I said, that decision is not up to me. However, as I reiterated before, lessons learned are very important, with the view to improving our response going forward.

The Chair: Thank you, Dr. Tam.

Next we have Dr. Hanley for five minutes.

Mr. Brendan Hanley: Thank you, Mr. Chair.

First, I'd like to add my congratulations to Dr. Ellis for being elected vice-chair.

I'd also like to welcome our new member, Mr. Jeneroux, to the committee. We enjoy a productive and collaborative committee here. I'm sure, as a new inductee, you'll learn quickly from your more experienced colleagues around the table.

Dr. Tam, it's good to see you again. I also want to add a comment—a reflection from my previous role pre-Parliament—on your connection to rural and remote Canada. You are a vital advocate for rural, remote and indigenous Canadians. I think a good example was about a year and a bit ago. There was a live Facebook update on a weekend with famous Yukon bhangra dancer Gurdeep Pandher, and a Q and A for Yukoners. You found many ways to connect with rural Canadians. That may be reassuring for Mrs. Goodridge.

On the note of the important theme that was just in the last questions answered, I wonder if you could comment, from the point of view of lessons learned, on how we work with evolving evidence through a new viral threat, like this COVID pandemic—there are many other examples—and adapt guidance. Perhaps you could reflect on the specific example of the new integrated risk assessment, and how that new unit is helping to provide that ability to keeps eyes around the world and adapt to risk and guidance quickly.

● (1210)

Dr. Theresa Tam: Mr. Chair, I thank the member for the question.

Of course, to add to my previous answers, we've been looking at lessons learned throughout the pandemic and evolving our response as we go along. We had OAG audits. We've been responding to those as well. We've also had external experts look at our risk assessments and the global public health intelligence network, and how we can better utilize that.

Yes, we took all those lessons and recommendations into account when we established a new centre for integrated risk assessment to bolster our risk assessment capacity. It was established in December 2021. We now have increased capacity to integrate different streams of scientific information, not just from data and monitoring systems, surveillance and ways forward, etc., but also from the scientific literature, which is certainly making it easier for us to produce risk assessment and threat reports. We're now using this centre and the methodologies to integrate laboratory genomics, epidemiology and clinical information of new variants of concern, and those updates have been shared with provincial, territorial and other partners as well.

While the methodology is being stabilized, we should be able to provide more of that in the public domain—although it's very technical information—so that people can see in a more transparent way how integrated risk assessments are done.

Mr. Brendan Hanley: Thank you.

If I have time, I'd like to pivot to Dr. Tunis. Thank you for being here today.

My question is around the ongoing evaluation of vaccine effectiveness. As I understand it, for the new bivalent vaccines, we don't have as yet the clinical effectiveness data. I'm sure that's expected in the future. Maybe you could comment on the antibody response data versus expected clinical effectiveness data, and how that might add to your recommendations.

Dr. Matthew Tunis: As the member has pointed out, the bivalent vaccines, which have been recently authorized and recommended in Canada—from both Pfizer and Moderna—have been authorized based on antibody levels and neutralizing antibody titres.

That's not the same as clinical effectiveness, where we see in the real world how many cases of COVID-19 or particularly how many severe disease cases, hospitalizations and deaths are being prevented. However, we have seen in general, throughout the pandemic, a fairly strong correlation with neutralizing antibodies: Higher levels of antibodies can be protective against some of these outcomes. We don't have a correlative protection, so we don't know exactly what line in the sand you can draw to say you will prevent *x* number of cases with *x* level of antibodies, but there does seem to be a general trend of correlation that we are observing.

Those new vaccines have been authorized and recommended based on higher levels of antibodies against omicron strains, which is a good thing. As Dr. Tam noted in some of her opening responses, the direction so far that we're seeing in the variant environment is continuing toward omicron subvariants, so there's an advantage to having the immune system primed or boosted with omicron-containing vaccines.

While we see higher antibody levels in these products, we don't yet have the real-world evidence, and there's generally been a pattern throughout the pandemic of how this evidence comes to bear. We have research partners in provinces and territories in Canada who conduct vaccine effectiveness studies and monitoring, or the surveillance of how the vaccines perform once they're deployed. We know that the U.S. and the U.K. also have strongly based research groups that can issue those kinds of data and those estimates.

The general trend we've seen through the pandemic is that once the vaccines are deployed, somewhere between two and six months after the deployment we start seeing the real-world effectiveness data come in. We're on that track now that the bivalent vaccines are rolling out in Canada. We know that many millions of doses have been used in the U.S. as well, and also in the United Kingdom, so we do expect to see those vaccine effectiveness estimates start coming in.

I will note that the entire vaccine effectiveness monitoring landscape is becoming increasingly complex, because we now have multiple different vaccine products that people have had in terms of boosters. They've had different vaccine experiences through their primary series, and also we have different levels of infection from either pre-omicron variants or omicron variants. We have a very different mix of population in terms of who's been infected and who's had *x* number of boosters, so to actually try to calculate vaccine effectiveness is becoming harder and harder. It's probably not going to be a simple answer that it's *x* per cent, because it has to take into account whether it will be *x* per cent for people who have been previously infected or *x* per cent for people who have had *x* number of boosters. It's becoming more and more complex, but we are well established to be able to monitor this and see research estimates coming in over the coming months.

I will also note that this is very similar to how we conduct influenza vaccine programs, where we, as Dr. Tam noted, have strain substitutions and launch new products in the fall. Then the effectiveness monitoring comes in months after, and we see how the products perform in the real world. We're making some early assumptions based on the way the vaccines have been studied in the trials, and then we're deploying them and following up with the real-world effectiveness, which can feed back into policies and guidelines that can be updated, so it becomes a research or a knowledge cycle.

Thank you.

● (1215)

The Chair: Thank you, Dr. Tunis.

Next we have Mr. Hoback, please, for five minutes.

Mr. Randy Hoback (Prince Albert, CPC): Thank you, Mr. Chair.

It's nice to be part of this committee for the day.

I guess where I'm going to go is on the credibility, Dr. Tam. One of the concerns I have coming out of the riding of Prince Albert is a lack of credibility now in our government institutions all the way around, and I think it shows automatically when you start to look at the people taking booster shots, for example. The numbers are substantially lower now than they were, let's say, this spring. I think part of that comes back to some of the things that have gone on over this last year.

For example, in Saskatchewan, Dr. Shahab would make a recommendation, and we'd remove masks. I'd fly to Ottawa, and we'd be fully masked. Canadians would say, “How come the science in Saskatchewan says one thing, yet the science in Ottawa says something different?” How do you build credibility back in those scenarios going forward?

What really scares me is that we don't have credibility in the organizations now, and if there was a bad virus that's really bad, where you needed to bring forward the lockdowns and things like we had to do, supposedly, at the start of COVID, Canadians wouldn't listen to you. They would say, “Never. We're never doing this again. We don't trust you. We're not listening to you.” We'd see then the massive deaths that would be the result of that because we don't have credibility or the trust of Canadians.

What is your plan to build back that trust?

Dr. Theresa Tam: This is really important, and this is why we must come together, work together, to earn that trust and keep it up. The outcome for Canada has been relatively good, but I—

Mr. Randy Hoback: Excuse me. I'm going to interrupt you here. The outcome—

The Chair: No, no, Mr. Hoback.

Mr. Randy Hoback: No, it's my time, Chair.

The Chair: You asked a question that lasted longer than a minute, and you interrupted her 15 seconds into her answer. She's entitled to at least as much time—

Mr. Randy Hoback: It's my five minutes—

The Chair: —to answer the question as you used to pose the question.

Go ahead, Dr. Tam.

Dr. Theresa Tam: Between myself and my other chief medical officers, we have regular interactions. They voiced the fact that, while we're in the same pandemic, everyone is in a different context. We do work with similar data, so mask use, for example, is very important if the mask is properly constructed and well fitted. Where it differs is how those policies have been applied, where the requirements have been applied versus recommendations. We've seen that undergoing evolution over time, but it's the same recommendation in terms of the importance of layering on those protections.

It also depends on the epidemiologic activity in the community or the province. That has to be taken into account, so listening to your local medical officers is very important.

However, it is difficult in a country as big and diverse as Canada, and we are not recommending a complete blanket approach to everything. That can sometimes undermine communication and trust, but we do have to recognize that there are differences.

● (1220)

Mr. Randy Hoback: The next level.... Being in Saskatchewan, we'd look across to the U.S. and into Montana, North Dakota, and South Dakota. When we were doing our lockdowns, we were watching what was going on there. We were saying, "Okay, their science is saying something totally different than our science."

We see even today that the ArriveCAN app was finally taken away. I do want to know what your involvement was in the creation of that app. That's one question.

We still have differentials in North America on what is allowed and whether people who are vaccinated, or not vaccinated, can cross the border. For example, anybody can come into Canada now, but going to the U.S. if you're not vaccinated.... I hear different stories. If you're at the border, a lot of the border officers will ask you, but some of them won't. It is different.

That difference creates confusion, so what is the communication between us and the U.S., for example, in this scenario? What is the recognition of science from other areas, as we go into making our decisions?

When you make that decision, I assume you make recommendations to the Prime Minister, and he makes the decision. How do you square things when the Prime Minister goes to a committee that isn't made up of science to make the final decision over what you recommended?

Dr. Theresa Tam: We do maintain close communication with the United States and, no, I'm certainly not responsible for the ArriveCAN application itself. We can refer you to our colleagues at CBSA, but our VP—

Mr. Randy Hoback: Was it necessary?

Dr. Theresa Tam: —who is in charge of borders is on our panel today if we need to refer to her.

Let me just remind you that the United States had three times the human deaths per 100,000 population than Canada, so we did do things differently, and have been doing things differently. Our outcomes are actually quite different if you just compare mortality rates, not to mention hospitalizations and other impacts.

Yes, you can look across the border, but we actually did better in the Canadian context by doing things a bit differently.

Mr. Randy Hoback: I'm not going to argue with you, Dr. Tam. I actually agree with you on that.

However, we did notice that the Americans could react a lot more quickly in their hospital scenarios. They could actually add intensive care beds. They could add the staff. Here in Canada, I think Alberta threw a billion dollars at it in June, and by September-October, it still didn't have one more intensive care bed. It comes back to, as you said, our health care system being so taxed that there's no grace, or buffer zone, for something like COVID, or something that comes along in the future.

It's even worse now, because we've postponed all these elective surgeries on knees, hips, and shoulders, and we're trying to get them back into the system. If we were to have another virus, or even COVID resurrected into a very deadly virus, we wouldn't have capacity, and nobody seems to want to address that.

The Chair: Thank you, Mr. Hoback. That's your time.

Mr. Matt Jeneroux: Mr. Chair, I have just a quick point of order, plus a point of clarification.

From your perspective—again, I'm new on the committee—you cut off my colleague at the beginning. You said the reason was that his time had to accurately reflect the witness's time. There have been times when I've been on a committee where people have interrupted and asked for a simple yes-or-no answer. They've gotten that, and they were able to move on.

I'm curious, and I imagine our whips will probably have this discussion, but before it gets to that point, could you clarify your ruling, so we have it at least on our side? If the situation comes up again, we'd at least know your perspective.

The Chair: In fairness to the people posing the questions and the people answering the questions, the rule of thumb is that the witness be allowed the same amount of time to answer the question as the person who has posed it. Therefore, when Mr. Hoback took over a minute to present his question and then 15 seconds into her answer he interrupted her, I intervened.

By the same token, if a member asks a short question, for example, and a minister drones on, it's entirely appropriate for the MP to interrupt the witness. If it's a short question, they're allowed to interrupt after a reasonable amount of time. That's been the rule of thumb, as I have applied it, in terms of chairing this meeting. It's how I've been chairing this committee consistently from the outset.

That's what happened.

Mr. Hoback, go ahead.

Mr. Randy Hoback: In regard to that, I have chaired committees before, and there are times when you need a minute to preface your question, but the answer requires only 15 seconds. When you see a witness not doing that, then you have the right to interrupt and say, okay, I need to ask...because you have only five minutes. It is my only time throughout the next six weeks to ask these questions, so if I feel that the witness either isn't answering the question or has answered it and I want to move on, then I have the right to interrupt.

Rules of thumb are great, but the reality is that it is not a functioning actual standing order within the committees in that regard. It is my time. If I decide to interrupt, I'd expect the chair to respect that and to respect my maturity. The reason I'm interrupting has very important context in terms of what I'm trying to do to get information for this committee. By interrupting, you've broken the flow of my questions. You've taken away my time and my ability to actually get to the bottom of some serious questions for this panel, because of how you did it.

I appreciate the rule of thumb, but in this case I think it was totally inappropriate.

● (1225)

The Chair: You always have the right to challenge the chair.

Mr. Jowhari, go ahead, please.

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

Thank you to the witnesses for coming today.

Dr. Tam, most of my questions are going to go to you.

I've heard various versions of “the pandemic is over”, or the emergency part of the pandemic is over. But the pandemic continues. Therefore, there is, naturally, uncertainty associated with that level of communication. It was recommended that we get our booster vaccine. I've done my primary as well as the two boosters. I'm looking forward to getting my bivalent vaccine soon.

We talked about the outcome, and that's the best way of being able to measure our success. Had we not followed the guidelines that were set, in combination with consultation with our scientists and data, as well as, let's say, the government policies, where would we be?

We know that today we are at 45,689 individuals who have paid the ultimate sacrifice. Where would we be if we hadn't followed those? That's really the end outcome. Can you shed light on that?

Dr. Theresa Tam: This is a really important point, and one on which public health needs to do a better job. Describing what did not happen and what is prevented is not an easy task.

The Public Health Agency scientists did provide a publication recently on what we call “counterfactual scenarios”, where we looked at the impact of vaccination and the collective response of public health measures in Canada. If we had done absolutely nothing.... And that was not going to happen. But just imagine that you did not have any vaccines, that you did not follow any public health measures. You would have had, of course, most of the population being cases, up to 34 million cases, two million hospitalizations—that's stress on your hospital systems—and up to 800,000 deaths.

Of course, there are many in-between scenarios, whether we look at the application of public health measures without the vaccine or the application of vaccines without public health measures. The bottom line is that you actually needed them both, particularly during different times of the pandemic when there wasn't a vaccine and then when there was a vaccine.

This is why I say that we have to remember the impacts of this pandemic. Relative to other G7 and peer countries, we did relatively well—that is, compared with the death rates in the United States, the United Kingdom and other similar countries. We have to learn and be humble. We have to learn from other countries that have done better than us, as well.

Mr. Majid Jowhari: Thank you, Dr. Tam.

We lost over 45,000 Canadians. Had we not followed the rules or the established guidelines, we potentially could have lost up to 800,000. That, to me, is simple and Canadians can understand.

You talked about communication. One of the comments you made is that we have to change the way we communicate uncertainty. Again, school is back. We are all going indoors. Most of us have had at least one booster shot. Uncertainty is coming. How should we communicate as a government or agency? How should our doctors, our pharmacists, our media or social media communicate this during this uncertain time?

● (1230)

Dr. Theresa Tam: Thank you for this timely question.

I think we are absolutely in a better spot, of course, than we were even a year ago, despite the arrival of the omicron virus. I think what one would say is that we are carefully monitoring the situation. We will indicate what we know as we go along and provide that data to Canadians, but the bottom line is that we do have tools.

We have vaccines. We have these bivalent boosters. We know how to layer on our personal protective equipment. We can do something about reducing transmission and severe impacts much better than we could before.

While there is uncertainty and we keep monitoring the data and the different variants that we talked about, there's agency. People can do something about this to keep us doing the things that we value the most, like going to school and going to work.

The Chair: Thank you, Dr. Tam.

[*Translation*]

I now give the floor to Mr. Garon for two and a half minutes.

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

As you know, the House of Commons is referring Bill C-31 here to the committee for clause-by-clause consideration. That will begin no earlier than next Monday at 7:00 p.m.

I would like to table a motion regarding committee work so that we can keep the last 25 minutes of today's meeting to begin planning our work on Bill C-31.

Since there is probably a willingness to hear witnesses, this must be done with additional resources before Monday.

So I move a motion that we reserve the last 25 minutes to plan our business, witnesses and additional meetings.

The Chair: Thank you, Mr. Garon.

I'll consult with the clerk, because it's really a procedural matter, but, if there's unanimous consent, we'll proceed.

I would ask you to wait a minute, please.

We have a suggestion. For my part, I think it is more than a suggestion. I guess you could say it's a motion that we plan now for the study of the bill that we're going to have to do.

[*English*]

Colleagues, the suggestion that has come forward from Monsieur Garon is that we now move to a discussion around the planning on Bill C-31.

First, I would like to ask whether the committee is comfortable to dismiss the witnesses now and embark on this discussion. If we can't proceed by consensus, then I think we probably need to have a discussion and a vote on it.

The floor is open. What's the will of the committee?

Go ahead, Mr. van Koeverden.

Mr. Adam van Koeverden: Thank you, Mr. Chair.

[*Translation*]

I thank Mr. Garon for his good idea.

[*English*]

I don't think it matters. I don't think the motion was in order, but I understand the purpose of it and I think we could probably move on. I don't think we need 25 minutes to discuss witnesses for Thursday, but I do think that we need to do it today if we are to have witnesses on Thursday.

With respect, I think there is still time with our witnesses. I don't want to disrespect our witnesses and their presence by suggesting that the last 27 minutes of the meeting are somehow disposable, but we are happy to discuss witnesses for Thursday at the end of this meeting, whether or not that starts now.

● (1235)

The Chair: Next is Dr. Ellis.

Mr. Stephen Ellis: Thank you, Mr. Chair.

Certainly, from our perspective, we're happy to proceed at the current time. We understand, though, the good nature of the witnesses in front of us, and that they will appear regularly, anyway. I think it has become very clear today that the COVID situation is ongoing and will require our attention in the future, so moving into a discussion of witnesses, at the current time, makes good sense.

Thank you.

The Chair: Thank you, Dr. Ellis.

Go ahead, Monsieur Garon, and then Mr. Blaikie.

[*Translation*]

Mr. Jean-Denis Garon: Mr. Chair, I would like to take this opportunity to thank the witnesses and then tell them that we are very pleased to have them here today and that it is not our intention to be disrespectful to them in any way. When we invited the witnesses to testify, we obviously could not have known that the government would impose a gag order to expedite Bill C-31.

Now the situation is this. The government and the NDP want C-31 to move quickly. We don't agree with that, but we respect that. We can probably start clause-by-clause on Monday night. That means that, because of the gag order, we have very little time—I agree—to call witnesses and begin our planning.

On the other hand, the motion that has been tabled in the House of Commons gives us priority in accessing the resources of the House if we want to hold additional sittings. Mr. Chair, that means that if those sittings are not held tomorrow, they should be held on Thursday or Friday.

First of all, I hardly see how we can wait until next Thursday to plan this work. That makes it impossible; indeed, the mission is almost impossible. From my point of view, democracy is already suffering.

Then we need to be able to plan what additional resources we are going to ask for, and how we are going to operate in relation to witnesses. When we finish talking about the motion, we will have 15 to 20 minutes left. That is already a tour de force.

For that reason, I will stop talking. I think we should get on with it, with a heartfelt thank you to the witnesses from the Public Health Agency of Canada for being here with us today.

[*English*]

The Chair: Go ahead, Mr. Blaikie.

Mr. Daniel Blaikie: Thank you very much, Mr. Chair.

Of course, I'm at a bit of a disadvantage, being a sub on the committee. It sounds like an important conversation for planning out committee business that I will not be a part of. My preference would be that the committee find time to do this after there has been a bit more opportunity for discussion among the parties, in advance of decision-making. I think that would be very useful, which is why I'm not keen to proceed to a discussion of committee business, where I'll be making decisions for others without what I take to be the appropriate context for the committee.

That said, if this is about responding to something happening in the House and there's a need for witnesses—and I'll speak from my experience, not at this committee but at others—that can often be resolved by the submission of witness lists. If, with the chair's discretion, there's going to be an additional meeting held tomorrow, or if the business for the meeting on Thursday is going to change and it's about ensuring we have appropriate witnesses for the subject matter at hand, that's something that needn't be done right now, at this table. It can be done through discussion among the parties shortly after this meeting. Parties could submit their witness lists by the end of the day, for instance.

I am not sure we need to lose what time we yet have with our witnesses in order to have a well-functioning and productive conversation about how to have witnesses in time for Thursday, for example.

The Chair: We have Mrs. Goodridge, and then Mr. van Koeverden.

Mrs. Laila Goodridge: Thank you, Mr. Chair and Mr. Blaikie.

The original conversations that were happening were to have these conversations around witnesses for Thursday, which would effectively leave no time to hear from witnesses before we embark on clause-by-clause.

I think a very intelligent compromise was found by our Bloc colleague, one that allows some space for witnesses to present. We're not saying we are going to pick witnesses in this meeting. This is about setting the agenda, through committee business, so we can proceed to having some witnesses appear on this bill prior to doing clause-by-clause, which is forced by government motion to happen starting on Monday.

This is simply to give a bit of space. I would think the New Democratic Party, a party that has always supported the democratic process, would be in favour of hearing witnesses on an important bill such as this.

The Chair: Go ahead, Mr. van Koeverden.

[*Translation*]

Mr. Adam van Koeverden: Thank you, Mr. Chair.

We are now about to discuss upcoming witnesses.

● (1240)

[*English*]

Out of respect for our witnesses, I would recommend that we excuse them. If we are to discuss witnesses, we should go in camera for that discussion, instead of having that chat in public.

The Chair: All right. There are no further speakers. I'm not sure that we have a consensus.

Mr. Blaikie, go ahead.

Mr. Daniel Blaikie: I guess my question is whether the purpose of the discussion that's envisioned by the motion would be to set additional meeting dates or whether it would be to talk about which witnesses would come to provide testimony. That's still unclear to me.

If I just had a better sense of what the decision points are that people want to arrive at, then I'd have a better sense of whether I can meaningfully contribute to those decisions in this moment, or whether we would need some time to consult with our critic, who's obviously not at the table today.

The Chair: Mr. Garon, go ahead.

[*Translation*]

Mr. Jean-Denis Garon: I am moving this to serve the committee and the parliamentary process. There's absolutely nothing partisan about it. We have a choice to make. We can either hurry up and start planning meetings and resources today, or we can plan nothing, call no witnesses, decide on nothing and do the clause-by-clause consideration without even settling on the process. We still have a bit of leeway right now.

I will even tell you that I don't have any witnesses in particular to call right now. I have no ulterior motive in introducing this motion. I just feel that if we don't do it now, we'll never get the chance to do it. Given that we have a gag order and we're facing an expedited process, it's only right that we move quickly to change our schedule now and work effectively.

[*English*]

The Chair: Seeing no further interventions, I guess we're ready for a vote.

Is it the will of the committee to dismiss the witnesses and embark on a discussion on planning for Bill C-31?

(Motion agreed to)

The Chair: It appears that it is in fact unanimous.

To our witnesses, first of all, thank you so much for your patience. Sometimes democracy is a bit messy. We always appreciate your expertise and how willing you are to come before the committee and answer some challenging questions. Thank you so much for your service to us and to Canadians. I wish you all a great day.

Colleagues, let me set the stage as follows and summarize some of the discussions that have been had and where we are in respect of Bill C-31.

The first thing I want to point out is that we are presently in public. If there is a wish to go in camera, that's going to take some time—probably all the time we have allotted. Normally, if we're going to get into discussion of witnesses, we would do that in camera.

Let me say this: If the motion, which I understand is being debated, passes without amendment, it will mean that we will be obliged to proceed with clause-by-clause on Bill C-31 on Monday. We are not allowed to commence that clause-by-clause before 7 p.m., but at midnight any debate on clause-by-clause amendments will be finished and, as of midnight, the only thing left will be voting.

The motion does not preclude us from starting, at any time, to hear from any witnesses we wish. The informal discussions that have been had were headed towards this Thursday's regular meeting slot being dedicated to planning whether to call witnesses other than officials and who they might be. That meeting would be in camera. If we had time at the end of that meeting, we would continue with the consideration of the health human resources report.

In any event, it was my intention to invite a legislative clerk to Thursday's meeting because for many this will be the first time actually going through the clause-by-clause process. I thought having a resource from the House here to either brief us or answer questions with respect to that process would have some value.

I know we have limited time. I would like to pose this to you: Given that we are in public, I don't think it would be appropriate to get into specific witnesses. I think it would be useful if.... Do we want to hear from witnesses other than officials after 7 p.m.? If so, how much time should we allocate to that?

We take precedence over all other committees with respect to House resources to get this through. We will allot as much time as the committee wants and then perhaps call for submission of witness lists so we can boil it down to who.

I would prefer if this discussion is about how much time and not about the specific identity of witnesses, given that we are in public.

The floor is open.

Mr. van Koeverden, go ahead.

● (1245)

Mr. Adam van Koeverden: Can I ask the clerk briefly, considering that everybody is in the room, would it take more than a minute to go in camera?

The Clerk: We're looking at that right now. The question is.... Party officials aren't in the room. The committee rules do allow party officials to join Zoom. If we were to proceed in that fashion, that would exclude those officials.

The Chair: Mr. van Koeverden, we can, by unanimous consent, waive the requirement for allowing officials, members from the government House leader's office, etc., to participate virtually. We can do that, but we'd have to do it by unanimous consent.

Mr. Adam van Koeverden: I feel like that's above my pay grade a little bit.

What I could ask is whether we want to discuss specific witnesses or discuss whether or not there are witnesses. We can do this out of camera, I think, if we're just discussing the broader concept of whether or not we're having witnesses.

The Chair: We'll go to Monsieur Garon, and then Dr. Ellis.

[*Translation*]

Mr. Jean-Denis Garon: Here's what I suggest we do. First, let's agree to schedule additional meetings to accommodate witnesses. Second, let's agree to submit our witness lists to the clerk by Friday at 5 p.m. so that we can plan our meetings.

I understand that Mr. Davies can't be with us right now and someone is sitting in for him on the committee. We heard some reservations about that. We could, for example, schedule two two-hour meetings for next Monday, perhaps three—that would make for a long day—so that everyone has time to prepare and the clerk has time to call witnesses. That way, Mr. Davies will be back and we will be showing respect for everyone. It seems to me that's a good way to do things. Obviously, Monday will be a long day for us, but so be it.

[*English*]

The Chair: Dr. Ellis, go ahead.

Mr. Stephen Ellis: Thank you, Chair.

I think a couple of things are important, just for clarification.

Obviously, we have priority for House resources. When does that actual priority start? Will it start on Thursday, for instance, and continue through the weekend?

I just have a couple of other things, but if you'd like to answer, please do.

The Chair: My understanding is that it will start the minute the motion is adopted.

Mr. Stephen Ellis: Okay.

Of course, after that, I do think it's important that we have an in camera discussion with respect to specific witnesses we want to appear before the committee.

I certainly think we have limited time today. I would suggest that we're going to need an in camera meeting on Thursday and submission of witnesses by Friday at five o'clock, which could also possibly mean meetings over the weekend on an urgent basis.

The Chair: Mr. Blaikie, go ahead.

[*Translation*]

Mr. Daniel Blaikie: I'd like to thank Mr. Garon for his suggestion. I feel it would be a good way to go, and I'd be willing to support a motion of that nature.

● (1250)

[*English*]

The Chair: Okay.

Colleagues, we have two suggestions. One is from Monsieur Garon, which is that in addition to meeting at 7 p.m. on Monday, we have two two-hour sessions to hear from witnesses. We have a suggestion from Dr. Ellis that Thursday's meeting be in camera and dedicated to the identification of those witnesses. I don't think those two suggestions are inconsistent.

Is that a fair summary of where we are? Are there any further interventions?

Mrs. Goodridge, go ahead.

Mrs. Laila Goodridge: Considering that the minute the motion is passed we gain access to priority resourcing, I would suggest that we not hold ourselves to waiting till Thursday. Perhaps we can have a meeting on Wednesday to have these discussions, so we're not behind the eight ball and having to work through the entire weekend trying to catch up.

The Chair: Dr. Powlowski, go ahead.

Mr. Marcus Powlowski: The question of working on the weekend has come up. I would suggest that several of us have family. I'm not sure what the urgency is in getting this done all of a sudden, requiring us to work on the weekend and forgo our time with our families.

The Chair: We have Dr. Ellis, and then Monsieur Garon.

Mr. Stephen Ellis: Thank you again for ceding the floor, Chair.

In response to Dr. Powlowski, I think the difficulty here is that it's your own party that's causing the difficulty. You are pressing this issue to say how urgent it is. This is not the doing of this side of the floor.

If we have to work through the weekend, then so be it. I don't want to work through the weekend any more than you do. That being said, maybe you need to have a discussion with your own party and ask them why they are pushing this legislation so hard and so quickly, when I think it needs...as does Monsieur Garon. I don't want to suppose that I speak for him, but this requires due process.

I think that in order for us to be any part of spending at least, let's be honest, $10 billion more—not a small stone thrown into a lake but a boulder thrown into a teacup of money—I think it behooves us to be able to be here to support the Canadian people and have appropriate lists of witnesses.

Does that mean that it's going to take the weekend? It may very well do that, and if it's uncomfortable, unfortunately, for several government ministers, then so be it. It requires their plans to change. I do think, as I said, that it behooves us as parliamentarians to look at a $10-billion piece of legislation in a very careful and systematic way, and also to be able to bring witnesses who will be able to contribute to that discussion in a very forthright and honest way. It is going to take some time to have a fulsome discussion on that.

It's unfortunate, as you said, Dr. Powlowski, that your government wants to push this legislation, but from our side of the aisle, I think we'd like to make sure that we have a fulsome discussion on that.

Thank you very much for bringing that forward. I really appreciate it, as always.

The Chair: We have Monsieur Garon, and then Mr. Blaikie.

[*Translation*]

Mr. Jean-Denis Garon: I'll repeat my motion that we schedule a meeting now for next Monday from 11 a.m. to 1 p.m., and another in the afternoon in addition to the 7 p.m. meeting. We could pass this motion today so that we can start planning those meetings.

We can agree to submit witness lists on Friday. We can discuss witnesses on Thursday, but make it clear right now that we will have two additional meetings on Monday so that we can work on our witness lists and continue the discussion on Thursday. We could then decide whether we want to hold an additional meeting on Friday or over the weekend.

I believe we should adopt the consensus part now, which is to add two meetings on Monday, and continue the discussion at the next meeting what we've all thought this through.

[*English*]

The Chair: Mr. Blaikie, go ahead.

Mr. Daniel Blaikie: I think Mr. Garon just put it very well. I'd be happy to move to making a decision on his proposal.

The Chair: All right. Monsieur Garon has proposed that we, on Thursday in camera, discuss witnesses, that we commit now to holding two two-hour meetings on Monday in advance of the 7:00 p.m. meeting where we're able to go to clause-by-clause, and that any additional time that may be required is something that we will leave to decide at our Thursday meeting.

Mrs. Goodridge has suggested that the Thursday meeting where we go in camera to discuss witnesses take place tomorrow.

Those are the two proposals in front of you. Again, I don't think they're necessarily entirely inconsistent. Are there any interventions? I see none. I'm going to put both of them to you in the form of a question.

Is it the will of the committee to schedule an in camera meeting tomorrow to discuss witnesses?

(Motion negatived)

The Chair: We will not be meeting tomorrow. We will be meeting on Thursday at our regular time, in camera, to discuss witnesses, and also to discuss what additional time needs to be allocated over and above the four hours on Monday.

Okay, I just said that as if it's a done deal.

Some hon. members: Oh, oh!

The Chair: The proposal before you now is that we will have an in camera meeting on Thursday to discuss witnesses, and we will set aside at least four hours on Monday for that purpose, and such additional time as may be decided on Thursday. Is it the will of the committee to proceed in that fashion?

Some hon. members: Agreed.

The Chair: We have consensus that we will meet on Thursday in camera to discuss witnesses, and for at least four hours on Monday, in addition to any additional time that we may decide this Thursday.

Is it the will of the committee now to adjourn?

Some hon. members: Agreed.

The Chair: We are adjourned. Thank you.