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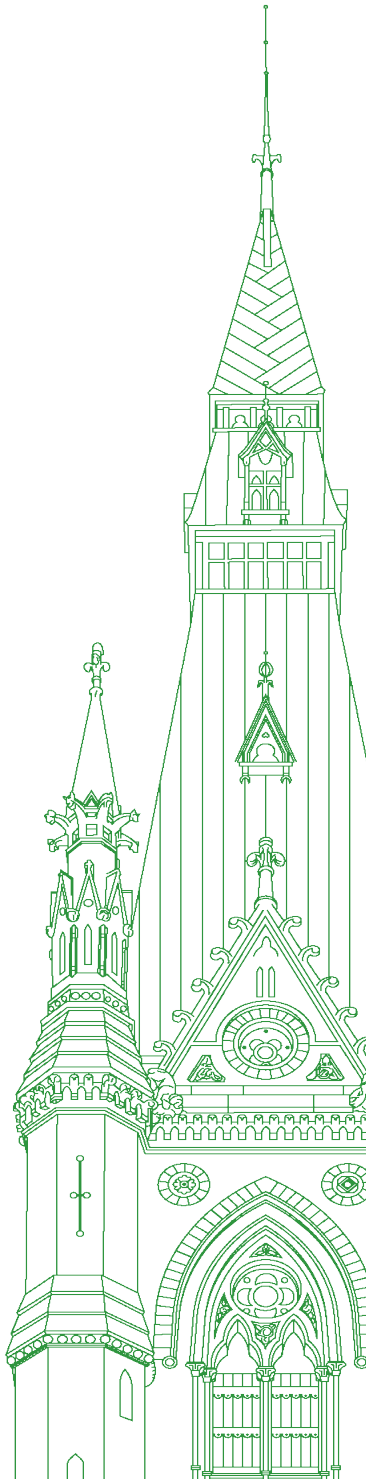

Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, October 18, 2023

● (1935)

[*English*]

The Vice-Chair (Mr. Stephen Ellis (Cumberland—Colchester, CPC)): Good evening, everyone. I call the meeting to order.

Welcome to meeting number 82 of the House of Commons Standing Committee on Health. Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I would like to make a few comments for the benefit of witnesses and members.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike, and please mute yourself when you're not speaking.

With regard to interpretation, for those on Zoom you have the choice at the bottom of your screen of the floor, English or French. Those in the room can use the earpiece and select the desired channel.

I will remind you that all comments should be addressed through the chair—that would be me. Additionally, screenshots or taking photos of your screen are not permitted.

In accordance with our routine motion, I am informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to the order of reference of Wednesday, February 8, 2023, the committee is resuming its study of Bill C-293, an act respecting pandemic prevention and preparedness.

I would like to welcome our panel of witnesses. Appearing as individuals and by video conference, we have Dr. Lisa Barrett, physician-researcher; and Patrick Taillon, professor and associate director of the Centre for Constitutional and Administrative Law Studies, faculty of law, Université Laval. Representing the Canadian Medical Association, we have Dr. Kathleen Ross, president, by video conference; and representing World Animal Protection, we have Melissa Matlow, campaign director; and Michèle Hamers, wildlife campaign manager.

Thank you for taking the time to appear today. You will each have up to five minutes for your opening statement. The order we will use will be Dr. Barrett, Mr. Taillon, Dr. Ross....

I'm unsure, so could you clarify, Ms. Matlow, whether you will do the entire five minutes? Very well.

I will remind you when you have one minute left. We're going to keep to a schedule here this evening.

That being said, thank you all for being here, and let's get the show on the road.

We'll start with Dr. Barrett.

Thank you.

Dr. Lisa Barrett (Physician-Researcher, As an Individual): Good evening. Thank you, Chair and the committee, for the opportunity to speak this evening, and thank you to all of you for doing after-hours work. I recognize that it's not early there.

I am an infectious diseases doctor, but I am also a clinician-researcher who does research in viral immunology, as well as the implementation of health systems related to infectious diseases. My involvement throughout this most recent pandemic, I think, is my primary reason for being here. I was involved at the municipal, provincial and federal levels in the domains of testing and the innovative generation of ways to test people for infectious diseases, particularly COVID. I was also involved in and continue to be involved in therapeutics for COVID and the delivery and different models of delivery within Nova Scotia and different provinces.

My view on the pandemic comes from there and all the biases and important information that may come.

After reviewing the bill as it stands at the moment, I'll divide my comments very quickly into three different sections. Those are the preparedness part, what we do and what we can do best in a pandemic, and then the post part, which I won't highlight as much.

To start with the prepandemic bit and predicting pandemics, I think one of the important parts that's mentioned within the bill at the moment is “one health” and the recognition that humans, while numerous, are a small part of the planet and not the most important part when it comes to predicting pandemics and pandemic disease. Recognizing there are other things that can cause pandemics and other threats, including antimicrobial resistance, pandemics are often caused by viruses that spread through the air.

One of the things we need to recognize more is that animal health is part of human health. We are one animal and we can't forget about all the others. It is noted in the bill that there should be consideration of this area, but I think it's something we've done extraordinarily poorly—not just in Canada, but in the world—and it should be a focus of the go-forward plan.

Sticking with viruses and going into a pandemic, it's important to note that there is an intersection between pandemic-potential pathogens—say that three times fast—and air, including clean air of various kinds. While the respirologists have been saying for many years that we need indoor spaces that are clean, this has highlighted the fact that when we are at a density of where we are with human populations—not just in urban areas, but in rural areas these days too—and the amount of time we spend indoors, this has to be a priority of where we go forward in how we live in terms of the cleanliness of air and what standards can be brought in to help that.

While that doesn't sound like a very infectious disease doctor thing to talk about, it is very linked to the mitigation of spread when you're talking about a country with cold weather and a lot of people.

The next part I would highlight is that we could have done a better job before and during this pandemic in understanding the patterns, pathogen disease and pathogenesis. Once we are in a situation where we have a pandemic, we really seem to get stuck many times in what the usual is, what the previous normal was and understanding what respiratory viruses are. Clearly, we don't understand that well, and I think we need to be very careful that in any bill that comes forward, we highlight that.

That's research and understanding viruses, and having a high standard for vaccine studies after they're marketed. There's a lot we don't understand about the variability of responses in humans. Some people respond well and some people don't, and we need to really hold to account companies and people doing vaccine marketing after the vaccines come to market, or we're not going to get far quickly.

I'll hold the rest of my comments until later.

Thank you for the opportunity.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Barrett. I appreciate that.

Mr. Taillon, you have the floor for five minutes.

● (1940)

[*Translation*]

Mr. Patrick Taillon (Professor and Associate Director of the Centre for Constitutional and Administrative Law Studies, Faculty of Law, Université Laval, As an Individual): Thank you, Mr. Chair.

I would first like to thank the members of the committee for this invitation to testify about Bill C-293.

Right from the outset, I'd like to share three criticisms of the bill.

First, it's an unnecessary bill in many ways; second, it distracts us from the real issue; and third, it contravenes the principle of federalism and provincial jurisdiction in the health field.

First of all, it is unnecessary, to some extent, because it aims to set up a preventive bureaucracy. Cabinet members, along with senior federal government officials, already have all the latitude they need to assess, forecast and anticipate the next crisis. It's already their role to do so. They don't need legislation to do it. It's already part of their job description.

Next, it's a bill that distracts us from the real issue, which is the need to take stock of federal action during the last pandemic. It seeks to anticipate the next crisis on all fronts, including those outside federal jurisdiction, rather than focusing on the important issues. Why was the federal government so slow to shoulder its responsibilities during the COVID-19 crisis? Why was it so slow to manage border controls, which are its responsibility? Why was border quarantine so slow to be established? Why did cities like Montreal have to try to make up for the federal government's shortcomings? Why were the maritime provinces forced to create borders within Canada to compensate for federal inaction? Why was the slowness in establishing rules and procedures to manage the crisis accompanied by a delay in withdrawing the measures at the end of the crisis? Why was the federal government always two or three steps behind?

The bill's ambition to coordinate everything is very unhealthy. It's a distraction. It deprives the federal government and its administration of a critical examination of its own action. Above all, the bill clashes with federalism and the provinces' common law jurisdiction in health matters. It is the manifestation of a centralizing intention, of the idea that everything would be better managed if it were coordinated from above. This standardizing ambition is clearly evident. It is evident, for example, in paragraph 4(2)(c), which states that care must be taken, with the provincial governments, to "align approaches and address any jurisdictional challenges [...]."

"Align" means everyone doing the same things, which is a euphemism for saying that we're really trying to standardize everything. To "standardize" is to deprive ourselves of the contribution of grass-roots initiatives, and of the freedom and autonomy that have made it possible for certain provinces within the federation to do well, and for others to imitate them. If we centralize and standardize everything, that means that, in the next crisis, the mistakes we make at the top will be made uniformly across Canada. This is the opposite of the spirit of autonomy and freedom that federalism implies.

The same section also mentions "the collection and sharing of data." Once again, this is a euphemism for a form of accountability in which the provinces are required to provide information in areas where they are nonetheless fully autonomous.

In closing, let me say that we shouldn't be naive. If the prevention and coordination work proposed in the bill is not really about decision-making, in that case we don't really need a bill, since the administration already has all the freedom to do the necessary reflection and coordination work. If, on the other hand, we're really looking to delegate new powers to the administration in order to coordinate and harmonize some things with the provinces, that means we're really looking to distort Canadian federalism, i.e., a federalism in which the bulk of responsibility for health care lies with the provinces.

Thank you.

● (1945)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Taillon.

[*English*]

Next we will have Ms. Matlow, for five minutes.

You have the floor.

Ms. Melissa Matlow (Campaign Director, World Animal Protection): Thank you, Mr. Chair, and committee members for the invitation to testify on Bill C-293.

I'm the campaign director at World Animal Protection. We're an international animal welfare charity with offices in 12 countries.

We conduct a lot of research on the intersectionality of animal health and welfare, environmental sustainability and human health. That research then informs our policy recommendations that we bring. Those intersections really are what “one health" is all about.

We have general consultative status with the United Nations. We have a formal working relationship with the World Organization for Animal Health and we're members of the National Farm Animal Care Council.

Joining with me today is Michèle Hamers, our wildlife campaign manager, who has an M.Sc. in animal biology and is co-author of the first published article on Canada's wildlife trade, specifically on the potential for disease risk and the lack of data and monitoring for it.

You may be wondering why an animal welfare group wants to testify on this bill. Seventy-five per cent of new and emerging infectious diseases originate in animals, principally from wildlife. It is our mistreatment of animals and exploitation of nature that is driving the frequency and severity of diseases, and it's not just us who are saying that. It is repeatedly cited in various UN reports like the report by the United Nations Environment Programme on pandemics, or the report by IPBES on pandemics, with regard to Mpox, Ebola, SARS, MERS, West Nile virus, Nipah, Zika, COVID-19.

It is widely acknowledged that a wildlife market played a significant role in the COVID-19 pandemic, whether it was originating the origins of the virus or amplifying it. These markets typically hold a variety of different animal species that wouldn't normally encounter each other in the wild. They are kept in cramped, stressful and often unsanitary conditions. These are called hotbeds for emerging diseases. When animals are stressed they become more vulnerable to infections and they become more infectious. That is why this is very much an animal welfare problem at the core.

We strongly support this bill because it takes a “one-health" approach and puts emphasis on prevention, it identifies the top pandemic drivers and requires government to address those drivers and mitigate those risks.

So often prevention is viewed as increasing surveillance and monitoring, but surveillance cannot detect asymptomatic animals that carry disease, nor does it prevent pathogen mutation and emergence. Scientists have warned that we are entering a pandemic era. If we truly want to reverse course, we must include pre-outbreak measures to prevent spillover at the human-animal-environment interface.

To quote from the IPBES report, “Without preventative strategies, pandemics will emerge more often, spread more rapidly, kill more people and affect the global economy with more devastating impact than ever before.”

Tackling the root causes of spillover is a fraction of the cost of responding to a pandemic. One study found that halting deforestation and regulating the wildlife trade could cost as little as 2% of the economic cost of responding to the COVID-19 pandemic.

It is also critically important that this bill mentions well-known pandemic drivers. These are already identified in the scientific literature by credible authorities and global agreements that Canada has committed to.

These drivers include the illegal and under-regulated legal wildlife trade, which is growing in volume, live animal markets, intensive farming methods, and land use changes. These have been identified, again, in the UNEP report and the IPBES report, which I believe are available to you.

The current draft of the World Health Organization's international pandemic instrument also mentions the need to address disease drivers including, but not limited to, climate change, land use change, the wildlife trade, desertification and antimicrobial resistance. Bill C-293 would help Canada fulfill its obligations to this new global agreement.

● (1950)

The World Health Organization refers to the rise in antimicrobial resistance as the silent pandemic and one of the biggest public health concerns of the 21st century. This relates back to animal welfare because three-quarters of all antimicrobials used in Canada and around the world are given to farm animals. For decades, these preventative antibiotics have been given in the absence of clinical disease to stop stressed animals from getting sick and to facilitate intensive farming methods.

Thank you for your time.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Ms. Matlow.

I'm sorry. I didn't give you the one-minute reminder; I gave you the 30-second one. I was hoping you were paying attention. That was well done.

Next, we'll hear from Dr. Ross.

Dr. Ross, you have the floor.

Dr. Kathleen Ross (President, Canadian Medical Association): Thank you, Mr. Chair.

My name is Dr. Kathleen Ross. I'm joining you from the traditional territories of the indigenous people of Treaty No. 7 and the Métis Nation of Alberta Region 3. We acknowledge and respect the many first nations, Métis and Inuit who have lived in and cared for these lands for generations.

I am a family doctor working in British Columbia. As president of the Canadian Medical Association, I represent the voices of the country's physicians and medical learners, those they care for and those who don't have access to care.

As the committee studies Bill C-293, an act respecting pandemic prevention and preparedness, it's important to hear from those who have been on the front lines since long before COVID-19. Already caring for patients in a broken system, health care workers were submerged under deeper backlogs and even greater system impacts with each subsequent wave. Canada's response to COVID-19 must inform our plans for future pandemic preparedness and prevention strategies. Appropriate planning to support our health workforce at the outset remains critical to keeping Canada safe.

The spirit of Bill C-293 is to improve the way we prepare for the next pandemic. We welcome the proposed steps towards collaboration across jurisdictions and are pleased to see an emphasis on building primary care capacity. The language that speaks to improving working conditions for essential workers while increasing the ability of health care workers to perform their duties in a scenario of increased demands is promising. However, the stark truth is that we must focus on alleviating the significant impact the pandemic continues to have on the health workforce today. Creating a safe, robust and healthy workforce can't wait.

The heroic efforts of our health workers continue, and we are at record-high levels of burnout and exhaustion. My colleagues are demoralized and looking to exit the profession. We hope the impact on the health and wellness of health professionals will be a big part of any review and an even bigger piece of planning.

Rebuilding the trust of our health workers and Canadians is critical to pandemic preparedness. Mr. Chair, the announcement of increased health funding earlier this year was welcomed. That spending must be targeted and invested in areas that truly bolster health care systems. Canadian physicians must be able to work where the needs are greatest.

As an example, in April 2021, COVID-19 cases were surging in central Canada and many communities were pushed beyond their resources. A cadre of health care workers, including physicians from Newfoundland and Labrador, assembled quickly to help struggling communities 3,000 kilometres away. That deployment necessitated a swift and temporary lifting of the usual provincial licensing restrictions, allowing physicians to get an Ontario licence within one week.

Look at the potential of that model: A single licensing system implemented across the country can alleviate the pressure on medical workforces, serve patients in rural and remote communities, provide virtual care across provincial and territorial borders, and provide more timely access. This is critical in preparing for future pandemics. Pan-Canadian licensure can be implemented across the country, which provincial and territorial health ministers committed to last week in P.E.I. This is the time to deliver on our promise to increase access to family doctors and primary care. Scaling up collaborative, interprofessional care is central to increasing access and limiting the spread of future disease.

Physicians are overwhelmed by unnecessary administration, a lack of interoperability, third-party and federal forms, and managing large volumes of data that are often incomplete. Admin burden amounts to 18.5 million hours per year. Those hours could be transferred to better patient care and physicians' own wellness—hours we cannot afford to lose in the surge of a pandemic.

We must plan for what our health workforce may face. Gaps in the availability of timely health data are critical. We need to be able to harness data in order to contribute to the development of an integrated pan-Canadian health human resources plan. Data is necessary to understand the breadth of the myriad of health care challenges we face and to chart a sustainable course for the future. Without a transparent and accountable blueprint, we are unlikely to reach consensus on our destination.

Mr. Chair, I thank you for the committee's time today.

I'll welcome any questions the members of the committee might have.

● (1955)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Ross.

Thank you to all of the witnesses.

Clearly, my system is very effective, I just want to point that out to the members here. I'm keeping folks on time. That was very good.

Thank you all for that.

Now we'll start rounds of questioning, beginning with Mr. Doherty.

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

Mr. Todd Doherty (Cariboo—Prince George, CPC): Thank you, Mr. Chair.

Mr. Chair, I want to thank our witnesses for being here today.

Mr. Chair, I've been in receipt of—as I think have all of our members on this committee—a letter from 17 of Canada's leading addiction medicine physicians.

Mr. Chair, I know that the clerk is in receipt also of the motion that we tabled on Monday. With your permission, I'd like to move that motion now, Mr. Chair, as follows:

> Given the recent letter, from 17 experienced Canadian Addiction Medicine physicians to the Minister of Addictions and Mental Health, calling on the government to cease funding of hydromorphone for people with addictions, that the committee recognize: (a) the substantial increase in opioid-related harms and deaths, (b) that the government's current policies are not working, (c) that the so called "safer supply" strategy is a failure, making the opioid crisis worse, that the committee call for an immediate end to the government's so called "safe supply" funding, and that the committee report this motion to the House.

Mr. Chair, I've been very public, very vocal and upfront about our family's own struggles with addictions and how I have a brother who lives on the street. We have struggled to get him off the street. I have gone into the dens of evil to pay off his debts, to save my brother, to save somebody whom we love.

We have rescued him in the middle of the night from a bridge, from gang members who were threatening to throw him over if he didn't pay the debt.

Two years ago he was shot twice with a shotgun in a drug deal gone bad. It was just mere days later, after saying all the right things, that he was back on the street from the draw and the pull of these drugs, with buckshot still in him, with his wounds, and with the tubes hanging out of him.

Mr. Speaker, that's how strong the pull of these drugs is.

To my colleagues across the way, we have to do better.

I get emotional talking about it. In 2016, there were 806 opioid deaths in B.C. In 2022 there were 2,410. Overdose is the leading cause of death of B.C. youth aged 10 to 18. That surpasses accidents.

We have to do better.

There are businesses in my province that are buying illicit drugs on the black market and selling them or giving them away on the street. How far have we fallen that these businesses can perpetuate somebody's addiction but we can't get that person into a bed for recovery?

If my colleagues across the way don't believe me, believe the 17 leading experts on this in our nation who wrote this:

> We are a group of experienced Canadian Addiction Medicine physicians who are calling on the government to ensure that all hydromorphone prescribed to people with addiction is provided in a supervised fashion or that funding cease for this harmful practice.

● (2000)

> Calling Unsupervised Free Government Funded Hydromorphone "Safe Supply" or "Safer Supply" does not make this practice safe. It is unsafe.
>
> Hydromorphone is a potent opioid which is approximately 4 times more powerful than morphine when taken orally and approximately 7 times more powerful than morphine when injected. Hydromorphone and other drugs are often prescribed for "Safe" Supply at 7 to 10 times the recommended morphine equivalents per day and pose serious risks to the patient and their communities from diversion.
>
> Unsupervised Free Government Funded Hydromorphone provided to people with addiction is causing further harm to our communities by increasing the total amount of opioids on the streets and providing essentially unlimited amounts of opioids to vulnerable people with addiction. As a result of this practice, we are witnessing new patients suffering from opioid addiction, and additional unnecessary overdoses and death.
>
> The FDA product monograph Dilaudid (hydromorphone) states this:
>
> "Misuse, Abuse, and Diversion of Opioids Hydromorphone is an opioid agonist of the morphine-type. Such drugs are sought by drug abusers and people with addiction disorders and are subject to criminal diversion. Dilaudid can be abused in a manner similar to other opioid agonists, legal or illicit. This should be considered when prescribing or dispensing Dilaudid in situations where the physician or pharmacist is concerned about an increased risk of misuse, abuse, or diversion.... Dilaudid has been reported as being abused by crushing, chewing, snorting, or injecting the dissolved product. These practices pose a significant risk to the abuser that could result in overdose or death."
>
> Unsupervised Free Government Funded Hydromorphone provides a significant source of income to people with addiction who divert their prescribed hydromorphone to the street market. There is widespread evidence that this is occurring. The money from diversion is commonly used to purchase more potent opioids such as fentanyl. While we understand the desire to minimize the morbidity and the mortality resulting from illicit fentanyl use, unlimited overprescribing of opioids is causing harm. Increased availability of opioids in communities leads to more opioid addiction.
>
> The unmonitored provision of Free Government Funded Hydromorphone to people addicted to opioids has become widespread in large part because of government funding and support. Unfortunately, this unsafe practice has become politicized in both government and the medical field, causing harm to both public and patient suffering from opioid addiction.
>
> The risks of Unsupervised Free Government Funded Hydromorphone prescribing include this:
>
> 1. People with addiction commonly prefer to inject hydromorphone. Injected hydromorphone creates a similar elevated risk of serious infections that all users of intravenous substances face, such as Hepatitis C, HIV, cellulitis, bacterial endocarditis, respiratory suppression, overdose, and death.
>
> 2. A large supply of free hydromorphone can make people's addictions worse and delay people from entering other treatment modalities which have been proven to be effective.
>
> 3. Diversion of prescribed hydromorphone to the illicit market is the most significant problem with Unsupervised Free Government Funded Hydromorphone. Hydromorphone tablets are sold and the funds are used to acquire more fentanyl. Paradoxically, Unsupervised Free Government Funded Hydromorphone increases access to street fentanyl for people with abdication and also increases the availability of street hydromorphone causing more people to become addicted to opioids.
>
> We anticipate the widespread diversion of hydromorphone, now taking place from these programs, will have results similar to our experience with the OxyContin epidemic. With OxyContin, we saw how the provision of abundant amounts of powerful opioid to communities made addiction worse for those with disease and, more importantly it caused many new cases of opioid addiction.

Mr. Chair, I can see my colleague from the Liberal side laughing while I'm struggling to read this letter. Perhaps Mr. Fisher doesn't have people who have been afflicted with addiction. Perhaps he hasn't sat with the parents of those who have passed away due to overdose.

● (2005)

I'll continue. The final quote from this letter is this:

> "Safe Supply" is a nice marketing slogan. The reality is it is not safe. It is harmful to give people addicted to opioids almost unlimited access to free opioids. It is harmful to our communities for inexpensive pharmaceutical grade opioids to be flooding our streets. We call on the government to ensure that all hydromorphone prescribed to people with opioid addiction is provided in a supervised fashion or that funding be ceased for the current harmful practice. Let's stop diverted hydromorphone from creating more children with addiction in our Junior High and High Schools.

Mr. Chair, I read this, and it's obviously something that is.... We are gripped in an opioid crisis in our country. Canada.ca, our own government's website, under the heading "Responding to Canada's opioid overdose crisis" states, in our government's own words: "Canada is facing a national opioid overdose crisis that continues to have devastating impacts on communities and families." Yet, we are sending taxpayer dollars to organizations that are buying illicit drugs, black market drugs, that are flooding our streets and our communities.

We're powerless to stop this. Somebody has to answer to this.

You can laugh; you're not laughing now—

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Mr. Chair, I have a point of order.

Mr. Todd Doherty: But you did earlier, Mr. Fisher. You did when you shouted across the way.

Mr. Darren Fisher: Mr. Chair, it is a reputational comment when someone makes this—

The Vice-Chair (Mr. Stephen Ellis): Excuse me. Before this deteriorates, remember that we have to be recognized by the chair, please.

I would really appreciate, Mr. Fisher, if you were to respect those rules. I know that you're new to our committee here, but please, before you begin speaking, remember that the person who has the floor has it. When I recognize you, you, too, shall have your turn to speak.

We all heard very clearly from the Speaker today about decorum. If your point is relevant, that's terrific. If it's not, perhaps we should continue.

Mr. Darren Fisher: I have a point of order, Mr. Chair.

The Vice-Chair (Mr. Stephen Ellis): Yes, please, Mr. Fisher.

Mr. Darren Fisher: Thank you, Mr. Chair, my apologies.

I would never, ever laugh at a topic this serious. I looked at the witnesses. I smiled and said "I'm sorry" to the witnesses. That's what I did, Mr. Chair.

Thank you very much.

The Vice-Chair (Mr. Stephen Ellis): Very good. Thank you for clarifying that, Mr. Fisher.

I will echo those comments; I'm sorry to the witnesses. Obviously this is committee business that is not related to Bill C-293. I am unsure as to how long this may take. I would ask my honourable colleagues to consider thinking about releasing the witnesses. This may take some time.

I'm at the will of the committee, but I would suggest to my honourable colleagues that, if it is your desire to release the witnesses and apologize to them, I'd be absolutely happy to do that. I'll leave it to the will of the committee.

Mr. Todd Doherty: I still have the floor.

The Vice-Chair (Mr. Stephen Ellis): Mr. Doherty, you have the floor.

Mr. Todd Doherty: I'll apologize to Mr. Fisher. I did see him look across the floor and say, "Hi Dan," mockingly. I thought it was mockingly; I could be wrong. Maybe he's just acknowledging the presence of our colleague from the NDP.

You know, my family lives every day with the fact that we're going to get a call one day that my brother won't be around, that he'll take one last dose....

Let me bring it back to 2008, when I was loading my bags into my vehicle to go speak at an event overseas, and my wife opened the front doors to our house and with tears said that her brother had been found dead from an overdose. He was not an addict. He didn't use drugs. He simply was in the wrong place at the wrong time, and somebody gave him something that was laced with fentanyl. That same person wiped his phone, so there was no evidence of who was there at the time. We don't know.

I apologize for moving this emotional motion, but it hits home. Given that I'm the shadow minister for mental health and suicide prevention, I sit with so many families who ask us to do something. I don't have the answers, but I don't believe that taxpayers' dollars should be going to fund these drugs. We should be doing everything in our power to make sure that we can get somebody into a bed for recovery. Recovery is always possible. Perpetuating somebody's addiction....

In British Columbia, I believe the wait time is 18 to 24 months. One mother came to me and asked, "Why is it that my son can get drugs, but I can't get him into treatment?" If they were wealthy or rich, then they could do that, but a lot of these people come from families that can't afford treatment. In 18 to 24 months, if her son is still alive....

We know what they're doing. They're taking these drugs, and they're selling them so that they can purchase.... Oftentimes, they're selling them to students so that they can purchase the higher dose of fentanyl. We have to do something.

I apologize to the witnesses, but after reading that letter, I had to say what I said. I've stood in the House so many times and talked about this. This government and my provincial government, we as leaders are failing Canadians when it comes to this. We have to be better.

I'll cede the floor to whoever's next. Thanks.

● (2010)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Doherty.

I do have a speakers list. It reads, “Dr. Kitchen, Mr. Majumdar, Mr. Fisher, Mr. Davies, Dr. Powlowski and Mr. Thériault.”

Dr. Kitchen, you have the floor.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair and to my colleague.

● (2015)

The Vice-Chair (Mr. Stephen Ellis): Yes, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): On a point of order, Mr. Chair.

I see the list of speakers who have requested the floor. Right now, our witnesses are attending this debate or discussion when we invited them for something else.

I'd like to lighten the mood by saying that I didn't think, Mr. Taillon, that your first argument, that this bill is useless, was going to be so convincing.

That said, I'd like us to release the witnesses.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Thériault.

[*English*]

As I said previously, I'm at the service of the committee. I have no power to do so on my own, but certainly, if members would like to do that, I'm happy to hear that.

Perhaps by consensus, is it the will of the committee that we release the witnesses?

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chair, I'd like to ask this before I cast an informed vote.

Is it Mr. Doherty and the Conservatives' intention to talk the entire meeting about this issue? If it is, then we should let the witnesses go.

The Vice-Chair (Mr. Stephen Ellis): Thank you for your interest, Mr. Davies. I don't think we'll going back and forth in that fashion.

My question, then, is back to the committee. I think it's a wise one that Mr. Thériault has brought forward.

Is it the will of the committee to release the witnesses? If not, we shall continue with the speakers list.

We will suspend for two minutes.

● (2015)

_____(Pause)_____

● (2020)

The Vice-Chair (Mr. Stephen Ellis): I'll call the meeting back to order.

What the committee has been tasked with is understanding whether they wish to dismiss the witnesses or not.

As I said, I'm serving at the will of the committee. It seems as though the Conservative members are willing to dismiss the witnesses.

Mr. Thériault is unsure at this time.

Liberal members...?

Mr. Fisher.

Mr. Darren Fisher: Thank you, Mr. Chair.

Is there a possibility that we could keep the witnesses for an hour, have a good conversation with the witnesses for an hour, ask them questions and then resume this conversation after that for the last 30 minutes of the meeting?

The Vice-Chair (Mr. Stephen Ellis): I would suggest to you that it would not be the regular convention. This motion is now, of course, the subject of the committee at the current time, so I will redirect the question that I had.

Should we dismiss the witnesses or not? Is it the will of the committee?

Some hon. members: No.

The Vice-Chair (Mr. Stephen Ellis): Okay, very good. Thank you for that. I appreciate it.

Dr. Kitchen, you have the floor.

Mr. Robert Kitchen: Thank you, Mr. Chair.

As I said earlier, my thoughts are with my colleague. I know how important this topic is to him and his family, and the huge impact it's had on his life. It's a prime example of that. The motion he's put forward is one that addresses this aspect of things, and it's something that should be addressed in a very rapid way.

It's not like this hasn't been going on for centuries. It has, but when we look at it statistically.... For example, I will speak from a Saskatchewan point of view. When we look at 2022, we had 421 reported opioid deaths in the province of Saskatchewan. So far in 2023, the province has already had close to 200 deaths. These are huge numbers that are just escalating, because of what we're seeing around the country.

Some of it is related to the price of the product, which has become more easily accessible. We have parts of the country where we have safe havens for this, so the drug prices have dropped to almost $2 in many cases, which makes it even easier for vulnerable people to use this.

We look at small communities.... My riding of Souris-Moose Mountain is 43,000 square kilometres in size. With that said, in Saskatchewan, 47 small communities in Saskatchewan, and most of them in rural areas, have had confirmed overdoses. In fact, in one of the small towns within my riding—and I'm very well aware of the challenges that have been there—it's disgusting to hear and see some of the things that are going on.

I had a constituent who approached me on the issue. She said that her community members knew where the drug house was. They told the RCMP where it was. They asked the RCMP to go in, and the RCMP basically said, "No, we're not going into that place, because of how dangerous it is." This lady took it upon herself—and I can tell you this, because she gave me permission to tell you this story—and went into this house on her own to confront what was going on. She saw many things that were going on to the point where she was saying that it was inappropriate. She confronted these big people who were carrying all sorts of weapons. She went from room to room. She went into one room where there was a 13 year-old-girl who was being molested at this drug-infested place. She went into this room, and tried to bring this young girl out of that room. The drug lords that were there confronted her at that point in time, and basically threatened her life. She was told to get out, or she would not be safe.

This transpires in a small community in Saskatchewan. It's going on all over this country, and it is despicable that these people are doing this and taking advantage of vulnerable people in many ways.

Looking at Saskatchewan, as I indicated, 291 humans have died from unregulated drug overdoses from January to June 2023. Motor vehicle accidents in Saskatchewan resulted in only 87 deaths. Motor vehicle accidents have fewer deaths than those from drug overdoses. That's just shocking. We know how passionate we get when we hear about motor vehicle accidents, whether it might be someone who's impaired, or just an accident where someone had a head-on collision. It is just unbelievable what we are seeing happening around this country.

● (2025)

It's a major factor when we look at things in Saskatchewan, and the life expectancy in our province has dropped since 1999. The average life expectancy was 78.48 years, and it's now down to 76.5 for men alone because of the deaths from drug overdoses.

These experts attribute this drop to the deaths among younger people from drug poisoning and suicide, and to the fact that there's been a 300% increase in drug toxicity deaths since 2010. That's just unbelievable. I mean, that's from 14 years ago.

Many of you may know my history, and some don't. I spent my life travelling all over the world when I was a youngster. My father was a military attaché, and we drove from Germany to Pakistan and back. We lived in Pakistan, Afghanistan and Iran for three years of our lives.

I remember my time in Afghanistan. In Afghanistan and Pakistan the silk highway is where a lot of these drugs are found.

The poppy plant, which is basically the *papaver somniferum*, is grown quite extensively throughout Afghanistan. If anyone ever wants to come up to my office, they're more than welcome, because I have pictures of these poppy fields from when I was a teenager. Everyone thinks about the red poppy, but it transitions from many different colours.

However, the reality is that the poppy plant basically creates morphine, codeine, heroin and oxycodone. There are so many different substances out there that you'll see people smoke, sniff or inject.

In my time as a teenager, when I was travelling through that part of the world, I saw the consequences to many of the local constituents who utilized that product. As I said, that's going back to 1973, and it goes back centuries. It's been going on forever.

However, now we're seeing it here in Canada and around the world, but more so for us as we talk as parliamentarians is the huge impact it's having on our families, friends and constituents. This huge impact is from this addictive substance, and that's what it is. When we look at it, it initially was designed—and I'm speaking from a health care point of view—for its value as an anaesthetic and its value in providing pain relief and assistance.

Ultimately, however, it's been taken one step forward, and it continues to be taken one step forward, because we see continuously these safe houses that are opening up around this country, that are opening up more use and increased uses of these products. My colleague talked about how that impacts us. We see the impact it has on our families.

I spoke to you earlier about what the lady in my community saw and the impact that had on her. I've had other constituents who have come to me or phoned me and talked about how their son has become addicted. They've tried to take steps to do things to release him from that addiction and they have had challenges because their son is over 18 year of age. Because of that, the son basically gets put into a centre where he dries out for two or three days, and then when he comes back out, he's back into the same area. He has become addicted, because there are no programs to protect these people and to assist them so they don't become addicted to these products.

That has a huge impact. This lady who was telling me about her son is basically fearful for her life, because when he gets out and is released from jail—because the police will catch him when he breaks into some place to get some money so he can purchase some of these drugs—

● (2030)

They release him, and the moment he's out, she's fearful because he comes and threatens her and her husband, and he comes to the house and threatens to burn it down. She has all of these fears that she has to deal with. It's so unfortunate. I can't imagine, as a parent, how I would deal with it personally if it were one of my own immediate family, or even my relatives, given how impactful it can be.

This motion that my colleague has put forward is one I think we need to act on as quickly as possible. It needs to be addressed.

I apologize to the witnesses for this, but I think it's of such an urgent nature that we need to get this brought forward and we need to address this issue as quickly as we can.

I wish my colleagues around the table will see the urgency for this and be very supportive in allowing us to get this done and put it forward, so that we can take the right steps to address this issue and get it addressed as quickly as possible.

With that, Mr. Chair, I will cede the floor.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Kitchen.

Mr. Majumdar, you have the floor.

Mr. Shuvaloy Majumdar (Calgary Heritage, CPC): Thank you, Chair.

I was listening to—

Mr. Don Davies: I have a point of order, Mr. Chair.

It's interesting to me that you've recognized three Conservatives in a row. I had my hand up very early on—

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Davies. Those are the people who had their hands up first.

Thank you.

Mr. Majumdar, you have the floor.

Mr. Don Davies: That's quite ironic.

Mr. Shuvaloy Majumdar: I understand the reluctance of the NDP to talk about the opioid crisis, given how much they've had a hand in facilitating it through their safe-supply policies for this country.

I was thinking, as I listened to my colleague Mr. Doherty's family experience with this, that there are a lot of us around the table who have virtue signalled around the question of an opioid crisis for quite some time now. We are the Standing Committee on Health. I am a rookie—a newcomer. I would imagine we would be exercised by the defining issues Canadians are being confronted with, particularly the most vulnerable Canadians.

In the aftermath, the PMB we're looking at pretends to be a review of the lockdowns. The lockdowns, COVID policies and pandemic policies we have been dealing with—which the witnesses are here to inform us about—have had massive impacts on the mental health of Canadians. Thousands of people lost their livelihoods as a result of terrible COVID policies. They have, in turn, turned to drugs.

The federal government is ready to offer up a solution with the safe supply of opioids. This Liberal-NDP coalition is obsessed with a culture of death through its policies on medical assistance in dying and safe supply. It requires leaders of conviction to step forward to confront it at this committee, in Parliament and around the country.

Mr. Doherty, I'm grateful for your courage in moving this motion.

I encourage all members of this committee to pay close heed to it.

I have a couple of reflections from my own home province of Alberta.

Seven thousand Albertans died of opioid poisoning between 2016 and 2022. That's seven thousand people. The numbers, as Mr. Doherty notes, are probably higher. This is what we know. The Alberta government and civil society have been informed by an amazing organization that is led by an individual in my riding. His name is Dr. Vause. His recovery-oriented model for victims of the opioid crisis is a force of nature. It is a holistic approach for patients and their families. It has returned 70% success for victims of opioid addiction.

This Alberta recovery-oriented system of care is something that, in our great federation, we could examine closely as a model that could be replicated everywhere. Their capacity is only about 23 patients and their families at a time. When you think about the scale of what I just described, with 7,000 people having died already, it's a scaling that cannot come urgently enough. Replicated properly, it will take a year or two to get teams of people deployed in places around the country.

In London, Ontario, because of the safe-supply policies of the Liberal-NDP coalition, the price of hydromorphone has gone from $20 to $2. They're flooding the market and killing Canadians. It requires us to examine this issue with the gravity it deserves, so we can bring home our loved ones drug-free.

Mr. Chair, I want to thank Mr. Doherty for raising these issues, and for the opportunity to reflect not just on what we're seeing in Calgary but also on the price we've experienced in Alberta.

I encourage members of this committee to take this as seriously as a heart attack and elevate it to the place it deserves in consideration of our public life in Parliament.

Thank you very much.

● (2035)

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Majumdar.

Mr. Fisher, you have the floor.

Mr. Darren Fisher: Thank you very much, Mr. Chair.

This is an incredibly important topic to talk about. As a committee, we're tasked with legislation. The legislation we are tasked with tonight on a tight timeline is Bill C-293.

Dr. Ross said it's important to hear from people on the front line. Dr. Barrett is famous for saying, “health without knowledge doesn't happen.”

With respect for our witnesses, I move to adjourn debate.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Fisher.

As we all know, this is a dilatory motion, which will of course mean that we will not have debate on this and we will have a vote immediately.

All those in favour of Mr. Fisher's motion?

(Motion agreed to: yeas 7; nays 3)

The Vice-Chair (Mr. Stephen Ellis): Therefore, we will adjourn debate as per Mr. Fisher's request. I need to confer with the clerk for 30 seconds, please.

Thank you very much, colleagues.

Ms. Sidhu, you have the floor.

Excuse me, Mr. Doherty, I have conferred with the clerk and I think we've had this convention before with the other chair that when we move a motion and it's been a member's turn for six minutes, whoever's turn it is, we consider that as having used the time. Therefore, we'll move on to Ms. Sidhu for six minutes. Thank you.

● (2040)

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

Thank you to all the witnesses for your patience and for being with us.

My first question is for Dr. Ross.

Dr. Ross, I want to recognize the importance of your organization and the knowledge you have gathered through the pandemic,. Earlier this month, during a meeting of health ministers, Mr. Holland spoke about the importance of data-sharing. What is the role of a reliable and accessible data system for both the health care system and the patients? Can you talk about that?

Dr. Kathleen Ross: Through the chair, yes, I'd be happy to speak about that.

There were several challenges that we faced across the country with regard to data, and I'll speak first about data regarding our health care workforce. We lack a standardized national database of health care workers in this country with specifics on what they are qualified to do, where are they working and what their area of expertise is.

If we're going to have a pan-Canadian workforce strategy, we need to begin with the basics of knowing who's doing what, where and when, and under what circumstances, to build forward.

The second has to do with the lack of consistent health data collection. We know that across jurisdictions in Canada, health data is collected in varying forms, and for that reason it is challenging to share across jurisdictions. If we are going to be prepared, moving forward, for the next pandemic or next health crisis, then I think it behooves us to actually have a database that we can access to know who's doing what and where in our workforce, as I said, and to have an understanding of where the gaps in our system are and where we are able to implement strategies to improve health care.

If I were to look backwards in time—and sorry, I don't want to take too much of your six minutes—there are definitely some public health lessons that we learned from the COVID-19 pandemic, which had to do with funding of our public health teams and organizations, defining our increasing awareness of our public health physicians and public health practices and service delivery.

Certainly it is critical, in managing our health care system, that we prioritize a sustainable investment in staffing capacity, acknowledge and address the significant burnout among health care workers in public health, and invest in and develop public health information systems. Decision-making, prioritizing community engagement, focusing on improving health promotion and prevention, and modernizing communications and training and strategies, all of these require a solid foundation in data and shared data.

Ms. Sonia Sidhu: Thank you, Dr. Ross.

My next question is for Dr. Barrett.

Dr. Barrett, could you speak to the process of early detection systems like waste-water monitoring to inform public health decisions for managing the present pandemic and preventing a future one? What can we see from waste-water monitoring?

Dr. Ross or Dr. Barrett, could you comment on that?

Dr. Lisa Barrett: I can start. Dr. Ross can chime in if she wants.

On the part of the bill that would be most relevant to what you speak of in terms of early detection, clearly there's a need for early detection and clearly we weren't doing it well. Waste water is a technology that became more used, probably for the first time globally, through technological innovation and need. That became very apparent very quickly. It was not quickly and uniformly adopted, I would say, and that's still the case.

This also speaks to part of the purpose of a bill such as this, to take things that can be useful and not require them to be used, but to collect the data and then, where places want to use that information, that they be able to do so. There are two bits there. One is innovation that quickly comes to pragmatic use, and the second is standardization of collection of data that can then be used in different provinces in slightly different ways that respect federalism and then the associated provincial jurisdiction. Also, three, it comes back to the idea on a bigger scale that things that are in a research domain have to become used and tested in a practical way, quickly and without bureaucratic restriction. In the pandemic preparedness world, parts of this bill would be useful in doing that.

● (2045)

Ms. Sonia Sidhu: Thank you.

Quickly, how can we combat misinformation and disinformation? We all know that the COVID-19 vaccine is very effective. Can you comment on that quickly?

Dr. Lisa Barrett: Is that question for me?

Ms. Sonia Sidhu: Yes, Dr. Barrett.

Dr. Lisa Barrett: I think this comes back to trust and understanding that we have to be respectful and mindful of both individual decision-making and population-based messaging. People are smart; we need to respect that. Where there's a need for education, combine that with science. That comes back to trust. Withholding information and parsing it is not a useful tool in a public health emergency.

Dr. Kathleen Ross: Chair, if I can add on to that—

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Barrett.

Thank you very much, Ms. Sidhu.

I'm sorry, Dr. Ross. You'll have to try another time. That's the end of Ms. Sidhu's round.

[*Translation*]

Thank you very much.

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

Mr. Luc Thériault: Thank you, Mr. Chair.

I thank the witnesses for their patience and apologize for the digression. It's not that the subject isn't serious and important, but I'd like to reassure you and tell you that, when the Standing Committee on Health receives witnesses, it usually conducts at least one round of questions before moving on to another subject, when the subject is important. We're going to do that now, but I wanted to apologize anyway. This is not the way the committee usually operates. I thought the motion would have been tabled after at least a first round of questions.

So, I return to Mr. Taillon.

I'd like to go back a bit, because over time, we may have lost a bit of the essence of your testimony.

First, you said that Bill C-293 was unnecessary insofar as you wondered whether legislation was really needed to put forward an action plan. On the other hand, are we to believe that the authorities currently involved are not already developing a plan and addressing the shortcomings of the pandemic?

Did I understand you correctly in this respect?

Mr. Patrick Taillon: Yes.

If Bill C-293 is all about planning and thinking, I'd say those are already powers amply available to the federal bureaucracy. So there's no need to legislate. All this is already possible and permitted. Otherwise, we're talking about giving the government coercive powers to force things through, particularly with regard to harmonization with the provinces and attempts to standardize. If that's the case, I think we're putting our energies in the wrong places.

When I heard Dr. Ross, with respect, talk about a registry for the training of health care personnel, I thought to myself that we were then touching on the field of education, which is a provincial jurisdiction. It's normal that at the federal level, we don't have this information, because it doesn't fall under federal jurisdiction. Professional corporations, which determine who can become a doctor or nurse, fall under provincial jurisdiction, as does hospital management.

The challenge in the next crisis—it may be opioids, it may be an environmental crisis, it may be something else—would be for everyone to get their responsibilities right. The federal government has had its shortcomings, such as border management during the pandemic, which wasn't always perfect. There was also the management of vaccine supplies, which wasn't always perfect either.

So we mustn't let Bill C-293 become an excuse to avoid doing the imperative assessment of how Ottawa has discharged its responsibilities. It's as if we were in primary school, with good students and mediocre students, and the worst student in the class wanted to teach the other students how to study.

That's not how things works. Everyone needs to do their homework on their own; the federal government has lessons to learn from the last crisis in its own areas of jurisdiction if it wants to better exercise its powers without trying to take control, coordinate everything, and harmonize what doesn't fall under its responsibilities.

Mr. Luc Thériault: In your testimony, something really struck me. You said that there's a danger in this desire to centralize everything, because when you make a mistake, you make it at every level, from coast to coast, and in a uniform way.

I think we were able to cope relatively well during the pandemic. People were able to experience different health measures from coast to coast, precisely because there was a capacity and a duty to coordinate, but the effectiveness lies in decentralized coordination, even in Quebec, as regards health measures.

● (2050)

Mr. Patrick Taillon: Absolutely.

Mr. Luc Thériault: During the pandemic, I sat on the health committee. Quebec was in charge of health measures. In fact, Quebec was the first to declare a state of health emergency, and the federal government was in charge of supporting people. That's how it was in Quebec. In Quebec, we applied a policy of different health measures. At a certain point, we realized we had to put an end to confinement, and all of a sudden, the vaccines arrived faster than expected.

What do you have to say about this? You've got one minute.

Mr. Patrick Taillon: Management that is as close as possible to citizens is more humane and closer to the real issues. It can also be a form of competition. If British Columbia makes a good move, it can inspire Quebec. If Quebec does well, it can inspire Alberta, and vice versa. This form of competition can become a source of inspiration, and in the end, everyone wins.

When faced with huge problems, such as those experienced during a pandemic, it's better to leave room for some local innovation than to have the ambition to have everything coordinated from afar by the government. In any case, we don't even have the information, since health care doesn't fall under federal jurisdiction, except in the case of indigenous persons and the military. These are areas where there's a lot to be done.

Perhaps the federal government should focus its efforts on the health of indigenous persons and the military.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Taillon and Mr. Thériault.

[*English*]

Mr. Davies, you have the floor now for six minutes.

Mr. Don Davies: Thank you.

Dr. Ross, a recent series from the British Medical Journal found that Canada's emergency response during COVID-19 was impaired by “long-standing weaknesses in [the] public health and healthcare systems, including fragmented health leadership...across the federal and provincial and territorial governments.”

Do you agree with that finding?

Dr. Kathleen Ross: The fact that we know the pandemic exacerbated our pre-existing fragmented and broken health care system is highlighted in that article. The pandemic raised awareness of the chronic gaps that we have in our health care system, which we continue to experience. The pandemic itself did not cause it.

This particular legislation certainly could help us identify what we could do to be better prepared for another pandemic because it takes into account not just what occurred during COVID-19, but also previous health crises. It could help us identify where we could improve as a country, as a unified health system and as a profession.

We spoke briefly about health data. I believe that's critically important. Canada lacks on interoperability in many different ways. We have the challenges in planning our workforce supply without adequate demographic service activity and geographical information.

That's the reality of the system that we're in right now. We need to work better together.

Mr. Don Davies: Thank you.

I noticed that the U.K. and some other countries have already started public independent inquiries. The British Medical Journal also outlines several reasons why an independent national COVID-19 inquiry is needed in Canada with accountability for implementation of recommendations. They listed some of these as “failing to look to the past will ensure an unchanged future“ and “lacking an independent federal inquiry allows others to step into the frame”. It would provide “an actionable framework for reforming Canada's health care and public health systems” which were struggling prepandemic, as you have pointed out. It would ensure “accountability for losses”, which included 53,000 direct deaths in Canada.

Do you agree with the arguments outlined in the British Medical Journal?

Would you endorse the call for an independent national COVID-19 inquiry for these reasons?

● (2055)

Dr. Kathleen Ross: I think I would approach that by saying that an advisory committee and a subsequent report would serve as a tool to consider what needs to be done immediately to help our health care system to recover.

The Canadian Medical Association believes that health leaders will need to find efficiencies and employ strategies to optimize our capacity, such as virtual care and patient prioritization to clear the backlog in procedures, but we also know that decisive action needs to be taken to address workforce shortages, particularly of nurses, and ensure that our health system is operating efficiently. These are immediate and urgent needs that we have to address in our health care system.

Mr. Don Davies: Thank you.

To World Animal Protection, in your submission to the committee, you wrote that World Animal Protection supports Bill C-293 because it takes a “one-health” approach to pandemic prevention, requiring government to address the underlying causes of pandemics.

What is the “one-health” approach, and how does it relate to both animal protection and pandemic prevention?

Ms. Melissa Matlow: Through you, Mr. Chair, “one health” is the intersection of animal health and welfare, the health of the planet and the health and well-being of people.

I think the way that animals are stressed in the wildlife trade, wildlife markets and intensive farming practices that necessitate the use of prophylactic antibiotics are all examples of how animal welfare can be the solution to reducing disease risk.

Mr. Don Davies: Thank you.

You also wrote in an open letter to the WHO that was published in The Lancet that over 200 medical and scientific experts identified industrial animal agriculture as a significant pandemic threat and major contributor to antibiotic resistance.

You touched on that. Can you expand on the role of animal health and welfare in preventing the emergence of zoonotic diseases?

Ms. Melissa Matlow: Through you, Mr. Chair, absolutely I can.

We just completed a literature review of animal welfare solutions to reducing prophylactic antibiotics. This includes everything from reducing animal density to reducing the mixing of unfamiliar animals, improving ventilation, sanitation, environmental enrichment and increasing the amount of time before animals are weaned and separated from their mother.

All of these are solutions to reduce the use of antibiotics given prophylactically, which is routinely done in Canada and around the world and the reason that 75% of antibiotics are given to farm animals today.

Mr. Don Davies: Turning to wild animals, you point out in your submission that more than 1.8 million wild animals were imported into Canada between 2014 and 2019, and 93% were seemingly not subject to any permits or pathogen screening.

Has the importation of wild animals led to the introduction of disease to domestic animal populations in Canada or provided any threat to human health?

Ms. Michèle Hamers (Wildlife Campaign Manager, World Animal Protection): I don't know if there are any direct links that I'm aware of, but it is certainly possible.

The most well-known link is chytrid fungus, which is affecting our native populations.

For farm animals, we do import mink, for example, which played a huge role during COVID in the spread and amplification of the disease.

The importation of wild animals, which is currently pretty unregulated and unmonitored, definitely poses a disease risk.

Mr. Don Davies: Can you tell us what the current state of knowledge or theory is about the source of the emergence of COVID-19? Is it still thought that it emerged from a zoonotic source? What can you share with us?

The Vice-Chair (Mr. Stephen Ellis): Ms. Hamers, I'll have to interrupt you. The time is up. I'll gently suggest that you submit that answer in writing. Thank you very much.

Thank you, all.

We're moving into our second round of questioning now.

Dr. Kitchen, you have the floor for five minutes.

Mr. Robert Kitchen: Thank you, Mr. Chair.

Thank you to our witnesses.

Dr. Taillon, your comments were very enlightening. Clause 2 of the bill talks about the purpose of the proposed act, which is to "prevent the risk of and prepare for future pandemics".

The function of the committee that it's trying to structure is as follows:

> The function of the advisory committee is to make recommendations for the improvement, throughout Canada, of preparedness efforts and response capabilities in relation to disease outbreaks in order to reduce the risks associated with future pandemics.

I'm sure, Dr. Taillon, you're well aware that the Public Health Agency of Canada was structured in 2004 after the SARS epidemic to do exactly what I've just quoted. In fact, when we look at the Public Health Agency's function, its function is to provide health promotion, health surveillance, health protection, population assessment, emergency preparedness responses and to "focus on preventing disease and injuries, responding to public health threats, promoting good physical and mental health and providing information to support informed decision-making."

Not only are they doing that, they have also doing it with a budget in 2022-23 of $7,439,195,456 just for infectious disease prevention and control, not to mention the $404,242,000 for health promotion and chronic disease prevention.

If all of this is in place with the Public Health Agency of Canada to do what this bill is proposing, do you feel that this bill is supportive of that, or do we need to get rid of the Public Health Agency of Canada?

● (2100)

[*Translation*]

Mr. Patrick Taillon: Mr. Chair, one thing is certain: it's important to recall, as the member did, the scale of the funds already invested and the mission that already exists.

If the bill simply repeats the mission that already exists in other words, then it's useless. Otherwise, it must be interpreted as a bill that seeks to create a diversion, i.e., we're preparing for the future to avoid really taking stock of what happened, the mistakes and blunders that may have occurred during the last crisis. This is normal, because no government is perfect. No administration is perfect.

Otherwise, we legislate because we want to tighten the screws, we want new powers or more coercive authority. My fear is that this coercive authority will be aimed at the provinces, which would be forced to harmonize their practices when they should instead be allowed to innovate and apply their know-how closer to the ground. This would also plunge them into a dynamic of accountability, which would be a way of subordinating them, when there should be no subordination.

By trying to intervene too much in things that stray from its mission, the federal level is moving away from the basics. Its mission should be refocused on what lies at the heart of federal jurisdiction, for example, procurement and strategic reserves. This is the role of the federal government.

[*English*]

Mr. Robert Kitchen: Thank you. I appreciate that. I'm sorry for cutting you off. It's just that I'm short of time.

Sir, former minister Patty Hajdu said in April 2021, "We are open to an inquiry that is as deep as necessary".

Former minister Duclos said, in response to a question, that he's "confirmed that the federal government still means to pursue some kind of review, eventually."

Would you consider this similar to a national pandemic review?

The Vice-Chair (Mr. Stephen Ellis): You have 10 seconds or less.

[*Translation*]

Mr. Patrick Taillon: Most importantly, there should be a review, an assessment or an inquiry into how the federal government has exercised its powers. I fear that the bill is a diversion to avoid doing this review, assessment or inquiry. I'm afraid it will take us somewhere else, either to repetition or unnecessary legislation, since these are things we can already do.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

I'm sorry, Monsieur Taillon, but that's the time.

Colleagues, we will now turn to Dr. Powlowski.

You have the floor for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I will start by addressing this question to Dr. Barrett.

Looking at the recent pandemics, COVID started in Wuhan; HIV/AIDS—I think that would be classified as a pandemic—started, we believe, in Africa; and H1N1 started in China or Mexico, but I'm not sure whether we know that for sure. Of the other outbreaks that we worried could become pandemics, MERS was in the Middle East, Ebola was in West Africa and SARS was in Guangdong, China.

In looking at how we can better prepare to prevent future pandemics, would you agree that we need to be better globally at detecting outbreaks of disease in poor countries early on and responding to them more quickly, before they become pandemics?

● (2105)

Dr. Lisa Barrett: There are two pieces to that.

If there's one thing we have reinforced for the general public, governments and medical practitioners, among other people, it's that the planet is very small and, unfortunately, very diverse in terms of resources. To your point, yes, we need to support countries that are still in a developing state with more resources to do effective and directed surveillance of what's happening in their countries.

However, to be frank—coming back to some of the comments earlier about taking away the power of people to be autonomous as entities, whether that's a country or a province—I think it's important to note this: No one is suggesting people shouldn't have autonomy, but there should be base standards and science used to determine what the base standards are.

It would be useful and helpful for a bill like this not only to provide direction around capacity-building for global surveillance but also to set some standards for what the science would suggest is a base standard. I guess it's not just generating the data but also sharing and using it in a way that generates base equivalence, so people don't come from have and have-not states, provinces or countries—as humans.

Mr. Marcus Powlowski: Thank you, Dr. Barrett.

It seems you agree that we want, both as a country and globally, to do better, so poor countries are able to detect and respond early on to outbreaks of infectious disease.

I have talked to Nate, the sponsor of the bill, about adding language that would ensure that Canada explores international legal agreements and includes, in those negotiations, consideration of legal instruments and potentially mandatory financial mechanisms. This would ensure rich countries provide under-resourced countries some of the funds they need to better detect and respond to infectious disease.

Should that be one of the things Canada is obligated to do? Is that what we're looking at in this bill—entering negotiations with other countries on how we can help poor countries have the capacity to detect and respond to outbreaks earlier?

Dr. Lisa Barrett: The mechanism for doing that is certainly beyond my scope of expertise.

I think it is very important to say that it's absolutely needed, and to be deliberate about wording in a bill that makes us an excellent global partner. Understanding that those would be durable and practically implementable would be important. I will leave the “how” of that to people who do this for a living. I'm absolutely sure that's not me.

However, the need for that is definitely present, as well as the need to build and guide science globally.

Mr. Marcus Powlowski: Kathleen, in our brief time, do you wish to respond to any of that?

Dr. Kathleen Ross: I would agree.

The CMA recognizes that equitable global access, particularly to vaccines, is a valuable public health tool. Again, though, where and how that gets implemented is outside the scope of CMA recommendations. Certainly, ensuring we are meeting our requirements as far as human rights obligations go is well within this bill, I believe.

Alongside this, it's about recognizing and understanding that access to basic primary care services around the world is lacking, and that investing in primary care is investing in preventative care. It's about getting to patients before they get sick and resort to overburdened emergency departments, or are unable to seek care before they infect others. These are critical pieces.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Ross and Dr. Powlowski.

Colleagues, seeing the clock and looking at the calculations we have done, I'll be clear: Monsieur Thériault, you will have two and a half minutes; Mr. Davies, you will have two and a half minutes; Mr. Majumdar, you will have five minutes; and Dr. Hanley, we'll finish with you for five minutes.

● (2110)

[*Translation*]

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

Mr. Luc Thériault: I'd like to talk about animal protection.

A brief sent to us by the Chicken Farmers of Canada criticizes Bill C-293, which aims to prevent and prepare for pandemics. In it they say that its content is not limited to pandemic preparedness, but includes a negative and biased perspective on poultry farming.

The producers' concerns about Bill C-293 focus on the type of language used to describe factory farming. The focus is on agriculture in the context of antimicrobial resistance, rather than using the “One Health” approach, and the overlapping jurisdiction of provincial governments in agricultural production.

Further on, they tell us about their strategy on the responsible use of antimicrobials approved by Health Canada's Veterinary Drugs Directorate.

What do you think of this critique of the bill?

[*English*]

Ms. Melissa Matlow: If I understood correctly, the question is, what do we think of criticisms by farmers who are concerned about the language used with respect to antibiotics?

I can sympathize with farmers who are concerned about the stresses and challenges they face producing food for our country, but I think the science is clear. Here I have a pile of reports that cite the drivers of pandemic risk. I think we need to be listening to the experts on this and looking for solutions so that we can save antibiotics and protect life-saving drugs for people and for animals. I think it's one of the biggest health crises that we're going to face. It's a silent pandemic.

[*Translation*]

Mr. Luc Thériault: However, Chicken Farmers of Canada says that, currently, their strategy on the responsible use of antimicrobials is based on key elements such as reduction, surveillance, management, research and innovation to meet consumer expectations and protect the health and well-being of poultry.

Do you agree with them?

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Thériault.

[*English*]

I'll have to advise, Ms. Matlow, once again that you provide a message in writing, please. Thank you.

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

Mr. Don Davies: Thank you.

To World Animal Protection, your submission states the following, “the Netherlands has expedited a permanent ban on fur farming to prevent further COVID-19 outbreaks and the German Federal Parliament has agreed to reduce the trade in wild animals for pets, ban the sale of wild caught animals and set up a centralized trade register.” Would you suggest Canada act in a similar fashion? If so, why?

Ms. Michèle Hamers: Absolutely. Currently there is very poor data collection on which wild animals are coming in. We don't know their history, and there's very little biosecurity at the border. We need a comprehensive, detailed dataset to analyze risks. What animals are coming in? What are the risks? What is their life history? Are they wild-caught? What kind of biosecurity risk do they bring with them?

At the moment we don't have this. All of the departments are siloed. They all have a different piece of the puzzle, and that's been acknowledged. We had a meeting earlier today. They need a more holistic mandate to approach this issue, because we're talking about an enormous trade that is happening and an enormous number of animals coming into our country, which we're not monitoring.

Mr. Don Davies: Finally, how does climate change and loss of biodiversity increase the risk of pandemics?

Ms. Michèle Hamers: When animals are stressed, whether it's in captive conditions or in the wild, and when we encroach on their habitats, they are being forced to interact with each other, which might not have happened before. They come into situations where the disease pressures are rising and they come more in contact with people. That's where that interface happens, so when we don't protect their natural habitats, when we encroach on them it increases the risk of pandemics and of zoonotic diseases' emergence and their spread.

Mr. Don Davies: Thank you.

I anticipate that the chair is going to tell me I have very little time.

Dr. Barrett, do you think we should have an independent national inquiry searching to get at the bottom and learn lessons from the way we handled COVID-19?

● (2115)

Dr. Lisa Barrett: I think there are already probably some mechanisms to do that within the organizations that exist. Should there be a review of what has happened from a comprehensive perspective that focuses on a go-forward plan as opposed to a blame game? I would love to see that happen. I think there have been many successes and many challenges along the way. We're coming to a time when everyone's fatigued and trying to ignore the fact that we still have risks, and it's a really difficult behavioural time for people. I think a very well done review and constructive process forward would be very helpful.

The Vice-Chair (Mr. Stephen Ellis): Thank you, Mr. Davies and Dr. Barrett.

We're at the last two rounds of questions.

Mr. Majumdar, you have the floor for five minutes.

Mr. Shuvaloy Majumdar: Thank you very much.

At the onset of the pandemic, the Trudeau government discovered it had dismantled a critical and successful early warning system. When the world began border closures to protect citizens, the “do as I say, not as I do” health minister Hajdu held to an ideology decrying conspiracy theories, accusing critics of being racist and parroting the People's Republic of China talking points and outsourcing critical national interest decisions to a World Health Organization bent on destroying its own credibility.

Bill C-293 is not a pandemic inquiry. It barely begins to assess pandemic prevention and it begs that we pay better attention to what decisions were made in that time.

Dr. Barrett, in the past you've stated that you're a fan of keeping masks on faces and have defended mandates on social media.

Let's see how that played out. The Alberta Medical Association survey cites 77% of parents who have reported that the mental health of their children aged 15 and over is worse than before the COVID-19 pandemic. According to the Canadian Institute for Health Information, during the first year of the pandemic, almost 25% of hospitalizations for children and youth were mental health-related.

Let me ask you a question. These mandates destroyed the mental health of Albertans and Canadians, and destroyed small businesses and destroyed the livelihoods of thousands of people who are now afflicted by an opioid crisis. Do you still stand by your comments today?

Dr. Lisa Barrett: That's not directly or exactly related to the bill, but I'm happy to take up the rhetoric and start with a response to the question that I think was there and address a little bit the leap of logic in the middle.

There are just as many studies that suggest that in certain settings and during certain points in the pandemic, masks were valuable at community levels and, particularly, not just for children, but also for people in very vulnerable situations. Yes, the recommendations I was making and am including now for acute care settings, where there are vulnerable persons who are still vulnerable, I would definitely defend.... I don't know that I needed to defend it.

Do I think the science supports continued masking in certain situations to prevent airborne and/or droplet borne diseases? I do.

To step back for a moment to address your gap between mental health and the pandemic being associated fully with masks, that clearly is a mistake because there were a myriad of things that developed many mental health issues regardless if people lived in countries, provinces or areas where masks were mandated or not. That's a multifactorial issue, but I do appreciate your asking the question.

Mr. Shuvaloy Majumdar: Thank you for your response.

The survey stated that “For children between the ages of six and 14, 70 per cent of parents reported their child’s mental health is 'worse' than before the pandemic.” A large portion of this is cited as being due to the “lost access to natural outlets for stress and anxiety—such as sports and after-school activities” due to these restrictions.

During the COVID-19 pandemic, the Toronto Star featured angry quotes about the unvaccinated on the front page, including on August 26, 2021, with the bold sentence “I have no empathy left for the willfully unvaccinated. Let them die.”Justin Trudeau added to the divisive rhetoric, saying “They don’t believe in science/progress and are very often misogynistic and racist”.... This leads us, as a leader and as a country, to make a choice: Do we tolerate these people?"

Dr. Barrett, do you agree with those sentiments?

Dr. Lisa Barrett: Again, it's not specifically about the bill, but I could link it to the bill.

I think that having pieces of misinformation and disinformation out there like that, particularly around vaccination, is part of the issue. If this bill can actually develop a process where science is promoted, as well as the dissemination of science in a trustful way, we could probably get rid of a lot of those statements. Those are not statements I would support, and I think it's a demonstration of overt mis- and disinformation from certain individuals. Hopefully, we can get beyond that and maybe there's some use for a bill like this to promote it.

● (2120)

Mr. Shuvaloy Majumdar: I'm stunned that such an evolution of thinking has not taken place given the impact of the decisions that were made during the pandemic.

Were the lockdowns valuable, Dr. Barrett? These mandates forced businesses to only have a few customers in at a time.

Do you really think this was an effective pandemic approach?

The Vice-Chair (Mr. Stephen Ellis): Dr. Barrett, unfortunately we are out of time. I would suggest, as I've suggested other times, that you could provide that in writing. Thank you very much.

Thank you, Mr. Majumdar.

Colleagues, for the final five minutes of questioning we will turn to Dr. Hanley.

Dr. Hanley, you have the floor.

Mr. Brendan Hanley (Yukon, Lib.): Thank you, Chair, and thank you to all of the witnesses for being here and also for their patience this evening as we get towards the end of this really interesting testimony.

Dr. Barrett, I'm going to stay with you for a while. Towards the end of your five-minute talk, you had started to touch on the need for post-market vaccine studies to better understand immunity to pandemic pathogens. Again, I'm thinking of how we are looking forward, how we are preparing for the next one.

I wonder if you can elaborate somewhat on that issue of what we need in terms of federal support and how this might relate to this bill.

Dr. Lisa Barrett: Thanks for the question.

If we're trying to build a situation of preparedness, obviously vaccines are a key and core part of that, particularly for illnesses of pandemic potential. When we currently are licensing very safe vaccines in Canada—which we know we do—the part that we often forget about is that we have great vaccines, but we can always expect to raise the bar and make them better. One way to do that is to have the people involved in the manufacture and dissemination of our vaccines to provide us with studies of immunity and effectiveness in real time—and real immunity. That's really important for us in order to go forward in building a real science base that adds trust in vaccines—ups the ante not just to 80%, but to 90% and 100% effective—and in understanding what people need at an individual level. We can do that, potentially through a regulatory way, especially if we demand in our pandemic preparedness and prevention plan that vaccines be maximally effective, licensed and subsequently modified as we go along, so there's rapid access, but high standards for modification afterwards.

Mr. Brendan Hanley: You mentioned trust. I again want to take you up on that a bit more. Despite the incredible success of the vaccine strategy, combined with the other application of public health strategies, we know there was a loss of trust in our population, and that's an enduring phenomenon we're seeing that spilled over into other areas.

Again, as we look at reviewing what we did with a view to looking forward, what do we see as the key elements to rebuild trust? If you could give me a 20-second or 30-second answer, then maybe I'll have time to switch over to Dr. Ross.

Thanks.

Dr. Lisa Barrett: I'll be swift. I'm not a trust-building expert. However, I do think that very effective, directed, and transparent communications and decision-making are key. I think we've fallen a little bit into a situation where we often strategize too hard and worry too much about what we should or shouldn't say sometimes. I think timely and transparent communication doesn't always have to be the same message, but about just having transparency around decisions and how they're made and why they're going to change would have been very helpful, and will be helpful going forward, I think.

Mr. Brendan Hanley: Dr. Ross, it's really good to see you. Thanks for your advocacy.

You, again, refer to the depleted workforce. I think of how we match that to the fact that we are in a pandemic era and that we're not necessarily insulated from another pandemic, just because we are still recovering from a recent one.

I wonder if you are looking ahead with some urgency to preparing and at the same time restoring our workforce. Could you give one or two most critical elements of being prepared for the next one? I think we have about 40 seconds left.

● (2125)

Dr. Kathleen Ross: Thank you. Through the chair, I'll try to be very quick.

PPE and vaccinations certainly made a huge difference in the pandemic, and as far as trust and trust-building go, we know that the most likely predictor of encouraging vaccine-hesitant people to get their vaccine was actually attachment to primary care.

As I look forward, I think Canada needs to have a hard look—and I hope the advisory committee would do that—at homegrown PPE, vaccines, medications, sustainable access to respirators, IV pumps, epidural catheters, all of those things that make our work as frontline health care providers possible. Having a close look at the impact of the basic income funding that came across and looking at social housing to support behaviours in self-isolation, these are all things that would support the work that we do as frontline health care providers.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Hanley and Dr. Ross.

It was a good try, Dr. Hanley, but unfortunately we're out of time.

Colleagues, I want to thank the witnesses for taking the time to appear to day and for sharing such valuable information.

I do understand that you probably had better things to do than listen to committee business, but I do thank you for your patience and for being here.

Mr. Brendan Hanley: I have a point of order, too, Mr. Chair.

Mr. Don Davies: On a point of order, Mr. Chair, we lost a lot of time with the witnesses. I'm just wondering if we could have the agreement of the committee to extend the meeting by 15 minutes.

The Vice-Chair (Mr. Stephen Ellis): Mr. Davies, excuse me.

Please wait to be recognized by the chair, if you would. If we're going to have some decorum here....

Mr. Don Davies: It was a point of order, Mr. Chair.

The Vice-Chair (Mr. Stephen Ellis): Yes, I understand that.

I do believe that Dr. Hanley had his hand up first. Thank you.

Dr. Hanley.

Mr. Brendan Hanley: Fortunately, it's on a similar theme.

Mr. Chair, my point of order is that, given that we have a stellar line-up of witnesses and we did lose some time at the beginning, I wonder if the committee might indulge at least another round of questions to get the most out of this session.

The Vice-Chair (Mr. Stephen Ellis): I will confer with the clerk to understand if we have more time. Thank you.

Thank you for that, colleagues. I understand that we have another 15 minutes available for translation.

If it's the will of the committee, we have time for one five-minute round each for the Conservatives and Liberals, and two and a half minutes each for the NDP and the Bloc Québécois.

Is it the will of the committee?

Some hon. members: Agreed.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, perhaps we should ask the witnesses, as a courtesy, if they also intend to stay.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): That's an excellent point, Mr. Thériault. Thank you for that.

In deference to our witnesses, if you have 15 more minutes, please indicate to me with a little wave, a hand up, thumbs up or something if you're willing to stay.

Excellent. We have the will and we do have the time.

As I said previously, we will now have five, five, two and a half, and two and a half.

We'll begin with the Conservatives and Dr. Kitchen.

You have the floor.

Mr. Robert Kitchen: Thank you, Mr. Chair. I appreciate the opportunity.

Again, thank you to the witnesses staying a little extra longer with us.

As I'm sure you're well aware, the BMJ has published a number of articles on Canada's response to the virus.

One of the quotes I will read to you states, “A national inquiry in 2023 is critical. Consistent with reports both before and after this pandemic, we call for a culture of data sharing that enables diverse use by a broader range of users.”

I'll start with you, Dr. Taillon.

Do you feel that this is a national inquiry that Bill C-293 would provide?

[*Translation*]

Mr. Patrick Taillon: No, this is not an investigation. Bill C-293 is forward-looking. Unfortunately, I'm afraid it's a diversion to avoid making an assessment that would be desirable. Ultimately, it's up to each administration to do its own assessment.

I think the agency could, on its own initiative, learn from experiences it has had in recent years. I'm afraid that by trying to anticipate a future crisis, we're sparing ourselves the critical examination that should be done to answer questions that are nonetheless quite simple. For example, why was the federal government so slow to manage borders? Why was it so slow to remove border obstacles? Why was it so difficult for it to manage vaccine supplies? These are matters for which the federal government is directly responsible. These are the questions we need to prioritize.

● (2130)

[*English*]

Mr. Robert Kitchen: Thank you, Dr. Taillon. I appreciate that.

Dr. Ross, you talked a little bit about database collection. I just read in the article from the BMJ the fact that we weren't seeing that data sharing.

When I was on the health committee in 2020 when this first came about, we heard that a lot from the researchers throughout, continuously. It was that there's no data sharing. Silos are being created and those silos are keeping that data internally as opposed to sharing.

I know you believe that we need to share that data. It's very important to do that across this country.

The bill addresses it, but does it provide enough information to allow us to get that data sharing and break down those silos?

Dr. Kathleen Ross: I am a huge fan of breaking down what I like to call “cylinders of excellence" instead of “silos”. I think we have to have data sharing, an ability to share data across jurisdictions, even from community into acute care, so we can get to that practical research that's timely and can inform the needs of public health and public health service delivery.

I think the fragmentation of data we have, the lack of interoperability, even sometimes across the street, and being unable to access data for our patients harms patients. Access to data and interoperability will, in fact, save lives.

Mr. Robert Kitchen: Thank you for that.

Five of the reasons that were brought up about an independent national inquiry were to basically.... Sorry, it's tough for me; I only have a minute, so I won't be able to do it.

The reality is that having that independent national inquiry is such an important thing. Canadians have been asking for it. The ministers have said they will provide it, and we need to do that. Our concern is that this report is going to be substituted for that national inquiry.

I'm wondering if you would agree with that.

Dr. Kathleen Ross: I think that, no matter which route this committee decides to proceed with, we have to look forward. There are lessons that we definitely can learn from how the pandemic unfolded. There's zero question that this was an unprecedented-in-our-lifetime event, and we do need to look forward to prepare for the next and learn from our lessons of the past.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Dr. Kitchen and Dr. Ross.

We'll now turn to Dr. Powlowski, and I understand that you'll split your time with Mr. Fisher.

Dr. Powlowski, you have the floor.

Mr. Marcus Powlowski: To the witnesses, I look at this act, and I think it's fairly simple. I think Nate himself has agreed on that. In terms of the review of the pandemic, he's not all that keen on that part, but he certainly wants the second part, which is basically, I think, setting up or requiring the government to make a pandemic preparedness plan and for various ministers to have certain things they have to do as part of that pandemic preparedness plan.

Two years after the act comes into force, that plan has to be tabled in the House of Commons, where it will be public and we and everyone can review that plan. Then, every two years afterwards, the plan has to be updated and reviewed and again presented to the House of Commons. Then not only us but the opposition will also get a chance to review that plan again and to comment on it.

I have two questions for Dr. Ross and Dr. Barrett.

Is that generally a desirable thing? I would have thought it is. We saw during the COVID pandemic that there were certainly a lot of questions as to what the plan was. Was there a plan? I would have thought this were a very desirable thing to begin with. Do you have any specific things that you would like to see as a requirement for the minister to include as part of those plans?

Maybe I could start with Dr. Ross and then go to Dr. Barrett.

● (2135)

Dr. Kathleen Ross: Thank you very much, and I'll be brief.

The CMA has been very active in pushing for transparent accountability with regard to the health care system in Canada, not just looking back at the pandemic and being prepared but also moving forward so that the citizens of Canada can understand where investments are being made and what outcomes can come from that.

I would be in favour of ongoing accountability measures.

Mr. Marcus Powlowski: Dr. Barrett, you have to leave a minute because somebody else wants to ask you a specific question.

Dr. Lisa Barrett: Yes, having a plan is a good idea—not a shocker there.

Yes, a pandemic plan would be delightful, no doubt about that.

Also, you might want to beef up the science bit and the accountability to science and not suppress it. Use it as not just guidance but the anchor. That's my answer.

Mr. Marcus Powlowski: Darren, I'll go over to you.

Mr. Darren Fisher: Thank you very much.

Dr. Barrett, I know it's late at night in Nova Scotia. You're closing in on 11 o'clock, and I'm sure you've had a very busy day, but I want to thank you on behalf of Canadians for your care and compassion. Your tone.... You were the face of COVID, at least in Nova Scotia and Atlantic Canada, but your knowledge, your care and your compassion were evident every day in people's homes on TV. Also, you had the best backdrop of COVID.

I'm interested in your key takeaway.

I think the key takeaway is the need for data and the ability to use data, but I'm interested in your key takeaway as part of future preparedness.

Dr. Lisa Barrett: It's raised the bar. We've been far too lax for far too long about data and health and what we expect from health prevention. Now is the time to up the bar and expect more and we're going to have to do that through science, both data generation and connectivity. That's what I think we need to do and I hope this will be a beginning step towards that in this bill.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Fisher.

Thank you, Dr. Barrett.

We'll now turn to Mr. Thériault.

[*Translation*]

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

Mr. Luc Thériault: The Standing Committee on Health sat through the entire pandemic. It's one of the only committees to have done so, and there are three of us MPs here who lived through the pandemic on the committee without ever looking to blame anyone. Instead, we looked for solutions.

I believe that Bill C-293 puts the cart before the horse and that we must first know what happened before claiming to have solutions. For example, how can we explain that the global public health information network could have been so ineffective, failing to raise the red flag in time and allow personal protective equipment to be sent to China, when our own stockpile was empty? The fact that in Quebec our CHSLDs, our long term care centres, ran out of masks had consequences.

Getting the answer to this question seems important to me, and I don't think an advisory committee could get to the bottom of the issue. Without looking for culprits, we first need to know what we've done, what we could do differently, and then propose a plan of action. A law won't fix this; we already have everything we need to do so.

Do you have any comments on the matter, Dr. Barrett?

[*English*]

Dr. Lisa Barrett: Again, I think a critical and root cause analysis would be part of whatever this group is going to do, and it's the look forward. This is the third time it's been said by two different people, that the look forward is far more important than, to your point, the blamey bits. A lot of what you mentioned will come up, and that's pandemic preparedness within our domestic group. That means PPE generation, it means vaccine development and bringing [*Inaudible—Editor*].

● (2140)

[*Translation*]

Mr. Luc Thériault: If this group is not independent, do you really believe it will have the leeway needed to get to the bottom of things?

Never have my colleagues and I, who lived through this pandemic, pointed the finger at anyone. That's why we don't think it's normal that in 2023, we haven't already carried out this analysis, this investigation. How is it that no analysis has been done?

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Thériault.

If you could tell us who, that was directed to, then I might be able to suggest they provide an answer in writing.

[*Translation*]

Mr. Luc Thériault: I was still addressing Dr. Barrett.

[*English*]

The Vice-Chair (Mr. Stephen Ellis): Thank you very much.

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

Mr. Don Davies: Dr. Ross, I noticed from your biography that you were a founding member of the doctors of B.C.'s diversity and inclusion advisory group. You were also a physician-lead for the Royal Columbian Hospital’s antiracism and unconscious bias working group. It mentioned that in those roles you were committed to fostering learning, awareness, education, and ongoing implementation of inclusive, diverse, and anti-racist practices in health care.

I put this next question in that context to you.

The British Medical Journal, in reporting on Canada's COVID-19 response, found the following:

> Despite ostensibly universal healthcare, the highest rates of covid cases and deaths in Canada were among people already disadvantaged: racialised ethnic groups, migrant workers, essential service workers, and those living in crowded housing. For some Indigenous peoples in Canada living on reserves, appalling lack of access to basic needs such as clean water rendered early covid hygiene advice impracticable.

In your view, do you agree with that finding, and what steps should the federal government take to ensure equitable protection of all residents in the event of a future pandemic?

Dr. Kathleen Ross: Thank you for the excellent question.

Through you, Mr. Chair, there's no question at all that we lack adequate data when it comes to race-based illness in this country. I think we've heard calls from many jurisdictions now to try to collect those areas so that we can identify and track health disparities and redeploy resources where they are most needed based on actual data.

I agree that the science and how we implement our measures are going to be critically important but we don't know where to point our additional resources if we don't track the data to understand the problem in the first place.

Mr. Don Davies: Thanks.

In 20 seconds, World Animal Protection, what do we need to know? What's your advice?

Ms. Michèle Hamers: I think what it comes down to is if you keep a lot of animals in a small space, they can't engage in natural behaviours and if they are with unfamiliar other species, they're going to get sick. That's the bottom line. We can't manufacture our way out of it with technology and such.

Better welfare is the answer to better animal health, which is the answer to better people health. It's a very simple connection, and we have all the evidence that it needs to be addressed.

The Vice-Chair (Mr. Stephen Ellis): Thank you very much, Mr. Davies.

I will try once again. This time, we are out of time. I want to thank the witnesses for staying later. Those of you not in this time zone, obviously we thank you even more.

That being said, I hope the information was valuable to you all. Hopefully, you enjoyed the discourse we had beforehand.

I have a bit of committee business. This is a reminder to members that the deadline to submit amendments to Bill C-293 is this coming Friday at noon.

In our next meeting, on Monday, we'll be doing clause-by-clause consideration of this bill, Bill C-293.

Thank you all for indulging the newness of this chairmanship to me.

Also, on behalf of this committee, I would like to wish our usual chair, Mr. Casey, Godspeed in what he is going through at the current time.

Is it the will of the committee to adjourn?

Some hon. members: Yes.

The Vice-Chair (Mr. Stephen Ellis): The meeting is adjourned.