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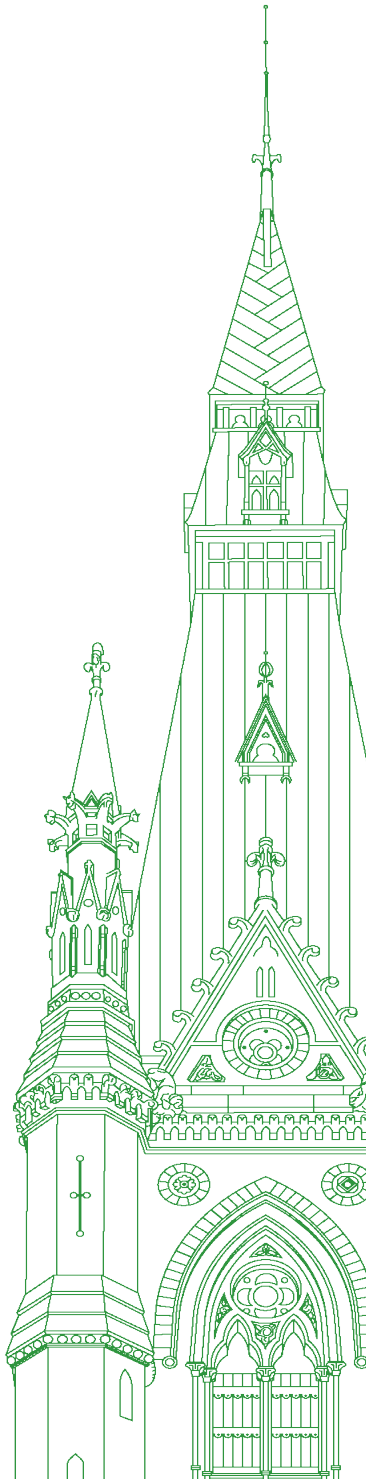

Chair: Mr. Ron McKinnon

Standing Committee on Health

Wednesday, April 15, 2020

● (1405)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call this meeting to order.

Welcome to meeting number 13 of the House of Commons Standing Committee on Health. Pursuant to the order of reference of Tuesday, March 24, and Saturday, April 11, the committee is meeting for the purpose of receiving evidence concerning matters related to the government's response to the COVID-19 pandemic.

Today's meeting is taking place entirely by video conference, and the proceedings will be made available via the House of Commons website.

As at the last meeting, the webcast will always show the person speaking rather than the entirety of the committee.

In order to facilitate the work of our interpreters and ensure an orderly meeting, I would like to outline a few rules to be followed.

Interpretation in this video conference will work very much as it does in a regular committee meeting. You have the choice at the bottom of your screen of either “Floor”, “English” or “French”. When I say the “bottom of the screen”, that's for those using a PC computer. For people using an iPad or something else, your experience will vary slightly.

Before speaking, please wait until I recognize you by name. When you are ready to speak, you can either click on the microphone icon to activate your microphone or you can hold down your space bar while you are speaking. When you release the space bar, your microphone will mute itself.

I remind everyone that all comments by members and witnesses should be addressed through the chair. Should members need to address the floor outside of their designated time for questions, they should activate their microphone and state that they have a point of order.

If a member wishes to intervene on a point of order that has been raised by another member, they should use the “raised hand” function. This will signal to the chair that you are interested in speaking. In order to do so, you should click on "participants" at the bottom of the screen, and when the list pops up, you will see next to your name that you can click “raise hand”.

When speaking, speak slowly and clearly, and when you are not speaking, your microphone should be on mute. The use of headsets is strongly encouraged. If you have a microphone on your headset that hangs down, please make sure it is not rubbing on your shirt during your questioning time.

Should any technical challenges arise—for example, in relation to interpretation or if you are accidentally disconnected—please advise the chair or clerk immediately, and the technical team will work to resolve that. Please note that we may need to suspend during these times, as we need to ensure that all members are able to participate fully.

Before we get started, can everyone click on the screen in the top right-hand corner if you're on a PC and ensure you are on "gallery view"? With this view, you should be able to see all the participants on a grid view, and it will ensure that all video participants can see one another.

During this meeting we will follow the same rules that usually apply to opening statements and the questioning of witnesses during our regular meetings. Each witness will have 10 minutes for an opening statement, followed by the usual rounds of questions by members.

I would like to now welcome our witnesses. As an individual, we have Dr. Joanne Liu—

● (1410)

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Mr. Chair, before we get going, I want to dispense with a motion relating to the business at hand, but before I do, I want to seek clarification from you and the clerk. I'll raise a couple of sentences here from page 980 of Bosc and Gagnon, where this is stated:

> Standing committees often need the collaboration, expertise and knowledge of a variety of individuals to assist them in their studies and investigations. Usually these persons appear willingly before committees when invited to do so. But situations may arise where an individual does not agree to appear and give evidence. If the committee considers that this evidence is essential to its study, it has the power to summon such a person to appear.

I have a question for you and the clerk. Does this committee have the power to summon witnesses, or merely to request?

The Chair: In general, the committee would have that power. However, we are operating under restricted authorization from the House at this point.

At this point, paragraph (n) of the unanimous consent motion that was passed on Saturday says this:

> (n) in addition to receiving evidence, the committees enumerated in paragraphs (l) and (m) of this order, while meeting by videoconference or teleconference, may also consider motions requesting or scheduling specific witnesses and these motions shall be decided by way of a recorded vote.

My first thought about this is that issuing a summons does not fit in that category. I would like to take that under advisement, and maybe we could discuss it during the meeting of our subcommittee members tomorrow.

Mr. Matt Jeneroux: I appreciate that bit of clarification. This committee, then, essentially does not have all the regular powers and privileges that it would normally have when we're meeting in person, so this virtual committee is a poor substitute for the real thing.

In that case I would like to move a motion that the committee invite Dr. Aylward, Canadian adviser to the WHO, to appear before the Standing Committee on Health for one hour, no later than May 1, 2020.

The Chair: Very well. The motion is in order.

We had a discussion. I thought we were going to deal with this sort of thing during the subcommittee meetings, but you have made—

Mr. Matt Jeneroux: With all due respect, Mr. Chair, that was before Dr. Aylward had cancelled on the meeting, so I think this is a unique circumstance, and whether or not he should come is certainly worthy of a vote with the committee.

The Chair: Well, as I said, the motion is in order. You can move it and you have moved it.

Is there any discussion on this motion?

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Matt, as moved, you're asking him; you're not summoning him at the moment, right?

Mr. Matt Jeneroux: That's right, Marcus. The Chair just gave the explanation that we can't summon him at this time.

The Chair: Are there any other interventions?

Mr. Don Davies (Vancouver Kingsway, NDP): I am happy to proceed with the vote, and I understand it will be a recorded vote. If not, I would make that request.

I just want to state for the record that I am not in agreement that the committee cannot summons, based on what you read out. I understand that's not the motion before us today, but I don't want it to be taken that our voting on this is a concession that the committee can't issue a summons, because it is my position that we can do so by the terms of the unanimous consent motion.

The Chair: This is simply a vote on the motion as moved. It has no implications on any other matter.

Is there any other discussion?

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Can you read the motion, Mr. Chair?

[*English*]

The Chair: Monsieur Thériault, did you wish to intervene?

● (1415)

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I was asking for the motion to be read again.

Furthermore, since we've taken the trouble to bring in witnesses, I was wondering whether this discussion could be held in the subcommittee.

[*English*]

Mr. Don Davies: Mr. Chair, I'm sorry, but I didn't get any translation. I am on the proper setting, but I didn't hear any translation.

The Chair: Mr. Thériault has just advised that he thinks this could be done in the subcommittee, given that we have witnesses, and he didn't hear the motion.

I'm going to ask Mr. Jeneroux to reread the motion, please.

Mr. Matt Jeneroux: Thank you, Mr. Chair.

I move that the committee invite Dr. Aylward, Canadian adviser to the WHO, to appear before the Standing Committee on Health for one hour, no later than May 1, 2020.

The Chair: Monsieur Thériault, is that okay with you? Have you heard the motion this time?

Are there any further interventions on this question?

Seeing none, I shall ask the clerk to undertake a voice vote. Go ahead, Madame Clerk.

The Clerk of the Committee (Ms. Erica Pereira): The vote is on the motion of Monsieur Jeneroux. I apologize, but I do not have your names in alphabetical order in front of me, so please listen carefully for your name. If you are in favour, say “yea”; if you are opposed, say “nay”.

(Motion agreed to: yeas 10; nays 0) [*See Minutes of Proceedings*]

An hon. member: I have a point of order. Does Mr. Van Bynen get to vote?

The Clerk: Oh, my apologies.

Mr. Van Bynen.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Yea.

The Clerk: The motion is carried.

Mr. Marcus Powlowski: Hold on. I didn't get to vote, but I vote yes.

Mrs. Kelly Block (Carlton Trail—Eagle Creek, CPC): Excuse me, am I subbing in for someone?

The Clerk: I don't have you as a substitute today, Ms. Block, just as a member attending.

Mrs. Kelly Block: Okay. Thank you.

The Chair: Carrying on from where we left off, I would like to now welcome the witnesses. As an individual, we have Dr. Joanne Liu, who is a physician and former international president of Doctors Without Borders. We have, on behalf of the Canadian Mental Health Association, Margaret Eaton, national chief executive officer.

From the Department of Public Works and Government Services we have Bill Matthews, deputy minister; Michael Vandergrift, associate deputy minister; and Arianne Reza, assistant deputy minister for procurement.

We will start with Dr. Liu. You have 10 minutes for your statement if you wish.

● (1420)

Dr. Joanne Liu (Physician and Former International President of Doctors Without Borders, As an Individual): Thank you very much, Mr. Chair.

Good afternoon. I would like to echo some of what I have written already in The Globe and Mail about my obsession about avoiding the worst-case scenario for Canada in tackling the COVID-19 pandemic.

I think all of us right now are holding our breath and are hoping that our physical distancing strategy will do the job to flatten the curve. The reality right now is we have put our health care system on pause in order to gear up and prepare for a surge of COVID-19 patients. Another reality is the managing of a pandemic with a shortage of medical resources.

My key message for you today—and I will bring forward a few examples—is to really prepare for the worst-case scenario but also very much to prevent what is preventable.

In terms of the health care system and the health care facilities, I am very adamant about pushing for dedicated medical facilities or dedicated parts of facilities with dedicated staff only for COVID-19 patients. It has been proven again and again that swapping staff from COVID-positive to COVID-negative patients may contribute to more infected patients. It is very evident that people working in a close circle of patients become much better at caring for patients. In this closed environment if there is a COVID-positive patient, they are going to go through the part that only COVID-positive patients would go through. There should be dedicated places, for example, to get an X-ray. A COVID-negative patient should not cross paths with a COVID-positive patient. That's a way to make sure our health care system doesn't become a vector for COVID-19. Additionally, a secondary gain is it might reduce the amount of personal protective equipment we might need.

I would like to draw your attention to a few special circumstances. It's about the vulnerable communities. It has made the headlines now about the homes for the elderly, but there are the shelters and the first nations as well. For me, it is mandatory to think about implementing radical shielding strategies. This means that we shield those vulnerable populations. It's what we call reverse isolation.

We isolate the sick, but we also isolate the vulnerable. We shouldn't do what has been done in Quebec, which is the double failure of isolating our elders and not giving them the right and adequate care. We need to make sure we avoid that.

There is another thing we need to bring in as quickly as possible. We need to test regularly the caregivers who care for those vulnerable communities. We know there is an increasing number of asymptomatic people, and they become what we call “super-spreaders” who are infecting others. The bottom line is we don't want to import COVID-19 into vulnerable communities. We don't want to bring it into our first nations. We don't want to bring it into homes for the elderly. We don't want to bring it into the shelters.

I also want to make a point about the health care staff, and I'm pretty sure that people from the mental health community will say something about this as well. For me it's mandatory. I have seen it with Ebola. I have seen it with cholera. I have seen it now with COVID-19 in my hospital. We need to protect our health care workers, first-line workers, physically and mentally. That's our last line of defence for this pandemic.

I'm bringing that to your attention, MPs, because I would say it's very uncivilized when my boss in the ER is telling me to please use PPE wisely. This is nerve-racking. I do understand that we have to use our PPE carefully, but if you want us to care for patients, I'm begging you to care for us and protect us.

It is important that you do everything to protect us physically and mentally as well. We should have hotlines to discuss what is going on, hotlines for the ethics committee that's going to help us make difficult decisions on patients who are on ventilators. They might want to remove the ventilator or stop care. We need to have psychological counselling and support all the time. Nobody should be blackmailed for not feeling comfortable to work in a COVID-positive environment.

● (1425)

Again, knowing the growing community transmission that's going on, I still think that as soon as we have enough tests, we should try to test our first-line workers regularly because of the asymptomatic carriers.

The last general point I would like to make is about the non-COVID patient. Life goes on even if we have COVID-19. It would be a disaster, a tragedy, if highly treatable and preventable medical conditions became lethal. We know that now, a patient with a heart attack is dying at home or with cerebrovascular accident is staying alone at home with their disease and illness. It is important right now that we make sure we're not creating a second-rate status for non-COVID-19 patients, because life goes on. We need to have a plan to relaunch the health care system in an incremental way. It is really, really important. You cannot put a whole health care system on hold forever; otherwise, we will start to die of very preventable diseases.

As a humanitarian aid worker, I cannot not talk about the more global message of where Canada stands on the global response in the world. I know we're tackling what we have here, but we know as well that the only way to win against COVID-19 is to win in every single country. My plea as well for Canada is to find out how we are going to support the low- and middle-income countries to respond to COVID-19, knowing that we are so interconnected and knowing that making all of us healthier depends on making each of us healthier.

So knowing that the Canadian government has invested $300 million, or at least pledged $300 million, for research and development, I beg you to make sure that there are all the safeguards—that the vaccine, the treatment or the tests that will be developed will be a public good; that Canadians as much as other people will have access to those new discoveries; and that it will be affordable and accessible to all.

Thank you very much.

The Chair: Thank you, Dr. Liu.

We will go now to the Canadian Mental Health Association and Margaret Eaton, national chief executive officer.

Please go ahead, Ms. Eaton. You have 10 minutes.

Ms. Margaret Eaton (National Chief Executive Officer, Canadian Mental Health Association): Thank you very much for this opportunity. I really appreciate being here.

As the national CEO of the Canadian Mental Health Association, I'm honoured to be representing the 86 divisions and branches that provide direct services and programs to people with mental health problems and illnesses. Our broad network of over 5,000 staff and 10,000 volunteers provides mental health services and programs to over one million Canadians annually. We are present in over 330 communities in each province and the Yukon territory. Right now the phones are ringing off the hook at those CMHAs all across the country, so today I want to talk about the impact of the COVID-19 pandemic on mental health and offer you some solutions.

We applaud the federal government for its swift whole-of-government response to this rapidly accelerating pandemic. We also commend the commitment to provide mental health support to Canadians during these unprecedented times, including the newly announced portal for mental health and substance abuse that has been named Wellness Together Canada. I'm very excited to see that announced today.

Now more than ever we need to ensure our mental health care system is empowered to meet Canadians' needs. We are already seeing signs of a potential "echo pandemic" of mental health issues as a result of COVID-19. Just last week the CBC reported on the surge in demand at CMHA Nova Scotia. It typically receives 25 calls per day, but is now fielding 700 daily requests for mental health support. These requests come mostly from people without a history of mental illness.

Canadians are very worried. They're worried about contracting the disease. They're worried about their family and friends. They're worried about losing their jobs and ability to make ends meet. People with serious mental illness and addiction are particularly vulnerable. Many of CMHA's clients are facing housing instability and live in situations where practising physical distancing and infection control is very challenging. In many communities, the programs, services and treatments they rely on have been suspended. They're at serious risk of infection, loneliness, increased symptoms and relapse.

Indigenous peoples are perhaps the most vulnerable of any population in Canada. Many community members live with serious mental health issues as a result of colonization and experience the highest youth suicide rates in the country. Older adults have small social networks and limited access to technology, which weakens their opportunities for connection. We're concerned that these issues will only be exacerbated by pandemic conditions.

Our health care and front-line workers are also at risk for mental health issues, as Dr. Liu so poignantly explained. As you've been hearing, the challenges and pressing needs they are facing on the job every day are triggering fear, anger and anxiety. The grave consequences of the substantial burden these workers are carrying is already emerging in China, Italy and the United States. A recent study found that health care workers who treated COVID-19 patients in China reported symptoms of depression, anxiety, insomnia and distress. In Italy, at least two nurses on the front lines have died by suicide. Health care workers in the U.S. are using the term "moral injury" to describe their experience of physical and mental exhaustion, fear of infection, inadequate supply of personal protective equipment, and the heartbreak of making very difficult decisions.

We're only just beginning to grasp the mental health impacts of COVID-19. As our experience supporting Albertans following the Fort McMurray fires revealed, recovery takes time, sometimes up to two years. Research conducted one year after the SARS epidemic found increases in psychological distress and post-traumatic stress disorder among patients and clinicians. We won't know the full picture of the impact, but our experience tells us the mental health impacts will be significant.

Simply put, Canadians need an immediate and substantial investment in mental health to prevent that "echo pandemic" of mental health problems. That's why we're supporting Canadians now and we're already planning for the recovery period ahead. As a pioneer and leader in community mental health since 1918, we're focused on mental health promotion and prevention.

● (1430)

We aim to keep people out of the hospital, shoring up the mental health of Canadians before their issues escalate, while supporting those with severe and persistent mental illness to help them live better during and after treatment. Our vast network includes mental health and addiction counsellors, therapists, nurse practitioners, peer supporters and recovery coaches. They're on the ground in the neighbourhoods where Canadians live, work and play. We stand ready to mobilize this network to bring more mental health supports to Canadians who need them most in this time of crisis.

We can quickly scale up proven programs in English and French to reach thousands of people. Our cost-effective, evidence-based solutions are designed for children and youth, older adults, indigenous people and first responders. For all Canadians, we offer a program called BounceBack. This is a skill-building program based on cognitive behavioural therapy. In B.C. alone, more than 11,000 people have participated, and 85% said that the program helped them make lasting, positive change to reduce anxiety and depression.

For front-line workers, we offer peer support through a program called OSI-CAN, and mental health awareness training through Resilient Minds. These two programs are based on professionals helping each other and have provided health and healing to hundreds of front-line workers since their inception. With rapid government investment, we can immediately scale and ensure that these proven programs have nationwide reach, including to rural and remote communities.

While getting resources to Canadians experiencing mental health problems and illness now, in the midst of the pandemic, remains our priority, it is also crucial to plan for the future. We are already looking ahead to the national recovery and ways to support people as they transition back to normal life. Our recovery colleges are mental health learning centres that provide education and peer support through courses on well-being. There are recovery colleges in 11 communities in Canada already, with many CMHAs eager to develop their own.

The Canadian Mental Health Association's mandate is one of mental health for all. We know that meeting this goal requires meaningful government investment in mental health. Canadians deserve access to publicly funded, evidence-based therapies, and to a complement of mental health and social supports. As the mental health impacts of COVID-19 will differ based on each person's economic and social circumstances, we know that good mental health starts with having the basics, such as meaningful employment and adequate housing.

In addition to helping people now, we must also ensure that we are prepared for the inevitable demands that are going to be made on the mental health system as a result of the increases in depression, psychological distress, substance abuse, PTSD and domestic violence that almost always accompany large-scale disasters. As the COVID-19 pandemic has revealed, our economy is completely dependent on the well-being of our population. To restart our economy and secure its lasting recovery, we must ensure that Canadians are healthy enough, both physically and mentally, to return to work and to their daily activities.

Canadians know that mental health is just as important as physical health. As we will underscore during Mental Health Week—which is May 4 to 10 this year, led by CMHA for nearly 70 years—while one in five Canadians experiences mental illness in a typical year, five in five Canadians need to protect their mental health.

We're truly at a crossroads. While motivation to seek help has never been higher, the mental health sector lacked capacity to meet demand before the pandemic began. We must act now to ensure we are prepared for a surge in mental health problems as a result of COVID-19.

Now more than ever, Canada must demonstrate true vision and leadership on mental health. We know Canadians will reach out for help. They're reaching out right now. We're simply asking you to please empower us to reach back.

Thank you again for the invitation to speak to you today. I look forward to answering your questions.

● (1435)

The Chair: Thank you, Ms. Eaton.

We go now to the Department of Public Works and Government Services.

Mr. Matthews, I believe you will commence. You have 10 minutes, please.

Mr. Bill Matthews (Deputy Minister, Department of Public Works and Government Services): Thank you, Mr. Chair. Good afternoon and thank you for having me and my officials here with you today to talk about the role of Public Services and Procurement Canada in the government's response to COVID-19.

Before I begin I would like to thank the people behind the scenes who are making this meeting possible, including our language interpreters who continue to do an exceptional job in ensuring that Canadians have the most recent information.

With me today, Mr. Chair, as you mentioned, is Michael Vandergrift, the associate deputy minister at PSPC; as well as Arianne Reza, the assistant deputy minister of the procurement branch.

PSPC is the central purchaser for the Government of Canada and is responsible for procuring goods that will help see us through the COVID-19 pandemic. Specifically we are helping to equip Canada with personal protective equipment and medical supplies for now and for the months ahead. It is no secret that we are operating in a highly competitive global environment, and this comes with challenges. The entire world is scrambling to get the same materials from a finite number of suppliers, many of whom are located in China. This is resulting in a complex and unpredictable supply chain. Add to this order restrictions and you end up with a highly unstable marketplace where orders don't always materialize into immediate deliveries.

I think I should spend a few minutes, Mr. Chair, talking to you about our procurement strategy. Then I will drift into some updates on specific goods that we are acquiring.

I can tell you that our procurement experts are working day and night aggressively buying from all available suppliers and distributors here at home and abroad. In support of Canada's front-line health workers, we buy supplies on behalf of the Public Health Agency of Canada, which consolidates requests from provinces and territories and also maintains our national stockpile. This procurement activity is over and above what provinces and territories are doing on their own.

I should stress that the strategy we're pursuing, which I mentioned I would share with committee, continues to evolve and be fine-tuned as circumstances change as we are dealing with global marketplaces such as we have never seen. I am sure that members are aware of the importance of PPE, personal protective equipment, given the global scale of this crisis and the importance of China from a PPE production standpoint. We're dealing with a situation in which many jurisdictions are competing for scarce supplies. At the same time, industry is trying to scale up to meet the global demand, which means that new players are emerging rapidly. Normally we would look to procure these types of goods through a Canadian distribution channel, but given the rapidly changing market conditions, a different approach was and is necessary.

Our procurement strategy is three-pronged. The first part involved buying existing inventory where we could, inventory that was already on the shelves. As you can imagine, given the pandemic, these goods were in short supply but they were important to obtain while we put in place the second part of our strategy.

Part two of the strategy, which is ongoing, was to place large orders to receive a steady stream of goods over a number of months. One of the benefits here is that big orders are more commercially attractive in a competitive marketplace. Ordering collaboratively with the provincial and territorial partners allows us to increase the size of our orders and get the attention of industry. We've also made the deliberate decision to order aggressively, or stated another way, to consciously over-order. This was and is a deliberate attempt to acquire goods given the uncertainty around the timeliness of receipts and delivery.

As you can imagine, close collaboration with provincial and territorial governments is imperative to our success. To that end, the minister of PSPC has established a federal-provincial-territorial ministerial table on procurement, which is helping to bring even greater coordination in identifying and meeting supply needs.

The third prong is domestic. Under the leadership of the Department of Innovation, Science and Economic Development Canada, discussions have been launched with domestic industry in Canada to help fill the gap on a medium- and longer-term basis. Many companies from across Canada have answered that call with some manufacturers completely shifting their production lines to meet the urgent need. My department's role in this case is to establish contracts with these companies. We've already begun to do so, and I will get into that in a moment.

There are some challenges and I would be misleading the committee members if I left anyone with the impression that procuring in this environment is easy or risk-free. There are many risks. We are buying products at a high volume from unfamiliar suppliers, and that situation can present challenges both in terms of delivery and in terms of quality. Limited availability of many of these products is resulting in buyers overbidding—I mentioned competition earlier—and established orders are often redirected to those who are willing to pay the most. On top of this, we are seeing export controls change in China and rules around requirements for medical supplies changing as well. I mentioned China already. That situation has changed a couple of times and it's worth keeping an eye on as rules change there.

● (1440)

Successfully navigating this environment requires significant support on the ground. This is an area where we have had to adjust our strategy to better align with reality. Given the emergence of new players and the shortage of supply, we can no longer rely solely on Canadian distributors to obtain products. Our officials are working closely with partners in other countries, including embassies, to ensure our supply chain. This on-the-ground support and expertise is proving invaluable, as diplomatic staff and external partners assist in vetting companies in advance to ensure better quality. This is in addition to the on-the-ground support to ensure product delivery, logistics and warehousing expertise to help secure our shipments and bring them to Canada.

This support includes receiving product as it comes off production lines, quickly inspecting it for quality, arranging for shipment to a warehouse we have secured at an airport and actively securing customs clearance.

Through all of this, we have had to significantly accelerate our procurement processes by making quick decisions and streamlining contracting steps. Contracts that would usually take several months to finalize are being put into place in days, if not hours. Traditional competitive approaches would mean that the product would be sold to another buyer before we made a decision, in an environment where prices are increasing rapidly and rules and regulations are changing overnight.

Even after our shipments arrive in Canada, the Public Health Agency must first inspect purchased supplies and then get them to where they're needed across the country. The same is true for any supplies we produce in various regions across the country. To help us with this logistics effort and to help our colleagues at the Public Health Agency of Canada, we have reached an arrangement with Amazon Canada to do delivery and warehousing inside Canada. Canada Post and Purolator are also playing a role in this effort and that is really to help the Public Health Agency of Canada make sure that the PPE gets to the locations where it is needed most. This is all about moving supplies from where they're manufactured into the eventual hands of our doctors, nurses and health care professionals as fast as possible. PSPC has a role in doing that.

Let me turn now to the latest numbers in terms of orders and deliveries. These numbers are as of April 13 and they change rapidly. We have managed to order more than 293 million surgical masks and more than 130 million N95 respirators, a key piece of protection for health care workers. To date, we have received deliveries of more than 17 million surgical masks, and just over 609,000 N95 respirators. To meet longer-term supply needs, we are working to establish a domestic manufacturing contract in Canada with Medicom of Pointe-Claire, Quebec for these masks. Like all of the equipment that countries are seeking, ventilators are in short supply. In this tight market, we have managed to secure orders for 32,000 ventilators from a variety of companies, including Canadian companies Thornhill Medical, CAE, StarFish and FTI professional grade.

In addition, we have ordered more than 20 million litres of hand sanitizer. Delivery has already started and will continue over the coming months. This is supported domestically in part by an agreement with Fluid Energy, a Calgary-based company.

We have ordered over 900 million pairs of gloves, and to date we have already received nearly five million. We have ordered 17 million face shields. This includes an agreement with Bauer, which has shifted its hockey skate production lines to make face shields that are so important for front-line medical staff.

Test kits are an area of frequent discussion. When it comes to test kits, supplies are being delivered, including hundreds of thousands of swabs and we continue to work to procure more. I would note that there's a global shortage of reagent, which is an important chemical used in testing. It's something we are aggressively seeking out and ordering. We continue to monitor the situation with Health Canada on the availability of global supplies.

I would also like to mention that Health Canada and the Public Health Agency of Canada are accelerating regulatory reviews of new tests and other products, so that more products are available to support our response.

Here at home we have recently awarded a contract to Spartan, an Ottawa-based company that will provide rapid test kits to test more than a million Canadians for the virus. This is on top of the testing that is already being done by provinces and territories.

These are just some of the things we've procured and a handful of the Canadian companies that are rising to the challenge and involved in the response. We are constantly adding to our orders and identifying our needs.

Just before I wrap up, there are a couple of things I should highlight to the committee because the department is offering support in other ways besides procurements. I've already mentioned our interpreters here today. The translation bureau is supporting the communication of COVID-19 related information to Canadians. This includes sign languages, official language and indigenous language interpretation for government officials, ministers and the Prime Minister.

As we manage one of the largest portfolios of real estate across the country we are currently inventorying our holdings to explore how to best provide communities with the support for secure accommodations that they may need in the future. This obviously involves working with local governments and provincial partners as well.

● (1445)

In closing, Mr. Chair, the most important role we're playing is the purchase of vital supplies. These are unprecedented times, and the government is taking unprecedented measures to get equipment to the front lines. While we are making significant progress, we are operating in a hyper-competitive market, and we must continue to be vigilant. We know that we may be dealing with spikes in COVID-19 infections in Canada for months to come, and we need to be prepared for all scenarios.

On behalf of the health officials that we support, my department will continue to seek out supplies and secure them and the necessary products our health care professionals need to keep Canadians and themselves safe.

Thank you for your time. We look forward to your questions.

The Chair: Thank you, Mr. Matthews.

We go now to our questioning rounds. As noted before, we have agreed amongst all parties that we will do three full rounds.

Mr. Jeneroux, please go ahead for six minutes.

Mr. Matt Jeneroux: Thank you, Mr. Chair.

Thanks to the witnesses for coming.

The intent of this is to better support and advise the government on pandemics current and potentially in the future. I appreciate you taking the time out of your very busy schedules to show up today.

Ms. Eaton, I have a couple of questions with regard to seniors. You highlighted them in particular as part of your opening comments. We're seeing right now that we're immersed in technology here with Zoom and others like FaceTime. I know that not all seniors are immersed in those technologies. Facilities have closed their doors to outsiders to protect seniors, but the stories of neglect are on the rise in the country.

Do you think that allowing family members or a designated family member to occasionally visit, using all appropriate health protocols, would be beneficial for a senior's mental health during this time? If not now, do you think it's an area the government should prioritize when it starts executing plans to get back to the new normal?

● (1450)

Ms. Margaret Eaton: I'm not an expert in the management of long-term care homes, so it would be difficult for me to comment on that. I can say generally that isolation is something that drives anxiety and depression in everyone, but particularly in the older population.

One good thing that I believe is happening with CMHAs across the country is that they've turned their walk-in services to virtual and telephone services. The telephone is a much-maligned piece of technology that has suddenly a lot of relevance right now during COVID-19. I believe that by reaching out to seniors' homes through the telephone and providing telephone support to residents could make a real difference in decreasing that isolation.

Mr. Matt Jeneroux: Thank you. I certainly don't need for you to be an expert on long-term care facilities. I'm mostly just looking for your advice on the mental health aspect of these questions.

What tools and measures need to be available to support Canadians' mental health once isolation starts being lifted and Canadians start adapting to a new normal?

Ms. Margaret Eaton: I think it's very important that community resources be available.

I mentioned the BounceBack program. I think that has tremendous relevance. It's a program that is delivered online and on the telephone. You get a coach who helps you work through a cognitive behavioural therapy program. That program is being scaled in Ontario and scaled in British Columbia, but unfortunately, smaller provinces do not have access to those tools and resources. We see a strong role for the federal government to play to help create parity of access to those kinds of programs that would give people in rural, remote and isolated communities an opportunity to have training that would make a long-term difference in their mental health.

Mr. Matt Jeneroux: Great, thank you.

You're in Alberta. Text4Hope is a very popular service that's been used.

At the beginning, you also mentioned the anxieties that some of the front-line workers you've heard from have experienced. Would you agree, again from the mental health perspective, that a lack of PPE for our front-line workers has led to mental health struggles?

Ms. Margaret Eaton: I believe that not having the equipment they need to protect themselves is one of their larger areas of anxiety, as Dr. Liu mentioned as well. That does create more anxiety. Yes, I believe that protective equipment is important.

Certainly, once again, we want to be there to support front-line responders, especially with peer-based programs created by professionals who have walked that walk, the same walk as the front-line responders, and have created the programs and supports to address their needs.

Mr. Matt Jeneroux: Great.

Is the government working directly with the Canadian Mental Health Association to address some of this during the pandemic, from mid-January to the current date?

Ms. Margaret Eaton: We're very pleased that a partnership we have with CAMH and with Crisis Services Canada is going to be funded by the federal government. It hasn't been announced yet, but we're really delighted to have that support.

Mr. Matt Jeneroux: Do you know when that's planned to be announced?

Ms. Margaret Eaton: I don't know at this point.

Mr. Matt Jeneroux: It will be sometime during the current pandemic, I guess. Is that...?

Ms. Margaret Eaton: Yes, I think it's imminent.

Mr. Matt Jeneroux: Okay. I hope you'll keep the committee up to speed on when that is put in place.

On the resources put in place in December and January, prior to the pandemic, to support our front-line workers, what types of resources did we see from the government?

● (1455)

Ms. Margaret Eaton: I am not familiar with those resources to front-line workers.

Mr. Matt Jeneroux: I was under the assumption that there weren't any, so I think you've cleared that up for me. Thank you very much for that.

Thanks, Mr. Chair.

The Chair: Thank you, Mr. Jeneroux.

We'll go now to Dr. Powlowski.

Dr. Powlowski, please go ahead for six minutes.

Mr. Marcus Powlowski: Thank you.

Obviously I think for a lot of people, especially the health care workers, the hottest topic right now is PPE and specifically N95 masks and their availability.

My question is to Mr. Matthews and the procurement people. You've said that you've ordered 130 million N95 masks, but to date there has been delivery of only 609,000, I believe. Can you tell us when we're expecting to get more masks, and specifically N95 masks?

Mr. Bill Matthews: It's a multi-part answer.

The product is coming in every couple of days. A lot of it comes from China, so we have arranged for fairly regular flights to come from Shanghai into Canada as the product is ready. Now we're seeing a pretty steady flow of products coming out of our orders in China particularly. We've also had some recently come in from 3M. That would all go into the Public Health Agency of Canada distribution system for distribution to provinces and territories.

One of the other things I should flag is that this is in addition to the procurement the provinces and territories are doing on their own, some of which is N95 related. Some of the materials we're bringing back from overseas on the charters we have arranged are specifically for provinces and territories, where we have room. We're adding that into the mix as well, but that would obviously go directly to the province or territory that ordered it.

Mr. Marcus Powlowski: For the N95s, every couple of days there are hopefully more supplies in. How long does it take from the time it arrives in Ottawa or Toronto, or wherever it arrives, to get out to the various places?

Mr. Bill Matthews: The process would be as follows. There would be an inspection of the goods once they arrive in Canada at the Public Health Agency warehouse. There is actually some specific testing that happens for N95s. There is a quality check there. That process takes a couple of days. It then goes out to the provinces, so we're looking to accelerate that.

Then after that step, frankly, it's up to the provinces to decide where the need is the greatest, so that goes into their distribution system. I really can't give you a good line of sight into how the provinces allocate it.

Mr. Marcus Powlowski: I think The Globe and Mail said something about procurement being a Wild West in China, with a lot of actors all chasing the same thing. What can you do to reassure us that we Canadians aren't being the nice guys too much?

I've lived and worked in a lot of other different countries and I have this picture that must have happened to me of waiting faithfully in line for a bus to come, and as soon as the bus came, everyone crowded around and jammed through the door, and I kind of stood there and waited. By the second time, you obviously figure out that the only way you're going to get on that bus is to fight your way onto it.

I have this notion and worry that as Canadians, we're doing all the right things and we're playing by the rules in China, and we're getting outbid and outfought for what we need. Can you reassure the front-line health care workers that we're in there duking it out with everyone else?

Mr. Bill Matthews: Thank you, Mr. Chair.

I think we can talk about how the strategy in this area has changed since day one. I did mention in my opening remarks that this notion of putting in longer-term contracts with a variety of suppliers to ensure a steady stream of arrival of goods is important.

On the steps we've taken, I'll talk specifically about what's on the ground in China. Understanding the market is very critical. There were some changes in export rules, and you need to deal with people who understand what those rules are, so we did engage the embassy overseas to help us in vetting suppliers and relationships with suppliers and making sure they understood the rules for exports.

We also adjusted our logistics process to make sure that, basically, when the product comes out of the factory, we have people there to get it, so we are receiving it directly on the factory floor. We are handling the logistics to take it to a warehouse that we rented at the Shanghai airport. We then have some partners on the ground who help us get clearance, and we take care of the cargo arrangements to bring it back home to Canada. That's an example of the adjustments we're making.

The number of manufacturers we're dealing with is significant, so the final check, I would say, is when we bring it back to Canada. As we get more experience with some of these manufacturers, we're getting a better sense of who's producing high-quality goods and who's having some struggles, and we cycle that back to our folks on the ground in China so we can make whatever adjustments we need to make.

● (1500)

Mr. Marcus Powlowski: Thank you.

Another concern is being able to access some important medications, such as propofol, Midazolam and fenantyl, things that you need to sedate people or anaesthetic agents for people who are intubated, and there's a possible shortage of those things. Can you tell us what the government has been doing in order to procure those drugs and if we have any capacity within this country to start making them?

Mr. Bill Matthews: The government's approach to securing those goods is probably a better question for our colleagues from Health Canada and PHAC.

I can tell you that PSPC, as a purchaser of these kinds of drugs, has historically been a fairly small player. We do have some activity. It's one that we expect will ramp up in the near feature.

I think you've touched on a key question: In addition to procurement, what's the domestic capacity? I think time will tell on that front. I know Health Canada is preoccupied with these things, and I suspect it will be an area for heightened engagement as we go forward.

Mr. Marcus Powlowski: I have a quick question for Dr. Liu.

You've had a lot of experience working in epidemics in other countries. You talked about protecting the front-line health care workers and the anxiety related to not having enough PPE. What do you think about the use of what I understand are called PAPR suits, the kind of haz-mat suits with respirators that were used with Ebola? My understanding is that in places where they used those kinds of things, such as Italy, zero health care workers became sick. I understand that isn't being suggested as necessary by the provinces, the Public Health Agency of Canada or the WHO, but I think people who are working all day with COVID-19 patients would like to have them. What do you think about the possibility and the desirability of using them?

Dr. Joanne Liu: Thank you very much for the question.

I think there is a plus and minus. When I was in the Ebola centre, I must say that with my haz-mat suit in west Africa and the DRC, I felt almost safer than being in my ER in Montreal, because I knew I was protected and I knew that if I was doing the right thing, infection would not happen.

The thing is, we're not in this kind of environment. The downside of those kinds of haz-mat suits is that you are dehumanizing health care, and patients don't like it. People don't like to have cosmonauts take care of them. You cut the human factor out of caring, much more than if you only have a shield with an N95 mask and a sort of vest on top.

I think if we were to have a really dedicated structure, where people could work in a room temperature that would be, I would say, bearable for everybody, maybe this is something you could entertain, especially for the ICU, where there's a lot of aerosolized particles and you are much more at risk of being infected. I don't think I would do that for all the front-line workers; I think it would be a bit over the top.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

I'll now give the floor to Mr. Thériault, who has six minutes.

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

I want to thank all the witnesses for shedding light on this issue.

My question is for you, Dr. Liu. You have considerable first-hand experience in dealing with epidemics. I know that we're managing this situation and trying to get through the first wave. Nonetheless, I want to know your assessment of our ability to do our due diligence in this situation.

In other words, how could we have been better prepared to deal with this pandemic, when the largest source of infection in the world is south of our border—

● (1515)

[*English*]

The Chair: We are having some audio problems with the interpretation for Mr. Davies. Sorry about that.

We will suspend the meeting for a while.

● (1515)

_____(Pause)_____

● (1515)

We will resume the meeting.

Mr. Thériault, I will reset your clock. You were about 40 seconds in, but we'll start from scratch so that we have the full context of your remarks.

Go ahead.

[*Translation*]

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

For the benefit of my friend Mr. Davies, I'll start again.

Dr. Liu, you have considerable first-hand experience in dealing with epidemics. Before asking you some more specific questions, I want to express my sincere appreciation for your presentation and your proposals. Public health is probably the most policy-oriented field of medicine. We're talking about public health policy. Since the start of this pandemic, I've suspected that it sometimes stands in the way of what should be done.

I want to know your overall assessment. Only a month ago, the Canadian borders were still open, and Canada considered that its citizens faced a very low level of risk. We now know, a month later, that the United States is the largest source of infection in the world.

Perhaps in public health, we're facing a low level of risk. However, it's a matter of concept and vocabulary. There are still deaths.

What should we have done differently? How would you assess our preparation for the first wave? The second wave could be the deadliest.

● (1520)

Dr. Joanne Liu: Thank you for your question.

Yes, I have experience with epidemics and pandemics. However, this is really our first time facing a pandemic of this magnitude on a global scale.

Could Canada have been better prepared? I think that there were some clear signs. I'm not privy to this kind of discussion in Canada. However, I wonder what Canada did to prepare for the global public health emergency announced on January 30, 2020. This issue must be reviewed in due course, once we get through this difficult time.

During a global public health emergency, preparedness mechanisms must be set in motion and a major analysis must be conducted.

I've participated in simulation scenarios before. I know that these scenarios are often created in an abstract way, without taking into account the ecosystem in which the pandemic takes place. I don't think that anyone could have predicted that the entire world would be hunting down N95 masks and personal protective equipment. Everyone was caught off guard. I think that this will be a major lesson.

Regarding borders, I think that the question is excellent. However, you should know that the World Health Organization's recommendations did not include closing borders. We can ask the WHO questions about how it guided our response to the pandemic. I think that there was a certain amount of complacency in some respects. People fell asleep at the switch. How will we respond next time?

I won't point the finger at Mr. Matthews, the third witness. I'm sure that he doesn't sleep at night in order to find protective equipment for all staff in Canada. I think that it will take a much quicker push to get things moving, to respond in a clear manner, and to use the authorities that have experience.

We have a great deal of knowledge in Canada. Several international organizations established in Canada have taken action during epidemics and pandemics in other parts of the world. They can share their knowledge. I don't think that we've used these organizations very effectively.

Yes, I think that we're behind. However, there are some mitigating facts. The WHO didn't send the right messages to make people understand that the situation was dangerous and that they should be properly prepared. The WHO recommended that the borders be left open, and this can be called into question. During the Ebola epidemic, we were told not to close the borders and not to quarantine people. At this time, we've done a 180-degree turn by closing the borders. The key strategy to avoid a peak of cases, which would completely overwhelm our health care systems, is physical distancing.

I think that we could have been better prepared. However, I also think that we're on a very steep learning curve.

● (1525)

Mr. Luc Thériault: We're bound to face a second wave. We may get the economy moving again quickly. The economy will come under pressure. As long as there are no health measures, vaccines or personal protective equipment manufactured here in sufficient quantities to handle all this, I imagine that we should keep up the fight.

Dr. Joanne Liu: Absolutely. That's a very important point. The upcoming second wave is certainly keeping me up at night. Everyone's patting themselves on the back today because things could have been much worse. We're glad that we didn't experience a scenario like the one in Italy or New York. However, we mustn't rest on our laurels, because a second wave is quite possible. We don't know the level of immunity that people will have following the infection. You can look at the medical literature on this issue.

A few Chinese studies that have already been published show that some people didn't develop a significant increase in immunity following the infection. This raises some significant questions. Will part of the population really be immune? Are we counting on this to handle the second wave?

To answer Mr. Matthews' question, yes, we need tests, including serological tests. Having answers from a serological perspective will probably help us determine who we can put at the forefront. If a person had COVID-19 and developed an immune response, that person will be able to work and will be less anxious. We can use this staff to carry out the front-line work on a broader basis. This isn't the case today. These issues are significant. We must get back to normal and get things moving again. However, we must do so gradually, one step at a time.

If West Africa could live with Ebola for two years, I think that Canada can live with COVID-19. We just need to get organized and to continue to maintain people's trust in our government institutions.

That's your role. When we ask people to make sacrifices economically, emotionally, physically and socially, as we're doing today, we must maintain this relationship of trust. This has been very difficult in West Africa, the Democratic Republic of the Congo and Yemen. I hope that Canada will succeed.

Mr. Luc Thériault: I have something to say to Mr. Matthews—

[*English*]

The Chair: Thank you, Mr. Thériault.

We go now to Mr. Davies. You have six minutes, please.

Mr. Don Davies: Thank you.

My first question is to Public Works Canada. This week Health Canada announced that it has approved a new rapid COVID-19 test kit to be used in remote and indigenous communities. Chief public health officer Dr. Theresa Tam has indicated that the federal government is looking to secure a supply of 40,000 of these devices per month in the coming months and then see how that progresses in the supply rate.

Could you confirm when these testing kits will be made available to remote and indigenous communities, and let us know if you're confident that 40,000 units per month will be a sufficient supply to meet the testing needs in remote and indigenous communities?

● (1530)

Mr. Bill Matthews: The test the member referenced, which was also referenced earlier this week, is one that I referenced in my remarks about Spartan, an Ottawa-based company that has recently been awarded a contract. This is new technology. I have no comments or opinion on the volume of testing required, but this company is scaling up a new business line.

What is interesting about this test is that in a traditional test, a sample needs to be taken from the potential client and then sent to a lab for testing. That obviously takes time. If you're in a remote community, that takes more time, and that's time that people are not comfortable with.

This test that we're talking about specifically here comes with a unit that's almost.... We can think of it as a laboratory in a box. The unit would go with it, so you can do the test on site. It's not just the number of tests; you also need the unit to go with it. Obviously, because of that type of technology, it would be particularly attractive for remote and isolated communities.

Mr. Don Davies: If I might, sir, I understand what the test is. My question asked when the test kits will be delivered.

Mr. Bill Matthews: Again, we're starting up here. We're hoping to hit full production in July. There's a gradual ramp-up. Again, it's new technology, so we're working with them to get that up and running. We're all anxious to get that going. The delivery details are being worked out, but we're hoping they hit full production scale by July.

Mr. Don Davies: Dr. Liu, reports are emerging that COVID-19 is disproportionately impacting racialized communities in the United States. In Chicago, for example, more than half of all confirmed cases and 72% of recorded deaths have been among African Americans, who make up just 32% of the population of that city. Are we seeing similar disparities in Canada? You spoke of vulnerable communities. Do we even have the data to make that determination?

Dr. Joanne Liu: Thank you very much for the question. It's a very good question.

I don't think that we have that granularity yet in terms of information on racial backgrounds. The only thing we have is on elders being more hit than the rest of the population.

Mr. Don Davies: You spoke of the importance, in your view, of ensuring that our health care system doesn't become, to use your word, a "vector" of transmission. If I understood your evidence correctly, you were suggesting that we have separate COVID-19 health areas in our health facilities. If I have that correctly, can you give us an idea of how well we're meeting that advice? Is that what's happening in our health care facilities across our country?

Dr. Joanne Liu: I think that right now very few people have decided to go for a stand-alone COVID-dedicated facility. What people are trying to do now is have a better, I would say, hospital in a hospital, a sector of a hospital totally dedicated to COVID-19, and trying to have a closed circuit in that respect.

It's feasible, but it's very challenging. It's hard to make people understand that they can't go from one side to the other side. I think you could do that if people would be willing to have COVID-dedicated staff, meaning that there would be nurses, doctors and aid to the beneficiaries only for COVID-19, and we commit to testing them regularly. I think it's feasible, as long as we don't have a scenario like that of New York.

Mr. Don Davies: I'm just trying to get a sense. I understand your advice, but are we meeting that advice? Is that happening right now? Can you give us any indication of that?

Dr. Joanne Liu: No. I don't think so, not for all the hospitals I'm seeing. People don't know what it is to have a closed circuit. People haven't worked in an Ebola or cholera camp before, and they have no clue about what it really means. They think it's *pas grave*. It's not. You cannot do that. You cannot swap from one side to the other side. You need to completely undress. You should go wash and then move to the other side. There's this sort of laxity.

Mr. Don Davies: You mentioned seniors homes. We know that close to half of all COVID-19-related deaths in Canada are in seniors homes. In response, the federal government has recently published a series of non-binding guidelines to reduce the spread of infections in long-term care facilities.

This is a two-part question. In your view, should the implementation of these guidelines be mandatory, and are there any additional measures necessary to address the systemic problem that long-term care homes make viruses easily transmissible?

● (1535)

Dr. Joanne Liu: I'm very limited, because I don't know the guidelines. I've been working on the expert panel, but we haven't put in our recommendation. I don't know the specific guidelines you're talking about. I don't know what's in it and what it implies. I'm sorry to be limited in that respect.

In the long term, I think it is important that we.... Everybody is mentioning it, but it's true. If want to have our elders cared for properly, then we need to have the adequate number of staff, but this is not what seems to be happening right now. That's all I can say on that.

The Chair: Thank you, Mr. Davies.

That concludes our first round of questions. We start now with our second round of questions with Ms. Block.

Ms. Block, please go ahead. You have five minutes, please.

Mrs. Kelly Block: Thank you very much.

Thank you to all our witnesses for joining us today.

Thank you for the opportunity to join your committee. I really appreciate it.

Earlier today, the CBC ran a story about two million N95 masks and approximately 400,000 gloves that were thrown into a landfill last year when the national emergency strategic stockpile warehouse in Regina, Saskatchewan, was closed. The story goes on to state that the gloves and masks had been purchased in 2009, that they had expired in 2014 and were thrown away in 2019.

Before I ask my questions, I do understand that PSPC had nothing to do with that decision. The NESS is managed by the Public Health Agency of Canada. However, I do have some questions for PSPC.

Can you tell us how much PPE your department has purchased on behalf of PHAC or the NESS in the past 10 years?

Mr. Bill Matthews: In terms of the last 10 years, I cannot answer that, but I'm sure we can easily undertake to get back to the committee on that.

Before I say that, I should ask my colleagues if they happen to know. I suspect their answer is the same as mine.

Hearing silence, we'll get back to you.

Mrs. Kelly Block: Okay. Thank you for that. I look forward to receiving that written response.

Can you tell us then if PHAC or NESS has an inventory management plan of any kind? Are you aware of a management plan? As PSPC, would you be part of that plan because you are procuring these supplies?

Mr. Bill Matthews: There's clearly a link with what comes in. From a procurement perspective, it gets delivered to the Public Health Agency, as the member indicated. They would then have an intake process in terms of inspecting, counting and warehousing, all of those things, and then a process to allocate it out. I did mention in my opening remarks that obviously distribution is very critical in this environment. PHAC with our assistance has recently put in a contract with Amazon, supported by Canada Post and Purolator, to help with the warehousing and logistics. They have a sense of their inventory and where it is. Then they are leaning on experts in logistics to help them get it out to where it needs to go.

Mrs. Kelly Block: This may be the same question, just asked in a different way. I'm not sure.

Does PSPC have any regular or recurring requests for procurement by PHAC right now?

Mr. Bill Matthews: We have an ongoing dialogue with PHAC on orders. We received several larger orders from the Public Health Agency of Canada, which we are calling collaborative buys with provinces and territories. I think the most recent—and Arianne can correct me here—came on April 9. It's a big bulk order that they are looking to fill over a number of months. It has something like 80 million N95 respirators. They're not expecting to get that filled overnight, but it does speak to the long-term planning behind their ordering. There is an ongoing series of orders coming in, yes.

● (1540)

Mrs. Kelly Block: I recognize that they would have orders right now. Just prior to COVID-19 striking our country and the world, did PHAC have ongoing or regular recurring orders with PSPC?

Mr. Bill Matthews: We would place orders for the government writ large, so we have a number of departments, including PHAC, that we would have a regular dialogue with in terms of orders. I will turn to Arianne for a second to see if her memory is better than mine on pre-COVID orders, but I'd encourage you to think beyond PHAC. We have the Correctional Service, Canada Border Services, a range of federal clients that would be ordering these types of goods. They would not be in the quantity we're seeing now, but certainly we would have a range there.

Arianne, is there anything you want to add regarding pre-COVID orders from PHAC?

Ms. Arianne Reza (Assistant Deputy Minister, Procurement, Department of Public Works and Government Services): No, I don't think there's anything further. My knowledge of this starts on this in late January and goes on to March.

Mrs. Kelly Block: Thank you.

I'll turn my questions in another direction, but they're still for PSPC.

With so many companies retooling and repurposing to make PPE, have there been any discussions within the department about how federal government procurement can encourage long-term domestic manufacturing of PPE here at home?

Mr. Bill Matthews: Certainly there has, and as mentioned earlier, this involves a great deal of leadership from our colleagues at ISED, the Department of Industry, in assessing a company's ability to scale up quickly, because speed is important here, and then what their ability to participate as a long-term player is in the various fields?

You have a couple of scenarios here. One is a company that is retooling deliberately, temporarily, as part of the cause, and another where you have a company that's looking to start up an ongoing business line.

We have relationships we are pursuing right now with a company called Medicom, which I believe I mentioned, to become an ongoing manufacturer of N95 and surgical masks on a go-forward basis, because we think the domestic supply is important.

We've seen other examples where companies have retooled to start producing hand sanitizer. Is that a permanent switch or is that just something they are doing temporarily because it was a pretty easy handover for them to.... I don't want to overstate it, but they were able to repurpose very quickly. Do they plan on staying in that business or is this temporary? That's a discussion to have with them as time goes on.

However, there's an ongoing need for the N95 or surgical masks, absolutely.

The Chair: Thank you, Ms. Block

We'll go now to Ms. Sidhu for five minutes.

Please, go ahead.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses joining us today.

Mr. Matthews, I have come to know that one of the largest Amazon distribution centres is in my riding of Brampton South. As you mentioned in your statement, you have a contract with them. What are you doing to ensure that critical supplies of PPE get distributed in a timely manner where they are needed most, including indigenous communities?

Can you explain that?

Mr. Bill Matthews: Certainly, I can.

There are two basic pieces. They are very obvious, but these are important for people. There is the procurement itself, and then once the goods arrive there is the logistics solution to distribute them. The system we have in place is that the Public Health Agency is managing the distribution. They get the goods into their warehouse. Amazon is assisting them, with Canada Post and Purolator, to distribute to where it's needed.

There are a couple of scenarios. One is where we have done bulk ordering collaboratively with the provinces and territories. That stuff would move fairly quickly to the province or territory that ordered it. There's another scenario in place where a province or territory realizes it's running out of something urgently, a bit of an unforecasted demand. There is a process—and again this is drifting into our friends at the Public Health Agency of Canada's territory—where they have tables that get communications about urgent need, and they would take care of urgent deliveries in the most efficient way possible to meet that need.

The distribution is critical and that's why there was a recognition that bringing in some outside expertise—Amazon, Canada Post, Purolator—to help with that was absolutely essential. Equally important though is the collaboration that the health tables—federal, provincial, territorial—would have in ordering who needs what.

● (1545)

Ms. Sonia Sidhu: Thank you.

My next question is for the Canadian Mental Health Association. Some Canadians are already struggling with mental health issues, such as young people and indigenous communities. Two weeks ago I heard from the members of my own constituency's youth council.

Today we launched the new mental health portal with Minister Hajdu's announcement of Wellness Together Canada. My understanding is that Newfoundland and Labrador has had similar provincial support for years. How do you see this helping vulnerable Canadians especially youth and health care heroes, and how are you going to raise awareness to make sure that all Canadians benefit from it?

Ms. Margaret Eaton: We're very excited and pleased to see this national hub. As we understand it, the hub will provide tools and resources for everyone, but will have specific tools that will address particular communities, and it will also feature a crisis line. I believe we've already done some social media to promote it and we will be sharing it with our branches and divisions. We see that as one step in a process to support Canadians, and certainly in the short term it makes excellent sense.

We hope the government will consider adding on some services as well to support longer-term recovery.

Ms. Sonia Sidhu: I am saying that because there are seniors who don't know how to use the technology. What kinds of services are you providing for that, especially to ethnic communities if there are language barriers? Can you explain that?

Ms. Margaret Eaton: I know that some of our services, particularly in metropolitan areas, actually provide services for different language communities. They are translated into key community languages. I believe that's true in Vancouver and also in Toronto, to address those issues.

We also know that one of the big issues for immigrants in particular is stigma around mental health. In addition to having those services, it's also really important that we promote those services to those communities and ensure that they feel welcome there.

Ms. Sonia Sidhu: Especially for our health care heroes who are on the front lines working now, is there any special arrangement for them?

Ms. Margaret Eaton: We have two programs that I mentioned, OSI-CAN and Resilient Minds, both of which are suitable for front-line workers and could be expanded to serve more clients.

The Chair: Thank you, Ms. Sidhu.

We'll carry on now with Dr. Kitchen.

Dr. Kitchen, please go ahead. You have five minutes.

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

Thank you, everybody, for being here. I greatly appreciate your taking the time to come to the meeting and do this video conferencing.

Dr. Liu, I really appreciate your comments. Mr. Davies touched on one of the questions I wanted to ask you.

We've talked about the issue of protecting our dedicated staff as well as dedicated facilities. I can tell you that here in Saskatchewan we have gone to certain hospitals throughout the province that are being designated as specific COVID-based hospitals. Other hospitals are picking up emergent and acute care types of situations, just so you're aware of that.

Your comments lead into my questioning a little bit more about testing and the issue of immunity testing, and whether you see that as something we should be doing at this present time with our present-day health care workers, those people who are on the front lines as they move forward. They want to get there. They want to be out there, whether it is in the hospitals or whether it's in our long-term care facilities, where they want to make certain that they're protected when they go in to assist the clients they care for.

Could I just have your comments on that, please?

● (1550)

Dr. Joanne Liu: In terms of testing, it's hard to make a strategy when you have scarce resources, but this should be a priority with regard to who can be tested, and I don't think it is clear yet.

I think this should be a recommendation for workers, because right now to be tested you need to have some symptoms. Now it is much broader than it used to be, but it needs to be much.... Now we have included the GI symptoms and the respiratory symptoms and you need to have only one symptom.

We know there are asymptomatic carriers, so this is why I think that when we are able to afford it, testing our health care workers or front-line workers, which would include those who work in pharmacies as well as other places like elder care homes, should be a priority.

This is something we are doing in some places. I think that in places like first nations areas, where we know we have a vulnerable community, we don't want to import COVID-19, so we should be testing. For example, when we have people from Montreal going back to Nunavut, if we just ask them whether they have symptoms, honestly I think that people who are dying to go back to their community are not going to share exactly what's going on, so I think we should just test people.

Mr. Robert Kitchen: Thank you very much for that.

Mr. Matthews, I appreciate your earlier comments. I recognize that you're in the process of procurement. How much interaction do you have with PHAC in their simulation models as they simulate a scenario? Does PHAC communicate with you as to what they might anticipate from that, such as where there might be a shortage or how they need access to certain PPE-type equipment? Is that part of the process at all?

Mr. Bill Matthews: It's part of the outcome. They run their models and then they place orders. As I mentioned earlier, some of those orders are very large. The orders they place with us would be the outcome of their planning. I mentioned that the last one we received was, I believe, for 80 million masks over a long period of time.

That would be the interaction. We wouldn't actually—

Mr. Robert Kitchen: It's after the fact, then. It's not during the process. They say, “This is our scenario. All of a sudden we're anticipating a need for 100,000 masks and we need them from you”, and they ask you how quickly you can access them.

Mr. Bill Matthews: We certainly have an ongoing discussion about supply lines and the time it takes. We're very well plugged in to our plans around domestic capacity with ISED and how long it might take for that to come online.

I think it's twofold. One is the long-term orders. Then, as I mentioned earlier, if any kind of immediate, unforecast urgency pops up in a province or territory, they will get on the phone with us urgently to say, “Can you get us something ASAP?” We have that one as well.

Mr. Robert Kitchen: You mentioned a lot about challenging times and how challenging it is for you to access equipment. In a number of situations that I've seen and that I'm sure my colleagues have seen, someone may be trying to improve a respirator, for example, by coming up with a product that might use one ventilator to create something that's able to deal with two or three types of issues. Those issues obviously have to be recognized and standardized, but it's a challenge for you.

At the finance committee meeting on Friday, April 3, there was a gentleman by the name of Mr. Veso Sobot. He said, “At a time when the government is appealing to the manufacturers to retool and produce needed plastic products for the health care sector”—masks, ventilators, hoses, IV bags, IV tubing, PPEs, like plastic shields—“labelling plastics as toxic is counterproductive”. He said it “disparages and demonizes” the Canadian plastics industry, which has worked very hard to alleviate the effects of the COVID-19 crisis.

Using plastic items such as these is necessary in treating a lot of those suffering from COVID-19. If we anticipate that the crisis is going to carry on for who knows how long, and we deem these plastics basically as schedule 1 toxic substances, does PSPC see this potentially having a negative impact on the procurement of medical devices and PPE with respect to COVID-19?

● (1555)

Mr. Bill Matthews: I can only speak to my experience in dealing with existing Canadian suppliers, as well as those looking to emerge into the markets. It has not been something that has been raised with me one bit, and that's both through interaction on our website in looking for supply as well as in our interactions with ISED in terms of tooling up the domestic industry. It has not come on my radar at all, although obviously others are hearing about it.

The supply chains for some of these products clearly involve plastic. It's an important component in what's being manufactured. Has the issue been raised with me as a barrier? Not to date.

The Chair: Thank you, Dr. Kitchen.

We go now to Mr. Van Bynen.

Mr. Van Bynen, please go ahead for five minutes.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

Last month the town of Newmarket launched a #StandApartTogether campaign, announcing a group of 10 community positivity ambassadors to spread stories about people doing good things and to spread positivity during these difficult times.

Also, both the Newmarket Chamber of Commerce and the Aurora Chamber of Commerce are providing their members with regular opportunities to check in on one another and stay connected, and to share best practices through virtual coffee conversations and virtual networking events.

My question is for the Canadian Mental Health Association. I'm wondering if you've seen many of these local activities surface to keep people connected, and what your thoughts are on their role in preserving mental health in our communities.

Ms. Margaret Eaton: We've been so pleased with responses across the country and the Canadian idea of caremongering, and there are wonderful Facebook groups across the country doing that.

One of our branches, the Quebec division in Quebec City, has set up a secure group chat for eight people at a time to talk about their issues, and we're seeing similar movements across the country. I think it's invaluable. I love walking around my neighbourhood and seeing signs that say, “We're in this together.” I think a lot of people expect there to be social decay when a pandemic happens, but in fact the opposite is true. We see social cohesion, and that is incredibly important for all of our mental health.

Mr. Tony Van Bynen: Are there any of these types of efforts in particular that stand out to you? If so, could you briefly share them with the committee?

Ms. Margaret Eaton: I mentioned our one Quebec group. There have certainly been these Facebook groups with people who are providing care and going out and shopping for people.

What we've seen from CMHAs is that some of them are actually keeping their doors open. Even though the general advice here in Ontario, for example, is to shut your doors, some of them have said, no, they have to be open for walk-in clients. They take precautions, but they are still aware and keeping the doors open because they feel that mental health should have a front-line response and they are front-line responders for people with mental health challenges.

Mr. Tony Van Bynen: I'm curious about the precautions you mentioned. We've seen so much misinformation on the Internet about COVID-19. What are your recommendations for people seeking out some of these chat groups or even virtual counselling? How can they be satisfied they're getting the types of credentials they're looking for?

Ms. Margaret Eaton: I think of programs that the CMHA runs, for example. The CMHA is often the first stop for people searching for mental health resources in their community.

As to looking for certifications, we offer a peer support certification. There are also other certifications. Certainly the Canadian Psychological Association and other registered professions have the credentials to provide you with the supports you need.

There is a lot of online information as well. I would turn to the new government application. That actually has evidenced-based tools and resources that can be used.

● (1600)

Mr. Tony Van Bynen: Great. Thank you.

Dr. Liu, since you started with Doctors Without Borders, the world has lived through a number of pandemics. To name a few, there was SARS, MERS, Ebola, H1N1 and Zika. Can you elaborate on how Doctors Without Borders contributes to the international response in a pandemic?

Dr. Joanne Liu: Doctors Without Borders is an organization with an operational budget of 1.6 billion euros. It works in 72 countries, and 55% of our countries of intervention are in conflict zones. We have about 68,000 people working for the organization.

In terms of the response to a pandemic, we answer epidemics all year long. The smallest one is the measles, which nobody hears about, or polio or cholera. We do it over and over again.

When it comes to the big pandemics, most of the time we have much more of a focus on low- and middle-income countries or those in protective crises, because that is where there are more needs. The reality now with COVID-19 is that we are deployed in high-income countries. For example, in Italy we are running four hospitals. In France, we are doing all the home care with the government in Île-de-France. We work in Germany. We work in Spain. We work in Greece. We will probably increase our budget in high-income countries by easily tenfold from what we have had in the past.

This is something very different, and it's probably linked to the fact that there are travel bans. It's probably also linked to the fact that we have an expertise to offer in terms of pandemic response, because most of our staff have worked at tackling epidemics in different countries. We work almost everywhere that we have an office.

Right now in Canada, MSF Canada will be working on infection prevention control in elder homes and first nations communities.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

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

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

Dr. Liu, you rightly pointed out earlier, at the end of your presentation, that patients who don't have COVID-19 and who are waiting for health care shouldn't be neglected.

We know that the authorities, when faced with a weakened health care system lacking all kinds of resources, decided to free up beds to ensure that intensive care units had room to handle the peak of the first wave. There may be a second wave, which could require even more intensive care should the mortality rate increase.

How long will it take to adapt to the situation? In all likelihood, some operations are being delayed.

How long will it take to restore balance so that we don't hit a wall in the medium term?

Dr. Joanne Liu: Thank you for your question.

Certainly patients who don't have COVID-19 are becoming second-class patients. This effect has been demonstrated in almost all epidemics. There are many examples of this effect in West Africa. The people who experienced a decline in health or who died from a disease other than Ebola likely outnumbered the people who had Ebola.

Therefore, we must resume medical activities for patients who don't have COVID-19, including outpatient and inpatient services. This is where the idea of having hospitals for patients who test positive for COVID-19 and other hospitals for patients who test negative makes all the difference.

Patients who go to the hospital to receive treatment for cystic fibrosis wouldn't be exposed to COVID-19. They wouldn't be putting themselves at risk. For me, this is important. I'm telling everyone that we must start planning for the recovery period now and that we must learn to live with COVID-19.

We must consider the research capacity when the second wave will hit. We'll need to be innovative. We'll need to reorganize the tasks of the different medical communities. We'll probably need to ask residents and our medical students to work at a higher level.

We really must consider this. I suspect that not many plans are being made in this area today. We can't keep a health care system on hold forever. There would be collateral damage and avoidable situations that could have been prevented, such as the fact that patients' health would decline.

If you must emphasize one thing, that would be it.

● (1605)

Mr. Luc Thériault: So if we allocated—

The Chair: Your time is up, Mr. Thériault.

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

The Chair: Thank you.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, you have two and a half minutes, please.

Mr. Don Davies: Mr. Matthews, on April 10, 2020, the Toronto Star reported that a shipment of more than 100,000 testing swabs that had recently arrived in Ontario were contaminated and unusable. That shipment was the first shipment of an order procured by the federal government with hundreds of thousands more from the contaminated batch on the way. I'm curious. How is it possible that the federal government procured hundreds of thousands of contaminated swabs? What quality control measures are put in place for a federal medical supply procurement, and if we have them in place, why did they fail in that particular case?

Mr. Bill Matthews: There are a couple of aspects to this. It's quite accurate in terms of the quantity that was received and deemed unusable. I'll come back to that in a moment. There is a long-term order in place with a well-known supplier, a provider of swabs. That is a key order for us in terms of ongoing fulfillment.

I did mention in my opening remarks that supply chains are strained and new players are coming on. You have factories that are ramping up. Any time factories add capacity it comes with risk. In this case, the supplier had recognized in a subsequent shipment that they had a quality issue so they recalled that, but these ones were obviously not caught in time.

Subsequent to that, we have been working with our lab to see if those swabs can be sterilized so they could actually be put back in the system for use. We are working on that angle as well. The issue around quality control depends on the piece of equipment. Swabs in this case are typically not a problem—a known supplier in this case—but it is a strained market, so for other types of goods that we procure there is an ongoing, active test on every piece that comes in to check for quality. Obviously on swabs we have changed our quality control measures, as has the supplier in this case. It put us in a bit of a scramble in the short term, but we're optimistic that they have rectified it going forward.

Mr. Don Davies: Thank you.

Ms. Eaton, Health Canada estimates that 11 million Canadians will access online mental health services. About two million Canadians are going to need one-on-one support—short-term therapy of two to four sessions per week—to get over the crisis, as has been estimated by Health Canada.

How are we ensuring that these two million Canadians, who, I would presume, have among the most acute mental health needs, are going to receive this one-on-one support?

● (1610)

Ms. Margaret Eaton: I believe that part of what the government has announced is that there will be a care provider that will be following up with those two million Canadians. They are going to be providing that short-term psychotherapy for those Canadians. I believe that is a generous estimate, but we really don't know what that impact will be. Frankly, that is short-term support. We actually believe that more Canadians are going to need something, not just something for the first four months of this planned intervention but longer. We don't know who those people will be at this point or exactly what their needs will be.

That is one of the great unknowns. How do we make sure we have the capacity to ramp up to serve all of the needs that are coming? That is why we are seeking support from the federal government to ensure that longer term needs are met.

The Chair: Thank you, Mr. Davies.

That wraps up the second round. We start now on the third round with Mr. Webber.

Mr. Webber, please go ahead. You have five minutes.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

I thank everyone for being here today. I'm going to address my two and half minutes of questioning to Margaret Eaton of the Canadian Mental Health Association.

Ms. Eaton, thank you very much. I really enjoyed your presentation today. Your mandate of mental health for all is wonderful. It would be a dream come true if we can achieve that mandate, because currently I truly believe that Canada severely lacks the capacity for mental health services, in particular in our addictions environment.

Ms. Eaton, you talked about your association and the help out there. It's far-reaching, 86 divisions and branches throughout Canada, 5,000 staff and 10,000 volunteers, reaching 330 communities. Your phones are currently ringing off the hook right now. Your demand has surged from 25 a day to 700 a day, as you mentioned.

My first question is that, of course, the 5,000 staff would be highly trained in dealing with these calls, but you mentioned 10,000 volunteers. What type of training do they have? Do they actually do the counselling in order to help someone who is perhaps at risk of suicidal tendencies? Can you talk a little more about the training of these people?

Ms. Margaret Eaton: Yes. The volunteers spread out across the country would have a variety of roles. Some might be people helping out in office work, but some are peer support workers. They are volunteers, oftentimes people with lived experience of mental illness, who have received training through their branch to provide support. Some of them would be in crisis response, but not necessarily suicide response. That would be a higher level of training, which some of them would have received.

The services are quite different across the country. Depending on the kinds of crisis lines and the kinds of support that are being provided, there would be various types of involvement.

There would also be paid staff answering phones as well. What a lot of CMHAs have had to do across the country to respond to this surge issue is set up extra lines and fortify the systems underneath these telephone lines to be able to actually deal with these phone calls. They were repurposing staff who would have been running programs or doing other work to get them on the phone to handle the triage level of support for people right now.

Mr. Len Webber: Excellent.

Like many others, I have shared phone numbers, such as the 811 number for the Alberta Health Link here in Alberta, and also the mental health hotline. In fact, this morning I called both in order to see how long I had to wait for assistance. I am pleased to report that in Alberta I was able to access both lines and to get somebody on the line immediately. I apologized to them. I didn't want to waste their time, so I just said, “I'm sorry. I'm okay.”

Anyway, I'm just wondering how other provinces are doing. Are people throughout the country able to get access as quickly as I was? You said that there's a vast difference depending on where you are.

● (1615)

Ms. Margaret Eaton: Yes. P.E.I., for example, has had to establish some new crisis call lines. They didn't have crisis lines they could turn to, so CMHA P.E.I. is expanding its services. Woodstock has found that its calls are up 50%, so they are repurposing staff there. Moose Jaw has also opened up a new crisis line. People are either upgrading what they have or repurposing people or adding new crisis lines in order to deal with the demand.

I think there was an initial surge in the first couple of weeks. From what I understand, it has died down a little bit, but I've been struck by the discussion this afternoon about the second wave. We do know these things come in waves, in surges. We are concerned about having enough support to provide meaningful care for people beyond a brief phone call and to be able to deliver services virtually.

A lot of the programs that people are used to going to, such as group recovery programs, one-on-one counselling or drop-in centres, have all been taken away. We've had to act very quickly to try to virtualize our services, if you will. We'll need some more support to do that and meet the demand.

Mr. Len Webber: Well, thank you for what you do. I assume my two and a half minutes are up. If not, I will ask this one quickly, Mr. Chair.

It's regarding other countries. They are weeks ahead of us, of course, in dealing with this pandemic. When it comes to mental health issues, are we able to learn from the experiences of these other countries, in particular in mental health?

Ms. Margaret Eaton: That is a wonderful question. I've been reaching out to some international colleagues and have been trying to get that information. It has been very hard to get in touch with people. I would love to come back to the committee with more of an update on what's happening around the world as people respond. Thank you for that.

The Chair: Thank you, Mr. Webber. By the way, it was five minutes, not two and a half.

We go now to Mr. Fisher. Mr. Fisher, you have five minutes, please.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Mr. Chair. As usual, I want to thank all of our witnesses today and all of our technical staff for being here and putting up with us for two or three hours a day.

Dr. Liu, this is a quote from your Globe and Mail story:

> Our health-care workers are our best and last line of defence in a pandemic. For their sake and ours, we need to protect their physical and mental health.

I thank you for that quote. I couldn't agree more. There is no doubt that the COVID-19 pandemic is creating mental health challenges for our front-line health care workers.

I think about how health care professionals need to think about their own mental and physical health. They need to think about their patients. They need to also think about their families back home, and I think this gets lost a little bit. Many I hear about are self-isolating from their families to protect not only themselves and their patients but also their families.

Dr. Liu, what measures should we implement to better protect the well-being of our health care workers during the pandemic, and what do we perhaps do afterward?

Dr. Joanne Liu: In terms of how to better protect them, I think that health care workers.... We already discussed the physical protection, and I know that Mr. Matthews is working on this. I think he heard the call and the plea.

In terms of protecting them in their environment, I think we haven't given enough guidance to health care workers on what to do about their families and haven't given them assistance if they want to isolate themselves elsewhere than their homes. As I've been suggesting, something we could decide to do is offer that you can go to a hotel, if you have an intergenerational house, not to risk infecting your mother who is 75 years old. But these things are not really enacted. I think there has been some initiative in different places, but there's no real guidance about that. I think this should be offered, because this is one of the things we always did at MSF. With Ebola, which I know is different, everybody was put up in a hotel. Everybody had their room, and everybody was isolated.

The reality of why I'm insisting on this is that we don't want them to infect their families, and the other way around: We don't want them to be infected by their families. If they were to be infected by their families, even if they were to only get a cold, they would be tested. When you get tested, most of the time you're put aside for 24 to 48 hours until you get the result of your test. If you get infected, then you're out for two weeks or even more, depending on how you pull through the event.

So there's the physical protection and the mental health protection, and I don't think there's enough of what we call *groupe de parole*, people to vent and speak to in different hospitals. I think mental health people from hospitals should be available for their staff as well, for all the staff. l don't think this is really happening right now in many facilities. I know there's a hotline you can call, but I think people would also like to be able to share in small groups in their hospitals.

In terms of other extra protection that nobody is addressing, the fact that.... People are putting their lives on the line, and what are we ready to do if they get infected and the outcome is death? Are we ready as a country to take responsibility for people who have put their lives at risk and made the ultimate sacrifice? Right now I haven't seen much conversation on that. I know that when SARS happened in Ontario it was addressed, but I don't think there were real conversations on that, unless I am mistaken. I haven't been told of anything like this.

I think the long term is going to be important. I'm not an expert on this; I think Ms. Eaton is much more than I am. Most of the time people can pull through the acute phase, but PTSD comes two or three months after. This is my experience at MSF. What are we doing to prevent that? l think we should be much more proactive to make sure that this will not happen.

Thank you very much.

● (1620)

Mr. Darren Fisher: Mr. Chair, do I still have time?

The Chair: No, you're slightly over.

Mr. Darren Fisher: Thank you, Dr. Liu.

The Chair: Thank you, Mr. Fisher.

We will go now to Mrs. Jansen.

Mrs. Jansen, you have five minutes, please.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): Thank you.

Thank you to everybody for coming out to this meeting today.

My first question is for Dr. Eaton. I heard a really morbid story about two farmers who are currently facing bankruptcy. They were discussing how they could make their suicides look like something else so that their wives would be able to get their life insurance. Then I heard the Prime Minister announce that restrictions will not be lifted until there is a vaccine available. My heart sank, because there are many people facing such an incredibly dark moment right now. It seems as though the message that we need to wait for a vaccine might be the straw that breaks the camel's back.

Do you think this sort of messaging poses a danger to those struggling with the current restrictions, the idea that there's really no light at the end of the tunnel? I don't think they're going to phone a hotline either, as Dr. Liu mentioned.

Ms. Margaret Eaton: Right. It is a dark time for many people. I think that is one of the things that are most difficult: We don't know when it will end. That is one thing that really contributes to people's anxiety right now, and there can be that feeling of hopelessness. I'm so sorry to hear about the two farmers.

Mrs. Tamara Jansen: Do you think the government could come with more of a light-at-the-end-of-the-tunnel type of message than what we are getting right now?

Ms. Margaret Eaton: It's interesting. I believe there has to be a balanced response. You have to say that you don't know what the end might be, but at the same time reassure people that we will get through it, and that we will get through it together. I think that's the balance.

● (1625)

Mrs. Tamara Jansen: Okay. Thank you. I appreciate that.

My next question is for Mr. Matthews.

You said a few things that I found very interesting. In my previous life, I was involved in overseas procurement. One thing we always had was boots on the ground wherever we were getting our product during manufacturing times, especially because, as you can tell, when demand is high, sometimes it shifts to a factory that you're not aware of, even though you're working with a known factory.

I'm just wondering why PSPC would not have its own boots on the ground. Why would you leave that in the hands of the manufacturers? Otherwise, you wait until it gets here in Canada to find out that something has gone wrong.

Mr. Bill Matthews: I think it's a bit of a mixed answer, Mr. Chair.

PSPC is largely based in Canada. In our traditional procurement, we would be dealing with a Canadian supplier, who would be our interface with the manufacturer. As the member notes, she has a background in procurement, and in times of high demand you have to take a different approach.

The approach that we have used in terms of boots on the ground is to work with our embassy, number one. We do have people on the ground in China, and they—

Mrs. Tamara Jansen: Are they health care professionals? Will they understand the level of quality that you're looking for?

Can they go to those factories and actually look as it's being manufactured and do the checks there, rather than doing them here in Canada?

Mr. Bill Matthews: Partly, yes. We have the embassy, but then we supplement that with some third party expertise, people who do have that kind of expertise.

On the ground in China, we are doing a few forms of vetting. Number one is vetting the company, the manufacturing facility itself, just in general. Understanding which manufacturers in China are able to export easily and which ones are not, as well as which ones produce medical-grade products, is very important.

Then we have made some adjustments on the fly, as I mentioned, to actually receive products on the ground. There's a quick inspection done in most cases. For some types of equipment, and N95 masks are a great example, you actually need a machine to do a test—

Mrs. Tamara Jansen: Can you bring that machine to the factory, or can that test only be done in Canada?

We would often get samples, and then we'd check the samples.

Mr. Bill Matthews: We are doing the testing in Canada now. When we started, we were doing it elsewhere. The testing is done in Canada. We are testing batches, so—

Mrs. Tamara Jansen: It's not in China, then.

Mr. Bill Matthews: Mr. Chair, the testing of the N95 masks is not being done in China right now. We are looking at ways to accelerate the testing to improve quality, but the feedback that we—

Mrs. Tamara Jansen: I'm sorry. I do have one more question. I want to get that in during my five minutes. Sorry.

My other question is in regard to what you said about having ongoing orders year after year. Back in the day, when I was doing sales, we would always do a year-to-year comparison. Of course, in the private sector, if you lose a sale, it doesn't look good on the bottom line. Do you guys have something in place for checking your year?

I realize there's no monetary reward for making sure that everybody is buying what they need, but you would maybe have noticed that some orders were being missed if you had that kind of year-to-year comparison, or perhaps a five-year comparison.

Mr. Bill Matthews: I think that given the circumstances we're in right now, Mr. Chair, year-to-year is.... I don't want to say it's meaningless, but we are in a world where the volume is very far above what we're used to. We're dealing with companies that we've never had to deal with before, so—

Mrs. Tamara Jansen: Right, right, exactly, but in the job that I used to do, you would always kind of look to where the sales had been in the past so that you could ensure that those people who did have stockpiles would be actually maintaining those as things were beginning to expire, just to maximize what's out there.

Mr. Bill Matthews: Obviously, vendors' performance and track records are very important to us, so we did reach out to the existing relationships we had and grab things off the shelves. Performance is critical.

Maybe I'll stop there, Mr. Chair.

The Chair: Thank you, Mrs. Jansen.

[*Translation*]

Mr. Thériault, it's your turn again. You have two and a half minutes.

[*English*]

Ms. Helena Jaczek (Markham—Stouffville, Lib.): Excuse me, Chair, but am I not next on the rotation?

The Chair: I apologize.

Dr. Jaczek, it is to you. You have five minutes. Go ahead.

Ms. Helena Jaczek: Thank you, Chair.

I want to thank all the witnesses we've heard from today. Perhaps, at this rather depressing time in Ontario with the peak of the first wave, hearing from CMHA and Ms. Eaton has been particularly important.

I'm going to take a leaf out of my colleague Tony Van Bynen's book to perhaps inject a little optimism. To quote Harriet Beecher Stowe, “Never give up, for that is just the place and time that the tide will turn.” Hopefully people will be able to see some light at the end of the tunnel.

Thank you so much to CMHA for all you've been doing, and with the new health web portal that was announced by Minister Hajdu today, of course we know you're going to continue to do some very good work.

My question is for Dr. Liu. Dr. Liu, at this committee we've been hearing quite a bit about the role of the federal government vis-à-vis the provinces, which of course have a major role in health care delivery in our country, and even the role of local health authorities. The federal government has been issuing national guidelines on a number of different subjects related to the use of PPE and also on care in long-term care facilities, which were issued by the Minister of Seniors federally.

I'd like your opinion on how the current situation is working in terms of what we hope is a very collaborative approach. Do you see the need for, perhaps, the federal level to go beyond guidelines in a pandemic situation?

● (1630)

Dr. Joanne Liu: It's a tricky question and it's a good question. I think we've been facing that regularly, but not to this extent. To a certain extent, to make it short, I think in times of a pandemic, when everybody is facing scarcity of resources, there should be an enhanced role for the government at the federal level because it has the helicopter view. Everybody else has the provincial view. I think there is some real added value in that respect.

For example, if you look at the supply of ventilators, the expert panel will say, “We have this many ventilators.” How are we going to redistribute the extra 50,000 ventilators that the federal government has? Who has the helicopter view? It's more at the federal level than at the provincial level. It can try to make an equitable redistribution that responds to needs.

There is also, it seems, this thing about “every man for himself", but we need to accept that there might be some places.... If we were to have a scenario like New York's in, let's say, Quebec, I would hope that people chip in. We've seen it recently, when we got help from the west.

This needs to happen, with an enhanced role for the federal government. If they always have this helicopter view and then help with the redistribution in a collegial way, it might be helpful. I know that is a very slippery slope, knowing that most of what is happening is at the provincial level.

Ms. Helena Jaczek: You've mentioned provision of personal protective equipment. Are there other areas? There have been suggestions that data collection has been varied and people are not using the same methodology in terms of use of tests. Even you mentioned in your opening statement that health care workers should be tested on a regular basis if they're working with COVID-19 patients.

Do you see other areas beyond PPE where there should be an enhanced role for the federal government during a pandemic?

Dr. Joanne Liu: I think it's largely about resources and making sure that if we are facing adversity as a country, we can also come together as a country to help each other and to enact it when it happens. It should be as well in terms of human resources and competencies, and yes, we should have harmonization of data collection and have the same definitions for things. For me, there is a real role for harmonization in how we do things, without being a dictatorship. It should happen, because if we could speak the same language, we would therefore get a much clearer view of what is going on across the country to help each other.

I do hope that solidarity will kick in between provinces and territories.

● (1635)

The Chair: Thank you, doctor.

[*Translation*]

It's now Mrs. Vignola's turn.

Mrs. Vignola, you have two and a half minutes.

Mrs. Julie Vignola (Beauport—Limoilou, BQ): I have a question for Mr. Matthews. I also have some questions for Ms. Liu and Ms. Eaton, but I have only two and a half minutes.

You said that you purchase disinfectants from Fluid Energy Group. Where exactly do the disinfectants used by this company come from? Does the company manufacture the disinfectants itself or does it purchase them from somewhere else?

Mr. Bill Matthews: Thank you for your question.

In the case of Fluid Energy Group, the company manufactured the hand sanitizer itself.

Mrs. Julie Vignola: Okay. I know that a number of distilleries, in both Quebec and Canada, have changed their production to manufacture various disinfectants. Therefore, I wanted to know whether these companies were supplying Fluid Energy Group.

I know about the global shortage of reagents for testing. I'm wondering about the type of reagent, whether an alternative reagent exists that's as good, safe and reliable in terms of results, and whether we can produce it ourselves. Do we have the necessary infrastructure to do so?

[*English*]

Mr. Bill Matthews: Thank you for the question. I am going to have to respond to this one in English. It's a little technical for me.

Reagent is a chemical necessary for the traditional testing. The main source has been from one company in the past, and there's a global shortage, as the member mentioned, Mr. Chair, so we are now using companies in Canada to manufacture reagent to fill the gap, and that comes with its own challenges. There is a certain kind of chemical called guanidine, which is a little challenging to procure, but we have some already and we're buying more, so we are well on our way to making reagent in Canada to fill in the gap because of the global shortage.

The Chair: I have lost the interpretation for Ms. Vignola.

How is everyone else doing?

Ms. Vignola, would you check your microphone, please? Something changed, because when you started, you were perfectly okay. Can you make sure you're speaking into your microphone? I see you have a headset. Try that. There is nothing.

Let us suspend briefly while we sort this out, please—

[*Translation*]

Mrs. Julie Vignola: Can you hear me now?

[*English*]

The Chair: All right, everyone can hear Ms. Vignola. The meeting shall continue. Thank you.

Ms. Vignola, please start your question again.

[*Translation*]

Mrs. Julie Vignola: Ms. Liu and Ms. Eaton, at the start of your testimony, I heard a cry of alarm, a cry for help. What can Canada, the territories, Quebec and the other provinces do to ease your tension? To be able to take care of others, you must first take care of yourself.

My question mainly concerns front-line workers, because they too must feel safe to be able to properly help others. What concrete steps can we take to help them?

● (1640)

[*English*]

Ms. Margaret Eaton: How do we help each other? I think it's very important to think about the landscape of mental health in Canada. We know that mental health has not been funded to the same extent that physical health has been, that there isn't parity. The Mental Health Commission of Canada recommends that 9% of the health budget go towards mental health, and currently it's only about 7%. While there have been big increases from the federal government in the last few years, we're feeling the pinch from that. More and more Canadians are identifying that anxiety and depression are at almost pandemic levels among Canadians, so adding the additional pressure of the pandemic has increased those needs manifold.

We are sounding the alarm that more needs to be done. There needs to be more of an investment at all levels of mental health to ensure that the gaps that already exist can be closed and new needs can be met.

I urge the government to think about keeping in touch. Please speak with your key partners, like CMHA, to help us help you, as we go through this pandemic together, to look for the kinds of reactions that we will have to make investments for. There are choices we're going to have to make over the next year or the next two years, potentially.

[*Translation*]

The Chair: Thank you, Mrs. Vignola.

[*English*]

We will now go to Mr. Davies for two and a half minutes, please.

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

Mr. Matthews, about two months ago, members from all parties on this committee expressed grave concerns about the number of ventilators in Canada. At that time, we estimated that we had about 5,000 ventilators across the country. Of course, we were all struck by the tragic images of doctors in Italy and other places having to make terrible decisions about which patient got access to a ventilator. I'm grateful to hear in your statement that orders have been placed for more than 30,000 ventilators from various companies, including some Canadian ones.

We expressed concerns about this a couple of months ago. I'm wondering if you can give us a timeline—at least be as specific as you can—for when those ventilators might be received and put to use in Canada.

Mr. Bill Matthews: The member has touched on a very important issue in his question.

Ventilators are in short supply worldwide. They're not sitting around on shelves. We are going to see ventilators start arriving in small numbers in the next couple of weeks, and this will ramp up through May.

I think the key to the Canadian strategy on ventilators is the domestic capacity. We've recently put in place three contracts with three different companies in Canada—one's a consortium—to build 10,000 ventilators each. This is a speed buy. We want them up and running very, very quickly because the need is rather urgent.

That's the real endgame here. While we wait for those other ones to be delivered, we will get the domestic capacity up and running because it's an important shortage.

Mr. Don Davies: Mr. Matthews, could you provide updates to the committee on your receipt and deployment of ventilators over the next few weeks and months? I'm wondering if that's something you could do. It would be helpful to keep us apprised of the progress on that.

Mr. Bill Matthews: I'm happy to provide the committee with updates of receipts. For distribution, I would encourage you to ask the Public Health Agency of Canada, because they would be the ones who would then distribute those out to the provinces.

Mr. Don Davies: Thank you.

My final question is for Dr. Liu. I know you've seen a lot of pandemics around the world. Yesterday, B.C.'s provincial health officer expressed concern about a COVID-19 outbreak at B.C.'s Mission Institution, a minimum-security federal correctional facility, where 41 people have tested positive for the disease and seven are being treated in hospital. According to data released over the weekend, over 100 inmates and corrections officers working at Canadian federal institutions have tested positive for COVID-19.

I'm wondering whether, through your experience working around the globe, you have any advice to give this committee about how we might best handle COVID-19 among populations such as inmates, who are obviously in extraordinary, exceptional positions.

● (1645)

Dr. Joanne Liu: This is a very good question.

We are actually tackling it right now, and we are working in detention centres in different countries as well.

The reality is that the only thing we are working on is to reduce the physical distance; we are trying to enact that as much as we can. It means that we keep everyone in their cells and there are no more community meals and so on. We have to put in a completely different routine, but this is the only thing we've done, the only thing we can do, to prevent it. We need to care for the inmates who are infected and put them in a separate section.

I don't think that detention centres are trained to address that. I think they're going to need extra human resources, public health and IPC, infection prevention and control, to make them able to address the issue.

That certainly is a very good point, and it absolutely should be answered.

The Chair: Thank you, Mr. Davies. Thank you, everyone. That wraps up our third round.

I'd like to thank all the members of our panel for sharing their time with us today and all their great information. Thank you for having such great answers to our questions.

Thanks to all the members.

Certainly, as well, we thank the House of Commons staff and technical people, as we are all mutually working through the glitches. We're getting there, and we'll get there all together.

Thank you, everybody.

The meeting is now adjourned.