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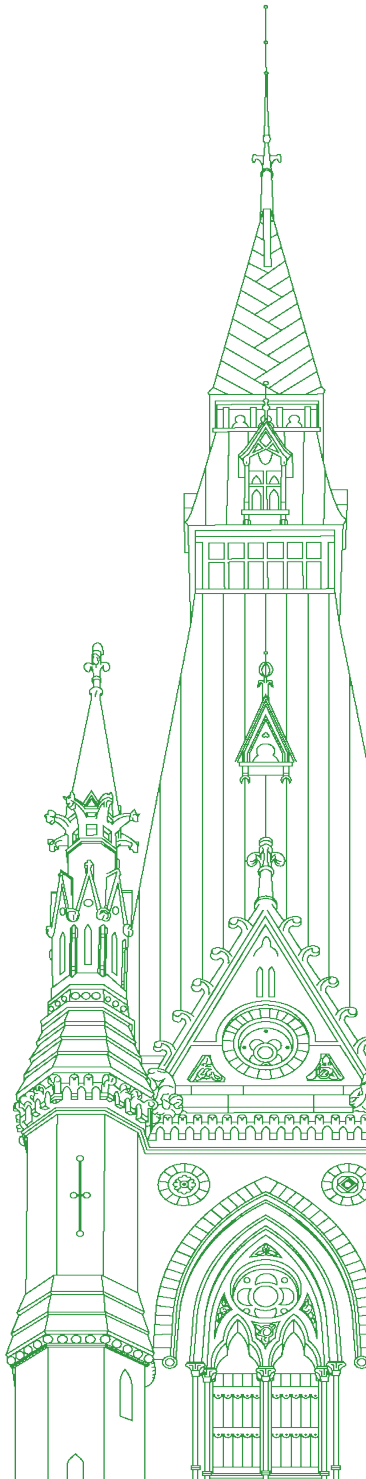

Chair: Mr. Ron McKinnon

# Standing Committee on Health

**Monday, February 1, 2021**

● (1100)

[*English*]

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

Welcome, everyone, to meeting number 16 of the House of Commons Standing Committee on Health.

The committee is meeting today to study the emergency situation facing Canadians in light of the second wave of the COVID-19 pandemic.

Today's meeting is taking place in a hybrid format, pursuant to the House order of January 25, 2021, and therefore members are attending in person in the room, and remotely using the Zoom application. The proceedings will be made available via the House of Commons website. The webcast will always show the person speaking, rather than the entirety of the committee.

Today's meeting is also taking place in the new webinar format. Webinars are for public committee meetings and are available only to members, their staff and witnesses. Members may have remarked that the entry to the meeting was much quicker, and that they immediately entered as an active participant. All functionalities for active participants remain the same. Staff will be non-active participants only, and can therefore only view the meeting in gallery view.

I would like to take this opportunity to remind all participants to this meeting that screenshots or taking photos of your screen is not permitted.

Given the ongoing pandemic situation and in light of the recommendations from health authorities, to remain healthy and safe, all those attending the meeting in person are to maintain two-metre physical distancing, must wear a non-medical mask when circulating in the room—it is highly recommended that the mask be work at all times, including when seated—and must maintain proper hand hygiene by using the hand sanitizer provided at the room entrance.

As the chair, I will be enforcing these measures for the duration of the meeting, and I thank members in advance for their co-operation.

For those participating virtually, I would like to outline a few rules to follow as well.

Members and witnesses may speak in the official language of their choice. Interpretation services are available for this meeting. You have the choice, at the bottom of your screen, of “floor”, “English” or “French”, and with the latest Zoom version, you may now speak in the language of your choice without the need to select the corresponding language channel. You will also notice that the platform's “raise hand” feature is now in a more easily accessed location on the main toolbar, should you wish to speak or alert the chair. I will note that the main toolbar is on the bottom of the participant's pane.

For members participating in person, proceed as you usually would when the whole committee is meeting in person in a committee room.

Before speaking, please wait until I recognize you by name. If you are on the video conference, please click on the microphone icon to unmute yourself. Those in the room, your microphone will be controlled as it normally is by the proceedings and verification officer.

A reminder that all comments by members and witnesses should be addressed through the chair. When you are not speaking, your mike should be on mute.

With regard to a speaking list, the committee clerk and I will do the best we can to maintain a consolidated order of speaking for all members, whether they are participating virtually or in person.

I would like now to welcome our witnesses.

As an individual, we have Professor Amir Attaran, Faculty of Law and School of Epidemiology and Public Health at the University of Ottawa. We have Dr. Isaac Bogoch, physician and scientist, Toronto General Hospital and University of Toronto. We have Professor Marc-André Gagnon, associate professor, School of Public Policy and Administration, Carleton University. We have the Honourable Paul Merriman, Minister of Health, Government of Saskatchewan.

I will now invite the witnesses to make a six-minute statement, and I will start with Dr. Attaran, please, for six minutes.

● (1105)

**Professor Amir Attaran (Professor, Faculty of Law and School of Epidemiology and Public Health, University of Ottawa, As an Individual):** Good morning, Chair.

I'm Amir Attaran. I'm a professor of law and public health at the University of Ottawa. I want to give you some of my background so you'll know why I'm speaking on the things I am.

I'm a scientist by training. My Ph.D. is in cell biology and immunology from Oxford University. I'm a lawyer from UBC. I taught public health at Yale. I taught government at Harvard. I'm a bit of a generalist.

In my work, I've advised organizations such as the World Health Organization, the World Bank, the UN development programme, Médecins sans Frontières and various pharmaceutical industries on health. In fact, I worked in the pharma industry, at Novartis, most interestingly, on a project where we had to scale up drug production by 6,000% in one year and solve the manufacturing and distribution problem.

Now, that reminds me of where we're at, because we now have a problem of too few vaccinations in the country. Per capita, Canada is lagging behind most of our peers. We've had fewer vaccinations than the U.S., the U.K. or the European Union. This is occurring for reasons I warned about in Maclean's magazine last August, and I'm very unhappy to see much of that proved correct.

I'm going to point to three areas where I think all parties agree that things are unacceptable. My goal is to try to tell you how you work together on those three issues.

The first is transparency, which is really just pathetically lacking. The current government I think has done a terrible job on the transparency of its efforts. On the work of the vaccine task force, for instance, none of the meeting minutes are public. It appears not to have met since last October. None of the conflict-of-interest declarations signed by the members are public.

We don't really know what's going on in that committee, and it doesn't inspire confidence. You can't have the most important science decisions in generations being made secretly. That has to end, and if it doesn't, my fear is that it will contribute to a bad-tempered political environment, where you fight with each other so much that you don't solve the substantive problems, and that wouldn't be desirable for Canadians.

Point two, the biggest substantive problem is manufacturing. Canada needs to build resilience to supply interruptions for vaccines. We've seen what happens when our supplies are cut by Pfizer and Moderna. We've seen what happens with the European Union potentially shutting off exports when Canada is 100% dependent on European exports of vaccines right now.

Countries like Australia, India, Japan and Brazil are manufacturing. The way they do it is that they voluntarily license and contract the production of the vaccines. This is, by the way, how the manufacturers themselves work. Moderna, Novavax and AstraZeneca are producing that product not in their own facilities, for the most part, but by contracting out production to other companies you've never heard of, like Lonza, Fujifilm and Emergent.

I think this is an important question for Parliament to grapple with: Why not pay those same contractors of the vaccine firms to lay on another batch for Canada, particularly in North American facilities where the supply interruptions would not be the same as with the European Union—

**The Chair:** Excuse me, Dr. Attaran. You need to speak a little louder and perhaps a little more slowly for the translators.

Thank you.

**Prof. Amir Attaran:** There are long-term capital investments needed to solve this. What there needs to be are contracts made with suppliers like Lonza, Fujifilm and Emergent that have the equipment and technology and that indeed are making vaccines for the companies you've heard of, like Moderna and AstraZeneca. Let's just amp that up.

The third point is, where is Canada's mass vaccination campaign? It's so scattershot right now. There's no plan for a national vaccination campaign once we have sufficient vaccines, and that, to me, is just a tragic failure. To put it in context, in 2014, Bangladesh, one of the poorest countries in the world, vaccinated 52 million kids in just three weeks. That's more than the population of Canada.

In 1947—old technology—New York City vaccinated five million people for smallpox in two weeks. These large vaccination campaigns are able to be done even in the world's poorest places. They happen regularly. That model of organization is one that should be considered for Canada, such that perhaps in the summer or in the fall, if there is an abundance of vaccines, they could be delivered campaign-style to millions of people within a week.

Any one of these three topics I've discussed—the transparency, the manufacturing, the campaign—I could talk about for an hour. I won't. I'll stop here and I'll invite your questions on those three or anything else within my expertise that you need to know.

● (1110)

**The Chair:** Thank you, doctor, we're well aware of your time.

We'll go now to Dr. Isaac Bogoch.

[*Translation*]

**Mr. Luc Thériault (Montcalm, BQ):** Just a second, Mr. Chair.

[*English*]

**The Chair:** Go ahead, Mr. Thériault.

[*Translation*]

**Mr. Luc Thériault:** I cannot continue to take part in committee meetings if the interpreters are unable to interpret. The excuses range from people not muting their microphones to sound checks not having been done to make sure the interpreters can hear the witnesses clearly.

Regardless, I want you to know that there is an issue right now. Throughout Mr. Attaran's entire presentation, which was highly relevant, the interpreter stopped speaking a number of times because she couldn't hear what he was saying clearly enough to interpret his comments. I, however, could hear Mr. Attaran perfectly when the interpreter stopped speaking. She flagged the problem repeatedly during his statement.

It baffles me that there is no mechanism to ensure the clerk receives the message quickly so you can deal with the problem right away. Even if I wanted to listen to the speaker in English, I couldn't. All I hear is the interpreter saying that she can't interpret what is being said.

As a member of the linguistic minority of Canada—and North America—I am just as entitled to hear what witnesses are saying.

[*English*]

**The Chair:** Thank you, Mr. Thériault.

I would certainly advise that if you're not getting translation to speak up as soon as you can on a point of order, and we'll try to deal with that as proactively as we can. I did get a note from the clerk during Dr. Attaran's testimony that it was too fast and too quiet, so I did ask him to speak louder.

Dr. Bogoch, I encourage you to speak slowly and loud enough. All of the witnesses have gone through the sound check.

Dr. Bogoch, do you have a headset?

**Dr. Isaac Bogoch (Physician and Scientist, Toronto General Hospital and University of Toronto, As an Individual):** I have done the sound check, and I've been told that it's A-quality. I do not have a headset, but I do have a special microphone that is of high quality.

**The Chair:** Mr. Thériault, I am certainly alert to your problem, and I am doing the best I can to ensure that translation happens. Please do not hesitate to raise a point of order if you're not getting translation.

Dr. Bogoch, please go ahead for six minutes.

**Dr. Isaac Bogoch:** Thank you so much. Good morning, everyone. My name is Isaac Bogoch. I'm an infectious diseases physician and scientist based out of the Toronto General Hospital and the University of Toronto. Thank you for inviting me to speak at this committee meeting regarding the COVID-19 second wave in Canada.

The focus of my few minutes is to discuss an exit strategy from this wave, and from the pandemic in general, with an emphasis on vaccination but also touching on other issues including non-pharmaceutical interventions.

The ultimate goal here is to halt our second wave and to prevent further waves of COVID-19. Now, most regions of Canada have emerged from peak cases in December or early January and are seeing a steady decline or a plateau in cases due to our current control initiatives. While this is laudable, we still have a long way to go. Vaccines are trickling in, but we won't really be able to really start massive expansion of these programs until the spring, so programs are appropriately focusing on those at risk or at greatest risk of severe outcomes.

I want to touch on three big topics: what's working in our favour; what is working against us; and how we navigate the winter, the spring and beyond.

Let's start with what's working in our favour. Number one, we have vaccines. Of course, the current short-term slowdown is preventing expansion of these programs, but we still have some and we're making good use of what we have.

Just to state the obvious, the sooner we ramp up these programs, the better. All vaccines approved by Health Canada and those under consideration have excellent efficacy against the virus, including the variant discovered in the U.K., while there is lower efficacy on other variants of concern—for example the one discovered in South Africa. However, the vaccines still appear to reduce infection, prevent severe illness, prevent hospitalization and prevent death—all very important metrics.

The second thing working in our favour is weather. Believe it or not, weather in Canada is actually working in our favour. As we leave winter, as we enter the spring and summer, warmer weather means less contact in indoor settings, where the vast majority of virus is transmitted. These fewer high-risk contacts add up at a population level and are going to help.

The third thing is that our current public health measures are working in much of Canada, and in general, Canadians are adhering to them.

What's working against us? Number one are the variants of concern. For example, the variant discovered in the U.K.—that's the B117 variant—is more transmissible and has a strong foothold in Canada. We have to respect this. We have to take it seriously. We need to drill down on our current control efforts until vaccine rollout is more widespread.

The second thing working against us is anything that jeopardizes vaccine delivery. This is way above my pay grade, and I'm going to leave it to you to sort that out.

The third thing is vaccine hesitancy. This is pronounced in some communities, but it's still important, and we have to address it.

The fourth thing is targeting misinformation and focusing on better communication, from both official and non-official sources. This is beyond the scope of my time, but it's still a huge problem that's impacting the pandemic in Canada and beyond.

The fifth thing is COVID fatigue. It's real. It's permeating all aspects of Canada. We can't let our guard down, especially as we see a finish line on the horizon.

Lastly, how do we stickhandle our way through the winter and into the spring and beyond?

First, we need to be very careful, and have a careful and measured reopening strategy, especially while vaccines are slowly being rolled out. The variant discovered in the U.K. will make this more challenging, but it can be done. It's foolish to lift public health measures if the drivers of community infection are not addressed. Vaccine rollout will not be widespread until the spring. There's no point having more lockdowns. Lifting measures has to be done at the right time, slowly and carefully.

Second, related to the point above, is creating safer indoor environments, and that includes schools and workplaces for essential workers and those returning to work. That means integrating rapid diagnostic tests or rapid screening tests, improving ventilation in these settings, having smaller class sizes, and providing wraparound services to ensure equitable access to safety and protection, etc.

Third is vaccine distribution. Now, let's separate politics from science for a second. It may be an unpopular political opinion, but it makes sense in terms of medicine, science and public health to divert vaccines from low-burden areas of the country that are able to control the virus to more heavily impacted areas while there is still a shortage.

Fourth is vaccine supply in the short term. Health Canada has to conduct its evaluation independently, but the faster we vaccinate, the faster we'll be out of this mess. Johnson & Johnson, Novavax and AstraZeneca are three products with excellent phase three clinical trial data. We have contracts with them. They are sorely needed.

Last is a long-term strategy. It's crucial to support Canadian scientists and Canadian industry in homegrown vaccine production. This is a major weakness and a major health security issue.

● (1115)

We have the talent and capability here, and it's long past time to enhance and expand these programs.

It's hard to sum up all that's required to strategically navigate the second wave in five minutes, but I hope that we can continue this conversation. I thank you for your time.

● (1120)

**The Chair:** Thank you, Dr. Bogoch.

We go now to Monsieur Gagnon, associate professor.

Go ahead, Professor, for six minutes.

[*Translation*]

**Dr. Marc-André Gagnon (Associate Professor, School of Public Policy and Administration, Carleton University, As an Individual):** Thank you, Mr. Chair.

Good morning.

My remarks will focus on COVID-19 vaccines as they relate to research and development and manufacturing.

I am an associate professor in Carleton University's School of Public Policy and Administration. My research focuses on the political economy of the pharmaceutical sector. I have more than 150 publications to my credit, ranging from scholarly articles, book chapters and research papers to technical reports and professional publications. Apart from my role in 2020 as an expert witness for Justice Canada in a Superior Court of Québec case involving the regulation of patented medicine prices, I have no conflict of interest to disclose.

When the COVID-19 pandemic was declared, it was impressive to see researchers around the world apply the principles of open science and work together to systematically share data, primarily to sequence the viral genome, monitor the virus's evolution and variations, and produce protective and screening equipment.

In March 2020, the Canadian government passed an act respecting certain measures in response to COVID-19, or Bill C-13. Under the legislation, compulsory licensing was permitted for a period of six months in relation to any technology that could play a role in the response to COVID-19, the idea being to overcome potential shortages. The provision was not renewed in September 2020, but the federal government can do so at any time, as needed.

In May 2020, the World Health Organization, or WHO, launched the COVID-19 Technology Access Pool, or C-TAP, based on the principles of open science. The purpose of the pool was to support the sharing of technological knowledge and know-how relevant to the fight against COVID-19. In addition, the Medicines Patent Pool, MPP, funded by Unitaid, expanded its mandate to facilitate the sharing of health technology patents that could contribute to the response to COVID-19.

In the beginning, technological co-operation and data sharing were thought to be guiding the global scientific effort, to help each country maximize its COVID-19 response. Unfortunately, old habits die hard, and private science, patents and monopolies on technology quickly prevailed. To date, no company has agreed to share its technology with C-TAP or MPP. Instead, each firm is working behind closed doors to maximize future revenues.

Even though governments invested more than $14 billion in the development of vaccines, the private sector's total monopoly over the vaccines continues to go unquestioned. For example, even though Moderna's vaccine was fully funded through public investment, the company has a monopoly on the vaccine because it owns the patent. Moderna is also charging the highest price of any of the vaccine makers, garnering it the Shkreli Award, a prize handed out every year to the worst profiteers in health care.

On its end, Canada launched the COVID-19 Vaccine Task Force in the summer of 2020, to provide the government with strategic advice on vaccine matters. The lack of transparency around the task force and the conflicts of interest related to its members have been decried by numerous experts. Microbiologist Gary Kobinger even resigned from the task force in protest. In its recommendations, the task force seems to have put companies' proprietary rights above overall public health needs.

That has given rise to the current reality: countries tripping over one another for first access to vaccines. Every country is trying to convince vaccine makers to sell it doses over the country next door, and to deliver those doses as soon as possible. Forget about global public health priorities; it's every country for itself. Welcome to vaccine nationalism.

Canada plays a pretty good game of vaccine nationalism, mind you. Canada is the country that secured the largest number of doses, equivalent to 500% of what it actually needs. Under the current agreements, Canada should be one of the first countries to achieve herd immunity through vaccination.

Although Canada has a flair for vaccine nationalism, the game, itself, is extremely problematic. The production delays at Pfizer-BioNTech and AstraZeneca have created tremendous international tensions. Instead of working together to produce the most vaccines possible, countries are working against one another, letting vaccine makers' priorities dictate the global distribution of vaccines.

Canada has the capacity to produce vaccines, so why is it not leveraging that capacity to help fight COVID-19?

Countries such as India and South Africa are calling on the World Trade Organization to suspend intellectual property rights related to COVID-19 technologies, to facilitate knowledge sharing and increase vaccine production during the pandemic. Nevertheless, Canada, the United States, Europe, the United Kingdom and Switzerland are categorically opposed to the suspension of those rights. In many ways, it appears that Canada has chosen to be part of the problem, instead of the solution.

I would be happy to answer any questions you have.

● (1125)

[*English*]

**The Chair:** Thank you, Professor.

We go now to the Honourable Paul Merriman, the Minister of Health for the Government of Saskatchewan.

Minister, please go ahead. You have six minutes.

**Hon. Paul Merriman (Minister of Health, Government of Saskatchewan):** Thank you for the opportunity to speak today.

If this meeting had taken place a week ago, my message today would be much more encouraging. Until about a week ago, Saskatchewan had been receiving a steady supply of vaccines from the federal government. While our provincial vaccine administration plan continues to be very effective, we are now virtually at a standstill with no vaccines having been delivered to Saskatchewan in over a week. Limited quantities are now expected in the next few weeks.

The vaccines we are receiving are going into the arms of Saskatchewan people as quickly as possible. Saskatchewan has the highest percentage of vaccines administered amongst the provinces. In fact, we have now administered 108% of the vaccines we have received. I know this sounds like a mathematical impossibility, but it's because our very efficient health care workers have been able to extract an extra dose out of some of the vials of the vaccine. I'll come back to that in a second.

This efficiency has lead us to a debate about relabelling the vials, which is a move that Saskatchewan certainly does not support.

I want to talk you through a brief history of our vaccine rollout in Saskatchewan to date. When Health Canada formally approved the Pfizer vaccine in December, we were ready. That same day we announced our vaccine delivery plan. As with many provinces, it was based largely on the national advisory committee and immunization guidelines. Saskatchewan's chief medical health officer did some modifications to accommodate Saskatchewan's demographics and logistical requirements.

Phase one of our vaccine delivery plan began on December 22. It focused on immunizing priority populations that were at a higher risk of exposure to the virus and at more risk of serious illness or death. This included certain front-line health care workers, long-term and personal care home residents and staff, seniors over 70 and all residents over 50 years of age in the remote northern communities. Due to logistical requirements of the Pfizer vaccine, we initially delivered it to urban centres that had the ultra-cold freezers. The Moderna vaccine was delivered to remote northern communities.

We post Saskatchewan's vaccination numbers on the Government of Saskatchewan website and in a daily news release, so the public remains informed of our progress.

Phase two of the vaccine delivery plan is expected to being in April. This will be the beginning of our mass immunization. However, these plans are in jeopardy now. The Government of Saskatchewan's ability to vaccinate our residents is entirely dependent on a reliable supply of vaccine and reliable information about the number of vaccines we expect to receive each week. Simply put, we need more vaccines. We need more reliable information about when we're receiving those vaccines.

The flow of information is almost as important as the flow of vaccines because these vaccines are far more complex to transport, store and administer than, say, the annual flu vaccine. Our health care workers are absolutely up to the task, but as you know, Saskatchewan is a large province with many remote communities. We need reliable information to plan appointments, transportation, refrigeration and the deployment of our health care workers.

When we have received the vaccines as scheduled, our program runs extremely smoothly. However, in the past few days we have had sudden and unexpected schedule changes, causing us to have to cancel clinics in communities where they had already been announced. We need to ensure that everyone who receives their first shot is able to get their second shot in a timely manner. Again, this is extremely difficult to plan and execute without a reliable supply of vaccines and without reliable information.

The announcement that both Pfizer and Moderna are delaying expected shipments of vaccines to Saskatchewan has forced our government to revisit this plan. Saskatchewan's February 8 shipment is to be a third of what was originally promised. Prior to the recent announcements from Pfizer and Moderna, we were only able to project receiving enough vaccines in the first quarter to fully immunize about half of our priority one people. Now, completing first and second doses for our priority population is becoming challenging. Simply put, Saskatchewan will not be able to vaccinate as many people as originally planned.

Saskatchewan is asking the federal government to do everything it can to ensure the vaccines are made available as soon as possible and that the province is receiving reliable information about vaccine deliveries. Information that suddenly changes at the last minute creates more challenges.

● (1130)

Saskatchewan is also very concerned about Pfizer wanting to relabel their vaccine vials to say they contain six doses instead of five, which will effectively result in a reduction of the number of vaccines the provinces are receiving. Health Canada should not allow this to happen.

Earlier I indicated that our health care workers have been able to get an extra dose out of the Pfizer. However, this should be viewed as an added benefit, not the standard for counting the number of doses. On average, we have been able to get a sixth dose from about half of the Pfizer vials. For a number of reasons we cannot consistently count on getting those six doses out of every vial. That's why Pfizer should not be allowed to reduce its shipments to Canada by simply relabelling the vials and counting six instead of five doses.

My message here today is Saskatchewan has been getting the vaccines into people's arms as quickly as we get them, but we simply need more vaccines. We need to get more reliable information about when we're getting those vaccines and simply relabelling the vials does not amount to more vaccines.

We all want this pandemic to be over and things to return to normal. That will happen when we have a significant portion of our population vaccinated. Our province and our health care workers are ready to do their part, so please just get them some vaccines.

**The Chair:** Thank you, Minister.

We will start our questioning now. We will have time for one round.

I believe you have the first slot, Ms. Rempel Garner, for six minutes, please.

**Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC):** Thank you, Chair.

My questions will be directed to Minister Merriman.

Minister, you just said that you're only on track to have one half of your priority one persons vaccinated by the end of March due to the supply issues.

Is that correct?

**Hon. Paul Merriman:** That is correct.

**Hon. Michelle Rempel Garner:** Based on the current projections that you have been given by the federal government on supply, when would every person in Saskatchewan have access to a vaccine?

**Hon. Paul Merriman:** As it sits right now, we probably wouldn't be able to have everybody have access to the vaccine until later this fall. Our priority population is about 190,000 people, which includes health care workers and seniors. We're projected to only get about 110,000 of those vaccines by the end of March.

**Hon. Michelle Rempel Garner:** The assumptions that you have been told to make those projections on, do they rely on AstraZeneca's and Johnson & Johnson's being approved?

**Hon. Paul Merriman:** No. These are just the Pfizer and the Moderna vaccines. We haven't got any information as far as AstraZeneca is concerned.

In a conversation with Minister of Health Patty Hajdu last week, they were saying that AstraZeneca could come on early, but we have nothing confirmed.

**Hon. Michelle Rempel Garner:** Has the health minister given you any sense of how many doses of AstraZeneca would be delivered to Saskatchewan over any period of time?

**Hon. Paul Merriman:** No. We haven't received anything official from them other than it's coming, but we've heard that about a lot of our vaccine shipments right now.

**Hon. Michelle Rempel Garner:** AstraZeneca has significantly different delivery methods or requirements from Pfizer and Moderna.

What kind of lead time would you need on that to be able to switch your delivery program?

**Hon. Paul Merriman:** From what I'm told, the AstraZeneca is a much simpler vaccine to administer so we could get that one out a lot faster to some of our pharmacists and into our drive-through clinics when we're able to open them. It would be easier.

The more information we know, the better for us so we can plan. We have a lot of logistics to do in Saskatchewan to make sure that—

● (1135)

**Hon. Michelle Rempel Garner:** Thank you.

Has the government given you any formal assurances that there would not be an export ban or export restrictions from vaccines coming out of the European Union?

**Hon. Paul Merriman:** No.

**Hon. Michelle Rempel Garner:** How much do you think that will potentially affect supply if it comes to pass?

**Hon. Paul Merriman:** I think it would have a huge impact on supply, and we would be down to next to nothing.

**Hon. Michelle Rempel Garner:** Have any of the details of the contracts with Pfizer, Moderna, AstraZeneca or Johnson & Johnson been made public to you specifically in terms of projected delivery schedules?

**Hon. Paul Merriman:** No. We haven't received anything.

**Hon. Michelle Rempel Garner:** Is it something that would be useful to you?

**Hon. Paul Merriman:** Absolutely. It would be very helpful for us to be able to see what's coming and what the quantities are.

**Hon. Michelle Rempel Garner:** Have there been any reasons given why those haven't been given to you?

**Hon. Paul Merriman:** They've just haven't been provided. We've informally requested that but nothing has been provided other than to say it's confidential.

**Hon. Michelle Rempel Garner:** Has the minister told you that the number of Pfizer doses that they're contractually obliged to provide is now going to be dependent on that sixth dose? Have they given you an indication that that's where the federal government is likely to go?

**Hon. Paul Merriman:** That's the indication, that they're going to relabel them from five doses to six.

**Hon. Michelle Rempel Garner:** We're not talking about the number of vials anymore. We're talking about the number of doses, with six doses in the vial. That's the indication that you've been given. Is that correct?

**The Chair:** Sorry, Minister Merriman, we're having trouble with translation again. Perhaps you need to cut your video again. Your audio was very choppy.

**Hon. Michelle Rempel Garner:** Sorry, that put me off my pace.

With respect to the sixth dose, my understanding is that you need a special syringe to extract that sixth dose. Has the federal government supplied you with that, on the assumption that there's going to be a "sixth dose" requirement?

**Hon. Paul Merriman:** We've been told that they're coming, but we haven't actually had any land in Saskatchewan yet.

**Hon. Michelle Rempel Garner:** Do you have any sense of when those would be arriving, in the quantity that you need to distribute the vaccine?

**Hon. Paul Merriman:** We're hoping it will be this week, but we'll wait until they actually arrive.

**Hon. Michelle Rempel Garner:** How much lead time are you getting from the federal government on understanding exactly how many doses you're getting per week?

**Hon. Paul Merriman:** We get a good lead time on what the projected doses are, but the changes come very quickly and they're always reduced.

**Hon. Michelle Rempel Garner:** This is my last question. Last week, in the House of Commons, the health minister made a throwaway comment about the question of supply. She said, using the example of Ontario, that there were doses left in the freezer.

When you have supply disruptions with the two-dose situation, I'm assuming that that forces you into difficult situations for figuring out how to allocate future doses to new people versus meeting that two-dose requirement window. Can you give us a sense of how much the supply disruption has impacted the second dose for high-risk populations?

**Hon. Paul Merriman:** It's dramatically impacted high-risk populations. We've had to change almost daily. We're always reacting on very short notice to be able to find out when we can get this. If we don't get everything that we're promised right now, it will be challenging to get the second dose to the people who have had their first dose in the recommended time frame.

**Hon. Michelle Rempel Garner:** Thank you.

**The Chair:** Thank you, Ms. Rempel Garner.

We go now to Dr. Powlowski.

Go ahead for six minutes, please.

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

My understanding is that the Prime Minister's statement that "all Canadians who wanted a vaccine would have one by September" is based purely on Moderna and Pfizer. Obviously, there are these other vaccines out there. We have the results of phase three large randomized, controlled trials for both AstraZeneca and Johnson & Johnson, as well as preliminary results from the Novavax study. They all look pretty good. When AstraZeneca mistakenly gave half the first dose, it had 90% efficacy. The vaccine from Johnson & Johnson—I think it was Great Britain— was about 72%, which is less than South Africa, but my understanding is that it has 100% efficacy in preventing hospitalization and death. This is certainly very significant.

Now they all need approval by Health Canada. Certainly AstraZeneca and Johnson & Johnson are more conventional vaccines—the more novel ones are Moderna and Pfizer, which have already been approved—so I would think they're likely to be approved.

There's some concern about AstraZeneca and Johnson & Johnson not living up to the 95% efficacy of Moderna and Pfizer, but these weren't head-to-head trials. There were different populations. There was the new British variant. Also I'm told, with respect to—

● (1140)

**The Chair:** Pardon me, Doctor, you need to slow down a little bit for the translator.

**Mr. Marcus Powlowski:** Also with respect to Johnson & Johnson's efficacy, Dr. Fauci has already stated that with a booster you could well get closer to 90%. My understanding is that with AstraZeneca—with all the vaccines—you could add another booster to increase efficacy.

I thought I'd first like to comment on the relative efficacy of these. More importantly, however, I know Health Canada has to do its due diligence and approve these vaccines, but what is the likelihood that they're going to get approved and what will that mean in terms of time frames for distribution? I know Dr. Bogoch is on the Ontario task force on vaccines. What is your thinking in terms of how fast we'll be able to get vaccines out, if and when these other vaccines are approved?

I'll start with Dr. Bogoch, then maybe Dr. Attaran can also reply.

**Dr. Isaac Bogoch:** Those are great points and great questions.

I completely agree with your points about looking at the relative efficacy of these vaccines, because they're not direct head-to-head trials. Certainly, the Pfizer and the Moderna vaccines were studied in an era that was not the variant of concern era.

I also agree that the metrics we should be looking at don't necessarily have to land on protecting individuals from getting the infection, but on mitigating severity of illness, limiting hospitalizations and limiting deaths. These would be very successful metrics, and would certainly be helpful to navigate our way out of the mess we're in.

The newer technologies are also very useful, because they're, quite frankly, plug and play. You can update your vaccine to reflect circulating variants, and mass-produce them in a rapid manner relative to older vaccine technology that takes a lot longer, and has other issues we don't need to get into on this call.

As you point out, I do sit on the Ontario vaccine distribution task force, and there are publicly available documents for Ontario, as has been mentioned several times in various mainstream media outlets, of the program to rollout vaccination. Yes, there have been bumps along the road, but in general, when we have access to more vaccines, you will see much more widespread distribution.

It's not a fair comparison to say this is the same as influenza or measles vaccine distribution. There are true limitations based on the vaccines we have and cold chain issues. Having said that, all these plans involve: first, distribution through primary care; second, distribution at pharmacies; third, distribution through mass vaccine sites; fourth, distribution through public health clinics; fifth, distribution through community centres, where some communities that might not be as comfortable with the government or health care in Canada will feel more comfortable going; and sixth, mobile trucks and mobile units to help care for underhoused populations.

That is part of the plan. Operationalizing it is another thing, but that's the plan.

**Mr. Marcus Powlowski:** Dr. Attaran.

**Prof. Amir Attaran:** All the vaccines are good. It's not worth getting into a question of which is the best. They're all good enough to use.

The problem we have is getting more of them, and getting them quickly, particularly now that it's become geopolitical.

In 1976, there was a swine flu epidemic, and the United States shut down exports of vaccines to Canada. I'm hoping that with the next question I can get to the issue of manufacturing, and how we can stay safe from that.

**Mr. Marcus Powlowski:** I guess, on that matter, I can ask Dr. Attaran. You've talked about domestic capacity, and Mr. Gagnon has talked about compulsory licensing.

What production facilities do we have in Canada that could ramp up production faster than the companies that are presently making them?

● (1145)

**Prof. Amir Attaran:** There are companies in Canada, like NeuVax or Therapure that have biological molecule production facilities.

For the cell culture vaccines, which are Johnson & Johnson and AstraZeneca, it's just a question of having cell culture capacity.

If we can't do that in Canada, it is the industry norm to do that with contractors. We could simply hire one of the contractors, like Emergent, Lonza or Fujifilm, and ask them to lay on another batch. That would be a very simple negotiation.

The lawyer in me feels that, with the company that is the patent holder, you would essentially be asking them just to expand their contract manufacturing with an established contractor. We pay the freight, and we take the risk on the production, so why not?

**The Chair:** Thank you.

We now go to Mr. Thériault.

[*Translation*]

You may go ahead for six minutes.

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

I want to thank all the witnesses for their participation.

Professor Gagnon, thank you for accepting the committee's invitation.

You mentioned something that we on the Standing Committee on Health noticed as well. At the beginning of the pandemic, all the experts and researchers told us about the extraordinary level of co-operation in the effort to find and develop a vaccine. The co-operation was certainly there.

The vaccine race has been on since August. Now that it's time to procure the vaccines, all that fine global co-operation and information sharing has gone out the window, and for good. We are nevertheless in the midst of a global pandemic, so borders are problematic. Until everyone on the planet is vaccinated, the problems caused by variants are not going anywhere.

You said this earlier, and you've talked about it in your articles: this way of doing things is disastrous. You said Canada had picked its side.

What could we do differently to achieve better public health results through a more unified position?

**Dr. Marc-André Gagnon:** Thank you for your question.

Take the AstraZeneca vaccine, for example. It was developed by the University of Oxford. Initially, the university had pledged to offer nonexclusive, royalty-free licences for its vaccine, but ultimately went back on its decision, opting to give AstraZeneca exclusive rights to the vaccine.

I read this week that, according to AstraZeneca's CEO, Pascal Soriot, the challenge is vaccinating as many people as possible, as quickly as possible, because the virus is spreading and mutating in parts of the world where people don't have access to vaccines. The vaccine protection people are acquiring now could drop, and even become obsolete as potential new variants emerge. However, when asked to make the patent royalty-free to provide access to the technology, as initially promised, so more manufacturers could use their facilities to produce the vaccine, AstraZeneca refused. It prefers to operate with licensing agreements.

It's important to understand something. The Pharmaceutical Accountability Foundation recently released a scorecard showing that AstraZeneca is currently the most ethical of the COVID-19 vaccine makers and is making every effort to offer accessible licences, but it's still extremely limited. Manufacturers are waiting even though their production lines are ready to go. Not only do they need to be given a compulsory licence and the formula, but they also need to have the knowledge and know-how. That's the only way they can help the effort. Under the current regime, companies seem quite reluctant to transfer that know-how.

What can we do, then? The thing to do would have been to ensure vaccine manufacturing capacity in Canada at the outset. The government made huge investments in Medicago to increase vaccine production capacity in Quebec. VIDO-InterVac, at the University of Saskatchewan, received considerable funding to boost its production capacity. Those are all positive steps, but Canada also needs to take a stand internationally and say that it wants to make the patents royalty-free. We are at war with a virus, so everyone should contribute to the war effort, not oppose initiatives to increase production capacity.

● (1150)

**Mr. Luc Thériault:** Isn't that the only way to overcome the shortage? Back in the fall, a number of pharmaceutical companies announced that they had effective vaccines, and similar announcements followed. Is it safe to say that companies rushed to take as many orders as they could but were unable to fulfill them? Now we are caught in this situation. As I see it, the only answer is to democratize vaccine production through licensed patents, so we can produce the vaccines ourselves in the middle term. Do you not agree?

We have to build our production capacity so we can alter vaccines in response to variants, if need be. Pharmaceutical companies will never be able to produce enough vaccines for the entire planet.

**Dr. Marc-André Gagnon:** I completely agree.

Early on, the efforts to find new vaccines were impressive. Many were developed. Now, pharmaceutical companies are signing confidential agreements with countries to deliver vaccines. We saw how quickly Pfizer-BioNTech ran into production issues—hence, this week's slowdown.

As for AstraZeneca, in Europe, the situation is much worse. Something of a trade war has erupted between Europe and the United Kingdom. If European countries want to prevent vaccine exports to the United Kingdom, under WTO rules, they have to prevent exports to Canada as well. We therefore find ourselves in a trade war where the companies are no longer able to fulfill their orders.

Countries adopted the strategy of lining up for pharmaceutical firms' vaccines and waiting for their doses, but now the doses aren't coming. What do they do now? It's late in the game to start coming up with new solutions.

Still, Canada has good vaccine production capacity—capacity that could be leveraged if royalty-free licences were offered on patents.

**The Chair:** Thank you, Mr. Thériault.

[*English*]

Mr. Davies, please go ahead for six minutes.

**Mr. Don Davies (Vancouver Kingsway, NDP):** Thank you to all the witnesses for being with us today.

Dr. Attaran, I would like to start with you. You stated last August that the National Research Council knows how to make vaccines. Its brilliant scientists were the world's first to fully deploy an adenovirus-vectored vaccine for rabies ahead of any pharmaceutical company. You have pointed out that the AstraZeneca vaccine is an adenovirus-vectored vaccine. Do you have any explanation for why Canada failed to negotiate the right to produce the AstraZeneca vaccine here in Canada? How serious an omission do you think that is?

**Prof. Amir Attaran:** I think it's a giant omission. As you know, there are many different vaccine technologies. You mentioned the adenovirus-based vaccines. There are two of those—AstraZeneca and Johnson & Johnson—and they're among the simplest to manufacture. We could manufacture them in Canada. It is a question of having a large vat in which you grow the cells that produce the vaccine. Then you purify the vaccine proteins, and then you formulate them and bottle them and all of that. We could do this in Canada. Contrary to the point of view that intellectual property is a big barrier here, AstraZeneca did license Brazil, Australia, India and several other countries to make its vaccine, and that has been done. Those countries are making the AstraZeneca vaccine. The intellectual property problems weren't that hard to solve. India is supplying it to its people as we speak. Brazil is rolling out the first doses this week. Australia, because it has so little COVID, is taking it more slowly.

This is something that Canada could do. The failure of the government to negotiate to produce the AstraZeneca vaccine back in the summer, as Brazil, India, Australia, Japan, Mexico and Argentina did, is a cardinal failure of this pandemic. Had we done so, we'd have something more right now.

● (1155)

**Mr. Don Davies:** Thank you.

Dr. Gagnon, I'd like to move to you.

In the roughest terms possible, what percentage of the research dollars that went into developing these vaccines in Canada was provided by the federal government?

**Dr. Marc-André Gagnon:** In terms of the development of vaccines in Canada, the main project we had in Canada was this partnership with the Chinese company. It didn't work. If you look at the global level—the contribution of different governments, basically—more than half of the contributions, in terms of investment, are first and foremost public investments. In Canada, the new challenger in terms of a vaccine is now with Medicago. It's still in clinical trials, but let's just say that it would be an interesting surprise if it could go through because we would have here a very significant production capacity for this.

**Mr. Don Davies:** Thank you.

I'll pick up on my colleague Mr. Thériault's questions. You have said that what we are seeing is, for you, a bit of a catastrophe. You said, “You end up with a handful of companies that are developing their own vaccines, each by themselves, working in silos.” You said, “So then you have a product with a patent, so monopoly rights on the product. And then you end up with this vaccine nationalism of all countries basically doing a free market negotiation in terms of who can jump the queue in order to get faster access to the vaccines.”

You said, “In terms of the priorities of global public health, this is pure nonsense.”

I'm wondering if we got the model wrong. We have a global pandemic. We're talking in terms of war. I'm wondering if we brought a stick to a gunfight. Is using the private-sector model of private companies' monopolizing the patent and the intellectual property the best way to get vaccines out to the world? What would you suggest as a different model for that?

**Dr. Marc-André Gagnon:** This is an excellent question. First, there are alternatives, and this is something very important. We need to understand that more and more the type of research and development that is being done in pharmaceuticals is requiring us to go outside the patent model. Basically, patents work very well for certain research niches. For others, they don't work well, and in the case of pandemics like this one, it's very problematic because with the amount of power we're giving to drug companies, we then need to negotiate with these drug companies. Now we're negotiating maybe not with a gun to the head, but basically with a needle in the arm, and then we need to decide what we're going to do. We do not want to scare away the company by imposing some policies.

Let's just say that if the focus was on open science from the start, basically it would have been way more interesting.

I would like to add one thing. I agree with Dr. Attaran in terms of AstraZeneca, but AstraZeneca has been a bit different from other companies. It's the one that has been the most forward in doing these partnerships with other companies around the world. If you look at the different scoreboards with different companies, you see it's the only one that has been so proactive in this. With others, basically, it's all about preserving the expertise and knowledge they have.

**Mr. Don Davies:** Thank you, Mr. Gagnon.

India and South Africa—

**The Chair:** Thank you, Mr. Davies.

I'd like to thank the witnesses. That brings our rounds of questions to an end. Thank you all for your time today and for sharing with us your expertise and your concern and care.

With that, we will suspend to bring in the next panel.

● (1155)

(Pause)

● (1200)

**The Chair:** We'll resume the meeting now.

Welcome, everyone, as we resume meeting number 16 of the House of Commons Standing Committee on Health. We are meeting today to study the emergency situation facing Canadians in light of the second wave of the COVID-19 pandemic.

As we welcome our new panel, I would like to point out to the witnesses that they may speak in the official language of their choice. Interpretation services are available for the meeting. You have a choice at the bottom of your screen of “floor”, “English” or “French”.

With that, I will go through the list of witnesses. We have Dr. Joel Lexchin, medical doctor, appearing as an individual; from the Canadian Public Health Association, we have Mr. Ian Culbert, executive director; with the COVID-19 Immunity Task Force, we have Mr. Timothy Evans, executive director. From Medicago Incorporated, we have Ms. Nathalie Landry, executive vice-president, scientific and medical affairs; and we have Mr. Nicolas Petit, vice-president, commercial operations.

We'll start with Dr. Lexchin. Welcome, and please go ahead, sir. You have six minutes.

● (1205)

**Dr. Joel Lexchin (Medical Doctor, As an Individual):** Thank you very much for the opportunity to speak to the committee.

I am an emergency physician and have been one since 1982. I taught health policy at York University from 2001 to 2016, and I've been researching pharmaceutical policy for about 40 years.

I'm going to go into four different areas.

First of all, we have the situation that Canada found itself in with respect to vaccine production at the start of the pandemic. Back in 1989, we sold off Connaught Laboratories to a French company. Then, in 2005, ID Biomedical Corporation was sold to GlaxoSmithKline. Therefore, when the pandemic hit, we had no domestically owned independent production. We did have warnings that we might need it back with SARS in 2003 and then with H1N1 in 2009. The Naylor report after SARS recommended that we develop an independent vaccine strategy, but we never did.

When the pandemic hit, we were vulnerable when it comes to vaccines. In order to try to ensure that we were going to be able to get the necessary vaccines, in June of 2020 the National Research Council set up an 18-member COVID-19 vaccine task force charged with making recommendations about vaccine acquisition to the federal government. Initially, the conflicts of interest of those committee members were kept secret until there was a public outcry.

The task force was highly selective. There was no representation for indigenous or Black people, the elderly, women or people with disabilities. Both the chair and the co-chair had significant conflicts of interest. Whether or not those conflicts of interest affected the recommendations they made to the government is unknown, because the exact nature of the recommendations is not public.

Other countries have handled the situation much differently. In the notes I submitted, you can see that Australia did things in a much different fashion.

We're now faced with the delays in the delivery of the Pfizer vaccine and possibly others. The delays in different countries are different. That might be due to the terms of the contracts that have been negotiated, but we don't know, because the contracts are kept secret. Also, we don't know anything about the price that Canada is paying versus the price in other countries. What are the guarantees about vaccine delivery and are there penalties for companies if they can't meet delivery schedules?

Finally, I want to talk about Canada's position on ensuring vaccine availability and affordability in low- and middle-income countries. Canada is one of the largest donors to COVAX. In July 2021, Prime Minister Trudeau signed a letter, along with other global leaders, which said, among other things, “We”—the global community—“cannot allow access to vaccines to increase inequalities within or between countries—whether low-, middle- or high-income.”

At the same time, Canada didn't support—and still hasn't supported—the WHO COVID-19 technology access pool. It hasn't supported the call by India and South Africa at the World Trade Organization for a temporary suspension of patents and other intellectual property. It has not publicly demanded that companies making vaccines ensure that they are available at production costs, and it has not said when it's going to donate excess vaccines to low- and middle-income countries.

I have four recommendations to make to the committee.

One, Canada needs to develop a national vaccine strategy that will consist of a strong and enduring financial commitment to publicly funded and publicly run vaccine research.

Two, we need a domestic, publicly owned vaccine manufacturing facility, so that in the future we can avoid the situation of privately owned Canadian companies being sold to foreign interests.

Three, Canada needs to make public the terms under which it granted money for COVID vaccine research and the terms of the contracts that it has signed with companies for vaccines.

Finally, Canada needs to publicly outline a detailed strategy about how it will contribute to ensuring that vaccine nationalism is avoided so that low- and middle-income countries can access vaccines in a timely manner in line with their needs.

● (1210)

Thank you very much.

**The Chair:** Thank you.

We go now to the Canadian Public Health Association's Mr. Ian Culbert, executive director.

Go ahead, Mr. Culbert, for six minutes.

**Mr. Ian Culbert (Executive Director, Canadian Public Health Association):** Thank you, Mr. Chair.

Good afternoon, honourable members of Parliament. Thank you for the invitation to appear before you today.

On behalf of the Canadian Public Health Association, I want to begin by expressing our gratitude and support for the public health officials and health workers across our country involved in the response to COVID-19. In communities across our country, they are doing everything in their power in this unprecedented time to help Canadians stay safe and to give them the hope that there is light at the end of the tunnel.

I'm pleased to announce that later this week, CPHA will be releasing its “Review of Canada's Initial Response to the COVID-19 Pandemic”. This report will provide a non-governmental perspective and overview of the public health measures taken to date. It is not meant to provide a detailed analysis of all actions taken, however. I will be pleased to provide the clerk of the committee with access to the review as soon as it is available so that it can be shared with members of this committee.

The review will contain a number of recommendations on topics of interest to this committee and relevant to addressing the second wave of the pandemic. These include data collection, testing, contact tracing and the need for a national approach to outbreak management. Whereas our data collection ended in mid-September, the review does not address the issues of vaccination that are of interest to this committee today. I will address some of these challenges now.

Clearly, the COVID-19 pandemic is Canada's largest public health crisis in over a century. We are seeing weaknesses in our systems as we attempt to secure timely delivery and dissemination of vaccines. Canada needs to develop the flexible, efficient national research and production systems needed to reduce our reliance on international vaccine manufacturers and to meet the needs of Canadians while positioning ourselves as a good international economic partner. To this end, CPHA recommends strengthening basic and applied research capabilities to support infectious disease research along with vaccine development and production requirements. We also need to rebuild our domestic supply chains and manufacturing capacities for vaccine production. Finally, the federal government, in collaboration with provincial and territorial governments and other stakeholders, needs to develop, test and implement national standards and strategies for the distribution of vaccines as part of our emergency response plans.

This pandemic has also highlighted the limits of our health care and public health systems. Within government, the delivery of health services, as you well know, is the responsibility of the provinces and territories, with the federal partner having responsibilities for leadership, collaboration and international relations, among others. The challenge is that the federal responsibilities for public health are not well defined through a policy, legislative or regulatory framework. This situation must change if our country is to respond efficiently and effectively to future public health challenges. CPHA recommends the development of a more unified structure that provides a national approach to public health while respecting provincial and territorial responsibilities. This goal could be achieved through the development of federal legislation for public health, a Canada public health act, with clear roles and responsibilities defined for all governments and stakeholders. Such legislation would require a national funding accord that incorporates performance measures for the delivery of public health services according to national standards.

The pandemic has demonstrated the strengths, resilience and weaknesses that exist within governments' collective abilities to meet the vaccination requirements of this country. Lessons can and must be learned from the past in order to end the current pandemic and provide the tools and capabilities to respond better to future emergencies. The current setback in vaccine deliveries is not unexpected. We are dealing with a novel virus, new vaccines, new technologies and new production processes. The manufacturers need time to expand their production facilities to meet the worldwide demand for vaccines. It must be viewed and conveyed to the public as an example of a short-term delay for long-term benefits.

When I spoke to this committee last April, I noted that how we respond as individuals may be the single most important factor in how well we fare as a country. As much as the hope that is provided by vaccines is the incentive to keep going, we have months of public health orders that we will have to continue to live through before this is over.

● (1215)

For better or for worse, this is playing out as we expected.

This is a deadly virus that preys upon the most vulnerable in our communities. Now is the time for Canadians to continue to make personal sacrifices for the common good, and elected officials at all levels must set that example. This is an unprecedented situation. As such, our response is imperfect.

I do not believe that Canadians expect perfection, but they do want to know that their elected leaders are working together with public health officials to solve the problems that arise.

Thank you.

**The Chair:** Thank you very much, Mr. Culbert.

We'll go to the COVID-19 Immunity Task Force.

Go ahead, Dr. Evans.

**Dr. Timothy Evans (Executive Director, COVID-19 Immunity Task Force):** Thank you very much for the opportunity to present today. I'll say a few words about Canada's COVID-19 Immunity Task Force.

The task force was formed in late April 2020 by the Government of Canada with a two-year mandate. Working virtually, the task force leadership group, co-chaired by doctors Catherine Hankins and David Naylor, is a representative set of volunteer experts from across the country who are focused on understanding the nature of immunity arising from the novel coronavirus that causes COVID-19 and understanding the prevalence of the infection in the general population as well as specific communities and priority populations.

The task force and its secretariat have been working closely with a wide range of partners, including provincial, territorial and federal governments, public health agencies, academic institutions, health organizations, research teams, other task forces, communities and stakeholders.

Most recently, the task force has been asked to take a major role in supporting vaccine surveillance for effectiveness and safety as the rollout of vaccines begins.

Our overriding objective is to generate data and ideas that inform interventions aimed at slowing and ultimately stopping the spread of SARS-CoV-2 in the population. We have four areas of focus, which I will describe briefly. These areas of focus are being supported through 55 studies that are currently in the portfolio of the task force.

First are seroprevalence studies, which test for the presence of antibodies that indicate a previous infection with the SARS-CoV-2 virus. These studies are ongoing as we navigate the second wave. They shed light on the level of immunity in the general population, as well as the level of immunity in priority populations such as residents of long-term care facilities, health care workers and racialized communities.

Initial studies with the blood banks in Canada, for example, reveal that at the tail of the first wave of the pandemic in May and June 2020, the level of population immunity in Canada was extremely low, at less than 1%. While that was a great endorsement of public efforts to limit the spread of infection, these low levels of immunity made it abundantly clear that across the country we remained extremely vulnerable to a second wave. Updated results in November 2020, in the midst of the second wave, suggest that while levels of immunity have risen—particularly in the Prairie provinces where they hover around 8% to 9% of the population—we are a long way from herd immunity. As such, accelerated vaccination is an urgent priority to move Canadians towards herd immunity.

A second area of focus is really understanding what immunity against SARS-CoV-2 looks like and how long it lasts. This science is happening alongside the seroprevalence studies. Results from one of the CITF-supported studies has just emerged, indicating that immunity following infection remains strong and protected for at least eight months. As the cohort of infected persons are followed further, we will get more insight on just how long immunity from infection lasts.

A third area of focus relates to immune testing, which includes, for example, research to validate dried blood spot specimen testing with made-in-Canada antibody tests that distinguish vaccine-induced immunity from post-infection immunity. These dried blood spot specimens can be used at home and are now being deployed in studies across the country to gather information about how population immunity is evolving as vaccines are rolled out.

The final area of focus is the newest. This is a focus on vaccine surveillance. The task force is supporting research partners from across Canada in a new collaboration that will monitor vaccine effectiveness and safety in the population at large and in high-priority groups.

Thank you very much.

● (1220)

**The Chair:** Thank you, Dr. Evans.

We go now to Medicago Inc. We have Ms. Nathalie Landry and Mr. Nicolas Petit.

Ms. Landry or Mr. Petit, please go ahead for six minutes.

**Ms. Nathalie Landry (Executive Vice President, Scientific and Medical Affairs, Medicago Inc.):** Thank you.

Good afternoon, Chairman McKinnon, Vice-Chairs Rempel Garner and Thériault, and members of the committee.

[*Translation*]

On behalf of Medicago, I would like to thank the committee for inviting us to participate today.

[*English*]

Medicago is a Canadian biopharmaceutical company with the mission to improve health outcomes by using its innovative plant-based technologies for rapid responses to emerging global health challenges.

Diseases know no boundaries. Medicago is working tirelessly to develop vaccines to help prevent disease, and to develop therapies to help treat those diseases.

Of course, no disease is more prevalent right now than COVID-19. We are proud to be contributing to the fight against COVID-19 by developing a made-in-Canada vaccine, which is currently in phase two clinical trials. Phase three is to be launched in the upcoming weeks.

[*Translation*]

We are proud to be a Canadian company based in Quebec City, and we make a significant contribution—

**Mr. Luc Thériault:** Sorry, Mr. Chair, but there's been a problem with the interpretation for a few minutes now. The interpreter is indicating that Ms. Landry's comments aren't coming through clearly because some mikes are not on mute. It would be appreciated if we could get that fixed.

I'll say it again. I don't understand how there isn't a mechanism to detect and flag the issue immediately, without my having to interrupt the witness every single time. I find it very uncomfortable to have to do that, so my apologies to Ms. Landry.

● (1225)

[*English*]

**The Chair:** I understand, Mr. Thériault.

I did not hear your point of order, if you raised one. I'm not really in a position to know when there are problems with the French translation, so I welcome your intervention to say so when the time comes.

I find that with Ms. Landry switching back and forth between English and French, there's a bit of a gap between each time.

Ms. Landry, if you could pick one or the other, we'd be probably better off, if that's okay with you.

**Ms. Nathalie Landry:** Yes.

**The Chair:** We shall carry on.

Hopefully, Mr. Thériault, you'll get better translation this way.

Please go ahead, Ms. Landry.

[*Translation*]

**Ms. Nathalie Landry:** My apologies in advance, but most of my notes are in English, so I'll carry on in English.

[*English*]

Medicago uses a proprietary plant-based technology to develop a vaccine and therapeutics. Our vaccines are virus-like particles that mimic the shape and the appearance of the virus without being infectious or being able to cause any disease. Because they look like the virus, the human body recognizes them and raises an immune response.

Our proprietary technology is extremely versatile and positioned to support rapid response to pandemics. It has been developed to support the fight against pandemic threats and other emerging diseases.

As soon as the genetic sequence of a virus becomes available, Medicago can develop clinical grade material for a vaccine candidate in only a few weeks—an important feature for this pandemic as we see new coronavirus variants emerging. During the current COVID-19 pandemic, Medicago has reallocated nearly all its resources to develop a vaccine against COVID-19 and to accelerate its path to increasing Canada's domestic vaccine manufacturing capacity.

In addition to our COVID-19 program, Medicago is advancing a number of programs in public health, including a pandemic and a seasonal influenza vaccine currently under review by Health Canada.

With respect to our COVID-19 vaccine program, I'm pleased to share some highlights of our phase one trial that has been completed. The data have demonstrated that 100% of the study participants who received an adjuvanted formulation of the vaccine developed high levels of neutralizing antibody response and cell-mediated immune responses after the second dose.

Our phase two trial is approaching completion, and based on these results and regulatory approval, phase three will be launched in the upcoming weeks.

The phase three portion of the trial will enrol 30,000 subjects in more than 10 countries to make sure that we have diversity within our trial, and the results of this phase three study are expected this spring. We expect regulatory approval for the vaccine this summer, at the point where we will start delivering doses to the Canadian government.

The Government of Canada's support has been instrumental for Medicago's COVID-19 vaccine development program and the construction of our large-scale manufacturing facility. It will ensure availability of Canadian-made vaccines to the population and provide much needed domestic manufacturing capacity for vaccine, antibodies and other immunotherapies.

In addition, Canada's advance purchase order of our vaccine has allowed Medicago to reserve supply for Canada and provide the security needed to pivot resources from other programs and to focus on COVID-19 vaccine development and production.

I want to take this opportunity to thank government leaders and partners who have made this investment possible: the Public Health Agency of Canada; Innovation, Science and Economic Development Canada; Public Services and Procurement Canada; and the Government of Quebec. We are very grateful for your support and look forward to continuing to work with our government partners to protect Canadians from the current COVID-19 outbreak and future public health emergencies.

As we look to critical factors involved in preparing for pandemics, it might be useful to structure our response according to three major axes: time, economics and competencies. Pandemic response requires long-term planning given the many years required to develop a vaccine platform and build domestic infrastructure. Private-public partnership provides strong synergies. While Canada needs to secure technology and domestic production capacity, industry requires terms to ensure sustainability and to encourage private investment. Competencies are critical to ensure a domestic response chain from early research to clinical development, production and distribution.

Government—

● (1230)

**The Chair:** Ms. Landry, I must ask you to wrap up ASAP, please.

**Ms. Nathalie Landry:** Yes.

In conclusion, we wish to reiterate our appreciation to the Government of Canada for its support. We are firmly committed to delivering vaccines to our population and serving Canadians to the betterment of our national public health, and we will welcome any questions.

Thank you very much.

**The Chair:** Thank you very much.

Now we will start our round of questions. We will have time for one round of six minutes per slot. We'll start with Mr. Barlow.

Mr. Barlow, please go ahead, for six minutes.

**Mr. John Barlow (Foothills, CPC):** Thank you, Mr. Chair.

Mr. Evans, we recently found out the immunity task force was not able to complete your antibody testing to see just how prevalent COVID-19 is in Canada. It seems a lot of this was related to your inability to access serology testing because of Health Canada's delays on their approval.

Do you think there have been some serious bureaucratic hurdles that are preventing our country from having the best possible COVID-19 response?

**Dr. Timothy Evans:** You may or may not recall, but when the task force was launched in April 2020 there wasn't a single approved immunoassay at that time. The first approvals took place in May. Those were approvals for assays that required a formal blood draw from a vein. We got those into the studies as quickly as we could.

The issue of looking at how to accelerate approval and the assessment of the efficacy of immunoassays is important to do. This is not specific to Canada. In virtually every country the standards for doing this, which involve assembling panels with diverse sources of blood, not only from infected people but from people infected with other conditions, and the period over which one looks at those bloods, meaning not only when they are first infected, but seven, 14, 21, 28 days later that whole process, in my opinion, based on our experience, could benefit enormously from stronger standardization, discipline and coordination with respect to making it work much more efficiently.

We did not have any point-of-care assays approved by Health Canada. Those are assays that can be used with a drop of blood from the finger. These assays can be used at home, so this allows you to test populations in a much easier way than to have people come and have a formal draw of blood with a needle. We worked very hard for a national microbiology laboratory to get an assessment of the validation of the dried blood spot. This we achieved in September. But this, again, is an area where I think if we looked at the process of getting the accreditation or the authorization that this was a valid and useful test.... I'm sure there's room for improvement.

The short answer is, yes, I think there's room for improvement in getting our testing assessed for accuracy more quickly.

● (1235)

**Mr. John Barlow:** Mr. Evans, do you know our national capacity to test for the variants?

**Dr. Timothy Evans:** I don't know the exact capacity. I've been part of discussions with an effort to mobilize capacity for tracking the variants. It's multi-faceted related to sequencing capacity, and also linking this to follow-up of the implications of the variant in its impact on transmission, as well as the disease profile of people who have those variants. I'm not in a position to comment on the scale of that capacity at this point, other than to say I've been part of conversations where plans are under way to scale it up.

**Mr. John Barlow:** Is it adequate, in your opinion, or is it not adequate? Can you give me a quick answer?

**Dr. Timothy Evans:** Canada has very impressive sequencing capacity through a set of institutions. Once they are joined together, we should certainly have that capacity across the country.

**Mr. John Barlow:** This is the last question, Mr. Chair. It's for Mr. Evans again.

How can we understand immunity if we can't test for those variants? How are we going to set that baseline if we can't test for the variants that are emerging?

**Dr. Timothy Evans:** It's a very good question. We're looking to understand the immune implications of the variants. This is a combination of observing the patterns of the variants in the population in terms of the impact they have on transmission and on the disease pattern, but also carrying out more laboratory-based studies that help us to understand how these variants might act differently from the other forms of the virus that we've been looking at thus far.

Everyone in the world is in a similar place on this front. There's an opportunity, not only in Canada but globally, to draw on that scientific enterprise to understand as quickly as possible what the consequences of these variants are for immune protection.

**The Chair:** Thank you, Mr. Barlow.

We go now to Ms. Sidhu. Please go ahead, for six minutes.

**Ms. Sonia Sidhu (Brampton South, Lib.):** Thank you, Mr. Chair. Thank you to all the witnesses for being here.

The federal government is still expecting to get six million doses by the end of March, with the two vaccines presently authorized. We expect that 13 million Canadians will be vaccinated before the summer, and we are on track to meet our target of 17 million doses by the end of September. Of course, this will go faster as even more vaccines are authorized. That is why we are hopeful that they will be.

My question is for Mr. Culbert. Vaccines are being administered by hospitals and public health agencies. As the supply increases over the coming weeks, do you think the agencies will be able to keep up with the demand, or do you think other locations of delivery, like pharmacies and doctor's offices, will need to be utilized?

**Mr. Ian Culbert:** First, it depends on which vaccines we're talking about. The need to track and have in an electronic registry a record of who has been vaccinated, to schedule their second dose and be able to track any adverse events, is going to be crucial. My concern about increasing the number of tracks of potential sites for vaccination is that it's so many more systems that have to be brought on board to track that information.

I would support greater investment in mass public health vaccination clinics, in multiple sites but organized by public health and bringing in as many vaccinators as you can. If pharmacists want to be part of the vaccination movement, they should be, but under the umbrella of mass vaccination clinics run by public health.

● (1240)

**Ms. Sonia Sidhu:** Thank you.

During the last panel, Dr. Bogoch was talking about the issue of vaccine hesitancy. Unfortunately, vaccine hesitancy is a problem among some visible minority groups. Misinformation is spread easily on social media, and official public health information is not always available in the necessary languages.

Could you speak to how our public health agencies are combatting misinformation and vaccine hesitancy, especially among multicultural communities?

**Mr. Ian Culbert:** Front-line public health organizations have links to those communities established. They work with them on a regular basis, so we'll be getting allies into community centres or other venues.

It's hard to have large groups, so it's more one-on-one. However, the ability to connect directly with those populations is absolutely crucial, and will be as we go forward. They need to hear the message from someone who looks like them and represents their interests but also has sufficient background to be able to answer their questions.

**Ms. Sonia Sidhu:** Thank you.

Dr. Evans, our government has provided over 17 million rapid tests to the provinces and territories. Ontario has received over six million of those tests, but according to updated numbers provided by the province's Ministry of Health on Monday, it had deployed only about one million of those tests. My community of Brampton has been one of the hardest hit and is home to many industrial and manufacturing hot spots. Do you think increased usage of the rapid tests would help to control outbreaks? Can you provide any explanation as to why the province has been so reluctant to use them?

**Dr. Timothy Evans:** I'd just like to clarify in answering your question that the COVID-19 immunity task force is not focusing on testing, either with antigens or with the real-time PCR, RT-PCR. However, I would say that the evidence from across countries is that where you have not only more aggressive or higher levels of testing but also much more timely determination of the results and follow-up of contacts, those countries are in a better position to control the epidemic

I think, again, in the spirit of learning, that Canada has a lot to learn with regard to how to manage testing systems such that they get to the populations where the problem is greatest and they're managed in such a way that you get timely results and can mobilize contact tracers in a way that mitigates the spread of infection. That being said, we need to look to our Atlantic provinces, where I think there's significant evidence of very good practice on that front thus far, and also take advantage of the way in which testing systems have been deployed in other countries.

**Ms. Sonia Sidhu:** I'm saying that because recently three Amazon facilities in Peel announced that they will be conducting their own rapid testing, which is helpful, as getting a test can often be a hassle and be confusing. Of course, not every company has the financial resources that Amazon does. Should the provincial government be deploying their tests to essential workplaces to help them control outbreaks?

**Dr. Timothy Evans:** My personal opinion on this is that getting more disseminated testing according to very clear public health standards is the only way to reach the levels of testing that are necessary to really mitigate the spread of infection.

**The Chair:** Thank you, Doctor.

Thank you, Ms. Sidhu.

[*Translation*]

Mr. Thériault, you may go ahead. You have six minutes.

● (1245)

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

I'd like to thank the witnesses for their statements.

In order to manage a health crisis of this magnitude, we have to ensure people continue to accept and follow the public health guidelines that are introduced. That means maintaining public trust. At the end of the summer, promising potential vaccines were announced, as were vaccines now authorized for use. Ever since, it seems to have become more of a challenge to maintain, or tighten up, the health restrictions in place. People became more lax, probably because of pandemic fatigue and the fact that their behaviours changed over the summer.

On one hand, according to the figures we have now, the government is claiming that everyone who wants to be vaccinated will be vaccinated by September 2021. On the other hand, the government has been anything but transparent about the timetable for vaccine deliveries or the terms of the arrangements. Is that the way to do things, Dr. Lexchin, if the goal is to maintain public trust in the authorities?

At the end of the day, all we know about the deals the government has signed is the quantity of vaccine doses. We know nothing about the price, the terms and conditions or the delivery schedule, and yet the government is asking us to believe that everyone will be vaccinated by September 2021.

What is your take on that?

[*English*]

**Dr. Joel Lexchin:** First of all, I think what we're dealing with is a lack of domestic capacity to produce vaccine, which leaves us vulnerable to what's going on in other countries.

We're seeing now threats, or moves, by the European Union to possibly restrict the export of vaccines from those countries.

Those are issues that we don't have any control over, nor do we really have the information to know what's going to be happening with delivery because we don't know anything about prices. Based on leaks from other countries, we know that there are differences in prices that have been negotiated.

For instance, the U.K. and Israel seem to have negotiated higher prices than the European Union, which may be affecting how quickly companies deliver to the European Union. We don't know the prices that Canada has paid.

This lack of information is a significant deterrent to being able to understand what our capacity is going to be to be able to vaccinate people over the coming months.

[*Translation*]

**Mr. Luc Thériault:** Mr. Evans, have you done any modelling around the progress towards herd immunity, based on the government's vaccine projections? People have started to receive their vaccines, and perhaps everyone will be vaccinated by September 2021, but that still does not mean that we will have reached herd immunity. Has the task force done any modelling around herd immunity? When do you think we will reach herd immunity?

With so few people vaccinated to date, is it not essential to keep the health measures in place for a long time, or even strengthen them?

**Dr. Timothy Evans:** Thank you for your question. It's a very important one right now.

We don't have any models indicating when the reproduction number will drop below 1, at which point we will have reached herd immunity.

We are working on building those models. To that end, we are working with the people who are making certain projections right now. For instance, we are trying to find out the schedule for vaccine distribution. In the current context, that information is still very hard to obtain or predict.

As for your second question, it's highly important that the population follow all the public health measures as closely as possible over the next six months.

● (1250)

**Mr. Luc Thériault:** As long as we don't have those models, it would be risky to consider easing the health restrictions.

**Dr. Timothy Evans:** I think we need to be very careful. There are always things we can't predict.

If the number of infections were to drop for four, five or six weeks in a row, we could see policies and projections changing. For the time being, however, I think it's smart, even necessary, to keep all the public health measures in place.

**Mr. Luc Thériault:** We need to do more testing, then.

**The Chair:** Thank you, Mr. Thériault.

[*English*]

Mr. Davies, go ahead please for six minutes.

**Mr. Don Davies:** Thank you.

Dr. Lexchin, I'm going to start with a couple of accountability questions and then, if I may, get into some substantive ones.

It's well known now that the federal government refuses to release a single word in a single contract that it has signed for the seven vaccine manufacturers that it has contracted with. Do you see any legitimate reason for the government's refusal to reveal to Canadians any details at all in these public contracts?

**Dr. Joel Lexchin:** I think the problem is that the vaccines are being treated as commercial products subject to commercial contracts. The vaccines are not a normal commercial good in the sense that computers might be. They're essential to health, and because they're essential to health, we need to understand the terms of the contracts so that everybody is aware of what the delivery schedule is going to be, the numbers and how quickly those doses are going to arrive.

I think Canada is just following what other countries have been doing or have done in terms of treating this as commercial goods, and I think that's a fundamental failure of the global community, not just Canada.

**Mr. Don Davies:** I'm going to get to that in a second, because that's a very important area, but we've been studying this subject for almost a year and we've had very few questions about the vaccine task force. You brought up this issue of conflicts of interest. I want to read to you something that was written about it just a few weeks ago:

> An important issue in the medical arena is the ubiquity of conflicts of interest at play and how we consider this to be almost normal....
>
> Public transparency of conflicts is not enough.... Independence is what is required for Canadians to gain trust in vaccine decisions. It is [therefore] mind-boggling, for example, that the task force decided that co-chair Mark Lievonen, who was the CEO of Sanofi Canada for 17 years (until 2016), who still owns shares in Sanofi, who is consulting with drug companies and who remains the director of two other drug companies, had no direct, material conflict of interest in assessing the Sanofi vaccine.

In your view, Dr. Lexchin, has the federal vaccine task force demonstrated sufficient independence and openness? What can you tell us about the way they've decided to conduct their activities essentially in secret?

**Dr. Joel Lexchin:** That's certainly a significant problem, that lack of transparency. One of the things we've been faced with over the entire period of the pandemic is that we need public trust in what is happening and what the health community and the government are doing in terms of trying to protect us from COVID-19, but without transparency in terms of what's happening on the task force, that trust is being eroded.

It can be done much differently. In Australia, for instance, back in April, the government in Australia funded a national COVID-19 clinical evidence task force to provide rapid evidence-based and continually updated advice on Australia's response to the COVID-19 pandemic. It set up an independent committee of four people to give advice over who should sit on this task force and release their conflicts of interest to this independent committee. The independent committee provided advice back to the Australian government saying, “No, this person shouldn't be sitting on the task force”, or, “Yes, this person is okay”. The Australian government has been following that advice, ensuring that when they get information from the task force, it's not tainted with possible conflicts of interest.

● (1255)

**Mr. Don Davies:** Thank you.

I want to put two scenarios by you, Dr. Lexchin. From an epidemiological and public health infectious disease point of view, if we could immunize all seven billion humans in the next year versus not doing that, but rather, say, immunizing only a quarter of the world and doing the rest over the next 10 years, does that have any impact on the ability of this virus to mutate, or is it beneficial from a public health point of view to do one over the other?

**Dr. Joel Lexchin:** In my view, what we want is a global strategy for this, so that the most vulnerable people in all countries get immunized to decrease the rate of spread. One of the things we know is that the faster the virus spreads and the more people it infects, the higher the likelihood that it's going to mutate.

That's one of the reasons we're seeing mutations coming from countries like Brazil, South Africa, the U.K. and possibly the United States. These are places where the virus has spread very rapidly and is widespread.

If we concentrate our immunization efforts, as we seem to be doing, on the rich countries, and then go to the low and middle-income countries, we're ensuring the development of mutations. Some of those mutations may be resistant to vaccines.

Canada should show leadership. Canada can't do this alone, but it can certainly show other countries the right course. The right course is for Canada to support the COVID-19 technology pool, to give more support to COVAX and to announce when we're going to be donating our excess vaccines to other countries.

**Mr. Don Davies:** Did you not say that South Africa and India are calling on the WTO—

**The Chair:** I'm sorry, Mr. Davies. Your time is up.

I'd like to thank all the witnesses for sharing their time and expertise with us today. Your input is extremely well appreciated, and will be most helpful to our study. With that, I would invite the witnesses to withdraw, and we will carry on with a bit of business left over from Friday.

On Friday, we were considering a motion by Mr. Van Bynen. At the point where we moved to adjourn until now, we were perilously close to achieving a meeting of minds. Mr. Van Bynen's motion was to instruct the analysts to prepare a report on the mental health study. It was simply instructions to prepare a report. There was no mention of taking any committee time for considering the report.

Mr. Maguire submitted a motion to amend that to require that any consideration of such a report only be done during a constituency week.

I see hands up. I have Mr. Van Bynen up first, please go ahead.

● (1300)

**Mr. Tony Van Bynen (Newmarket—Aurora, Lib.):** Thank you, Mr. Chair.

Let me start by thanking my colleagues for proposing that we continue this debate today after we've heard from witnesses on our second topic under the current study. Hopefully, everyone has had some time to think about what I proposed last week. I hope we can get to an agreement and continue to be productive in our roles as members of this committee.

With respect to the standing committees, *House of Commons Procedure and Practice*, third edition, 2017, chapter 20, page 979, indicates that each committee:

> is given the power to examine and enquire into all such matters as the House may refer to it, to report from time to time and to print an appendix to any report, after the signature of the Chair, containing such opinions or recommendations, dissenting from the report or supplementary to it, as may be proposed by committee members.

On Friday, January 29, I proposed to you, my colleagues, that we committee members instruct the analysts to prepare an interim report on the topic on the impact of COVID-19 on the mental health of Canadians, based on the four meetings held on this topic as part of our current study.

We were instructed by the House to look into the emerging situation facing Canadians in the light of the second wave of COVID-19, to hear from Canadians across the country on the impact this has had on our lives and to study the government's response to the coronavirus pandemic. As such, our committee agreed to a plan. Each party would submit four topics in the study, in order of priority. Each topic would be examined, in turn, by priority on the following rotation: Liberal, Conservative, Bloc and NDP. We determined by majority the number of meetings per topic, with a minimum of one and a maximum of four meetings. Each party would be entitled to an equal number of witnesses.

Now, this is a SparkNotes or a Coles Notes version of it, but I'm sure the clerk, the analysts, or the appropriate person would be more than happy to send an email to all members with a reminder on what was agreed upon in this plan.

If I remember correctly, it was Mr. Davies who suggested our committee move forward in such a manner and moved the motion that outlined our current plan. Maybe he's able to give us a better summary of it than I am.

I do know, however, at that time I said it was a reasonable approach, and I still believe that to be the case. However, I have since come to realize that interim reports, as part of our study, will help, not hinder, as it was suggested on Friday, our ability to effectively work as members of the health committee in the pandemic.

I will once again quote our favourite book, this time on page 991:

> In order to carry out their roles effectively, committees must be able to convey their findings to the House. The *Standing Orders* provide standing committees with the power to report to the House from time to time, which is generally interpreted as being as often as they wish.

As the Standing Committee on Health in the middle of a pandemic, I see creating interim reports on each topic of this current study as our duty to the House to the task we've been given, to our colleagues and to Canadians.

I want to be very clear because, perhaps, I wasn't on Friday. I'm proposing the analysts produce an interim report on the topic we had just finished. I'm not proposing that we stall witnesses on vaccine delivery or the ministers in front of the committee next week. I'm not proposing that we interrupt, impede or delay any of the meetings on the topic of vaccines or future topics. I want to remind you that all parties submitted the topic of vaccines as a priority.

I'm not asking analysts to take any time away from their work in the meetings on the topic of vaccines, or any future topic, to write an interim report. On Friday I asked our analysts their thoughts on this. The answer was clear, and I quote:

> I think writing an interim report would be very helpful. It would help the committee to focus on what they heard during those first four meetings, and it takes the study in some easier to consume bites. We're fine to go ahead and start to draft an interim report. If the committee wishes, each of the members could submit what they hope to be in the report. That could be submitted through the clerk.

● (1305)

*House of Commons Procedure and Practice* is clear on reports. It says they "may be short documents of less than one page in length or...more substantial and separately bound works." That is on page 990 if anyone would like to check.

I see no problem in our being able to provide our requests and recommendations in writing through the clerk. I am also not asking us "to be wasting meetings deliberating things like punctuation on a report that's not material to getting tools to end this pandemic." I'm confident in our analysts' ability to punctuate properly, as well as to dot the i's and cross the t's. To question our analysts' ability to properly punctuate is offensive, as is insinuating that documenting our work is not material to getting tools to end this pandemic when it very clearly is the opposite.

It's unacceptable that one year, 36 meetings, 198 witnesses and 63 submitted briefs since our first committee meeting relating to COVID-19 we have not yet reported our findings and recommendations to the House.

Mr. Chair, and colleagues, I'm once again seeking agreement on how to find a way for our analysts to produce an interim report. We just wrapped up the meetings on one topic. Let's have an interim report on that. Once we wrap up the next topic, let's have an interim report on that and so on.

This is a large study. It encompasses a variety of important topics for me, my constituents, you and yours. Let's make sure that the witnesses we bring in, their testimonies, their requests and the questions that we are asking are reflected and reported in a timely manner without impeding, interrupting or delaying the following topics. We're all professionals here, and I trust that we can work together to find a solution to move this forward.

Thank you, Mr. Chair.

**The Chair:** Thank you, Mr. Van Bynen.

Mr. Kelloway.

**Mr. Mike Kelloway (Cape Breton—Canso, Lib.):** Thank you, Mr. Chair.

Hello to my colleagues.

Like MP Van Bynen, I reflected on Friday's committee meeting over the weekend. I think it's pretty clear, at least from my perspective. I want to break it down a little bit, and I promise to take only a few minutes. I believe that there's consensus that an interim report would be great, but it seems to me that we're on the fence or just can't decide on what the topic should be.

Like I said last week, none of us on this committee have any intention—zero intention—of delaying a vaccine study. We're simply suggesting that an interim report be written on a concern for millions of Canadians: mental health.

Now no one is saying that when we conclude the four meetings—or five meetings, if you include the minister's appearance—we can't do another interim report on vaccines and so forth and so on. All members of this committee know how important the mental health study is to Mr. Van Bynen, to all of us. It's important to Canadians, and it would be great to work on this together.

Last week, I think—and I hope I have this right—Ms. Norris said—and we can check the blues on this—that "an interim report would be...helpful" and really allow the study to be produced in easy-to-consume chunks, a comment Mr. Van Bynen referred to. I look at that as a real, practical and effective approach, in my opinion.

Mr. Chair, I'm wondering.... We have the analysts here. We have the researchers here. Can we include them in this conversation? After all, they're part of team HESA.

Thanks.

**The Chair:** If the committee agrees, I can ask the analysts to step in here and give a response. Is there any opposition to that?

**Mr. Don Davies:** Yes, Mr. Chair. I think we should hear from more than just the Liberals on the committee before we hear from the analysts. There are different perspectives on this.

**The Chair:** Okay, well, we'll carry on.

We have Mr. Fisher next.

● (1310)

**Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.):** Thank you, Mr. Chair.

Everything that I was going to say has already been said, and I think Mr. Davies is right. We'll hear from members of the opposition. I'm glad that Don's.... I think that Don's up next. I always like hearing from Don and the way that he finds a hybrid for what we're all saying, so I'll put my hand down.

Thank you.

**The Chair:** Thank you, Mr. Fisher.

Mr. Davies, please go ahead.

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

I do think I will have a suggestion, but I think it might be a better approach to have a couple of preliminary remarks.

I don't think interim reports are a bad idea, particularly given the current issue before us. I must say in 12 years I don't recall our ever doing one. I've never done an interim report. That includes some very lengthy studies too. We studied pharmacare, as Mr. McKinnon and Ms. Sidhu will remember, for a good two years. We didn't issue an interim report in that.

Having said that, I'm not opposed to the concept of an interim report. The question really is what should that interim report be on.

Of course, we opened this study back in February of last year, and we heard a lot of evidence from February into mid-July, I think, when the committee stopped sitting on many issues. Some of those were extremely important issues.

We heard today about vaccines. We've heard about issues on domestic production, transmission reduction strategies and the impact on racialized communities. In fact, I think today we've heard some evidence on an extremely important issue, which is whether the world is even using the right model to get vaccines to the population. We're using a private, corporate commercial model that is clearly unable to get enough vaccines to people instead of a global approach.

The question really is, out of all those things should we issue an interim report on mental health based on four meetings that we just heard?

I think mental health is important. I think it's as important as many of the other issues I've mentioned, but I'm not sure it's more important than many of the other issues we've heard about.

The other thing, of course, is that what Mr. Van Bynen's motion is really asking is for this committee to issue an interim report on mental health based on four meetings, which happens to be the priority of the Liberal Party, and to issue that report. Although we're all interested in mental health, that was the Liberals' choice for the first priority, and we have not heard the first priority of the other three parties yet.

If I understand Mr. Thériault's approach correctly—and he can correct me if I'm wrong, and the error in reciting this is mine not his—I prefer his approach. If we were going to issue an interim report, what I would like to do is have the analysts summarize all of the evidence they've heard to date, and then wait until after we've at least heard from each one of the four parties about their first priority, which will take about another maybe 30 days or so. Then we would issue an interim report that summarizes the evidence to date in a global, comprehensive way. At least it's fair because we've heard about all parties' first choices not just the Liberal Party's.

I would point out as well that although I don't think it is a big deal we were hampered a little bit by the prorogation. I don't think it mattered a great deal, but it did cause the committee to lose three or four meetings in order to get up and running again back in September, as we had to rejig. I think what that has done has made us forget a little bit of the incredibly important evidence we've heard on profound issues of importance to Canadians from February until now.

I would say as well that I also trust our analysts very much, but this committee time will be taken up in reviewing a report. We have to. We can't just say to the analysts to go write a report and then issue it. The report has to come back before this committee, and we are obligated to go through it line by line, and have debate, discussion and amendments on that report, so that will take committee time.

I'm not necessarily opposed to doing that except I don't want to be doing that now before we've even had a chance to hear from the Bloc or the NDP on our first priorities.

For those reasons, I'm not in favour of this motion at this point. I would suggest that maybe we can go back and think about this: that all members of this committee reflect on the suggestion I've made, to wait and hear about the first priority of all four parties in the first round. Perhaps even now we can instruct the analysts to begin the very laborious process of summarizing the evidence heard to date, which has to be done at some point. Then we can revisit this issue and discuss issuing an interim report after we have heard the first priority of the four parties.

● (1315)

My final comment will be this. I have great respect for this committee, and I think when we speak, we speak with a force to Parliament. We are fortunate in having the Parliamentary Secretary to the Minister of Health, Mr. Fisher, serving on this committee. There's nothing preventing the Liberal members of this committee, or Mr. Fisher, from going to the health minister at any time. They sit in caucus every week with the Liberal Party, the governing party, and could bring this information to the government to influence policy. The government does not have to wait.

In my experience, they generally don't actually listen to what the health committee tells them to do in any event. I mean, this committee issued a majority report urging the government to, in a timely way, bring in public pharmacare. That was three years ago. We can't get the Prime Minister or the health minister to even commit to the concept.

For all those reasons, I'm going to vote against this motion. I do like the idea of an interim report on a broader array of issues, not limited to just one issue. As important as it is, it is not the only important issue facing Canadians.

Where I'll conclude is, if there is one issue which I think we should be issuing an interim report on right now, it should be on vaccines. The reason is that it's vaccines that are going to actually provide the answer, as we've heard from these witnesses today, to the health crisis facing us. The mental health issues are a derivative. They are a secondary impact of the fact that people are dealing with an out-of-control pandemic. If there were a need for an interim report and advice to government on anything right now, to me it would be on giving the government advice on how it could expedite the delivery of vaccines to Canadians. If we do that, I think we'll start seeing amelioration of the mental health impacts to some degree.

Those are my comments on the motion.

**The Chair:** Thank you, Mr. Davies.

I'd like to clarify, however, that Mr. Van Bynen's motion did not ask to issue a report, only to instruct the analysts to prepare one.

Next we have Mike.

**Mr. Mike Kelloway:** Thank you, Mr. Chair.

Don, thank you for that. I'm just playing with wording on my screen here. I wonder if I could read something to you and by no means is it something to commit to at this moment. I just want to make sure I got what you're saying.

What if we amended the motion to instruct the analysts to prepare an interim report for each of the topics of study as we conclude their meetings and for them to be reviewed at the end of the first round of topics? Is that where you're heading with it? I just wanted to make sure.

**The Chair:** Mr. Davies, did you wish to respond to that question?

**Mr. Don Davies:** Yes.

Thank you, Mike, for that question. That's one derivative. I actually hadn't put it that finally, but I think it's a fairer issue to perhaps do an interim report just on the first four priorities. What I was saying was summarize all the evidence heard to date, but I think your suggestion is one that would be worth considering too.

**Mr. Mike Kelloway:** Thank you, Mr. Chair.

**The Chair:** Thank you.

I see no other hands up.

I should remind everyone that the vote at this moment is on Mr. Maguire's amendment, which is to require that any consideration of the report mentioned in the main motion would not happen except on a constituency week.

Still seeing no hands raised, I will ask the clerk to conduct the vote on Mr. Maguire's amendment—

[*Translation*]

**Mr. Luc Thériault:** Mr. Chair, could you remind us of Mr. Maguire's amendment?

● (1320)

[*English*]

**The Chair:** Certainly.

As I mentioned earlier, Mr. Van Bynen's motion was to ask the analysts to prepare an interim report. Mr. Maguire's amendment was that we restrict any consideration of such a report strictly to constituency weeks.

Are you clear now on what we're doing, sir?

[*Translation*]

**Mr. Luc Thériault:** If I understand correctly, the amendment pertains solely to timing. All he is requesting is that we consider any such report outside our parliamentary schedule. The amendment has nothing to do with the discussion that just took place. Is that correct?

[*English*]

**The Chair:** Well, it does, because if we pass Mr. Maguire's amendment, and then if we pass Mr. Van Bynen's motion, we will instruct the analysts to prepare a report and that such report, if and when we choose to consider it, would have to be done during a constituency week. That's the upshot of the motion and the amendment.

Ms. Rempel, I see that you have your hand up.

**Hon. Michelle Rempel Garner:** Thank you, Chair.

For me, I think, Mr. Davies has raised some good points. On the mental health study, I think the testimony we got was just devastating. It really showed the impact of the continued, prolonged lockdowns and the impact of not having an adequate vaccine supply and rapid tests. I think it really sets the scene for some of the recommendations that I expect will come forward in the vaccine component of the study; perhaps rapid tests.

To Mr. Thériault's comment, I'm comfortable voting against Mr. Maguire's motion and then against the main motion as well.

**The Chair:** Thank you, Ms. Rempel Garner.

(Amendment negatived [*See Minutes of Proceedings*])

**The Chair:** Thank you, Mr. Clerk.

Mr. Maguire's amendment does not carry. We now go back to debate on the main motion.

Mr. Kelloway, please go ahead.

**Mr. Mike Kelloway:** Thanks, Mr. Chair.

I'd like to move to amend the original motion to instruct the analysts to prepare an interim report for each of the topics of study as we conclude their meetings, and for them to be reviewed at the end of the first round of topics.

**The Chair:** We now have a new amendment on the floor.

Ms. Rempel Garner, do you wish to speak to this amendment?

**Hon. Michelle Rempel Garner:** I do.

In my 10 years in Parliament, analysts were preparing a summary of evidence and working on the report while witnesses were coming forward. I'm not sure what this amendment would do.

I would also note the situation we're facing is changing almost daily; it's getting worse. I'm concerned if we're just coming up with interim reports right now, and that's what this amendment would do, that if new information came forward with regard to the lack of supply on vaccines, on mental health in health care workers, it wouldn't be fulsome. Other witnesses might want to submit written briefs.

I'm wondering if perhaps, Chair, after our fourth set of topics, we could have a business meeting at that point to look at what comes next and review evidence. I think that's standard operating procedure.

At this point, after we dispense with this motion, I want to talk about a couple of procedural things. We're having amazing witnesses at these committees and we're barely being able to scratch the surface of their testimony because we're taking up six minutes of housekeeping on the front end of the meeting.

I'd rather let the analysts do their job. If there is a moment when we need to issue an interim report, the committee can do that. At this point, I would rather keep the process open for Canadians to submit written briefs that the analysts and committee members can use in their deliberations, and that we do one set of topic selection. Because of that, I will be voting against this amendment, with the hope that more Canadians can participate in the process.

Thank you.

● (1325)

**The Chair:** Thank you, Ms. Rempel Garner.

I should note again there's no suggestion of issuing such a report on these bases. It doesn't preclude the briefs. In effect, it implies the briefs received certainly to date are going to be considered.

Mr. Davies, please go ahead.

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

I have something to say, but I'm also a little confused. This is the second time you've referred to not issuing a report. I'm not sure I understand what you mean by that. I thought the whole purpose of the motion is to have the analysts prepare a report. Obviously we'd have to go through it. That's what an interim report is.

Maybe you can come back to me, Mr. Chair, for my comments on the main thing, but could you clarify what you mean when you say there's no suggestion we would be issuing an interim report?

**The Chair:** Yes. My understanding of Mr. Van Bynen's motion is we ask the analysts to prepare a report. That report could be made available to us as a committee, but it doesn't go on to say that we issue it to Parliament on any particular time schedule. It's up to us as a committee to decide whether or not to issue that report or whether to consolidate it with other reports as we accrue them over time.

Certainly if we wish at some point to issue the report to Parliament, we would have to take some time to go through the report and make sure the recommendations were appropriate from our respective points of view and so forth. But Mr. Van Bynen's motion is simply to ask the analysts to prepare such a report.

That's how I understand what we're dealing with. I hope that adds clarity.

Go ahead, Mr. Davies, if you wish to resume.

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

It could be just me, but that's not at all how I understood it. Even judging by the comments of Mr. Van Bynen and other members, I think most members are understanding that the purpose of this would be to have a report prepared for us. We would go over it and of course we would issue it. It wouldn't be of any assistance to anybody to produce a report on mental health for our own purposes. I would think the value of it—once we come to an agreement—would be in issuing that report both for the public and for the government.

You may be correct that it just wasn't mentioned in Mr. Van Bynen's motion. In my mind, the purpose of an interim report would be to produce something productive that we could then issue as a committee.

I like Mike's suggestion. I think that's a reasonable one. I want to make sure I understand it. To me, it seemed that his motion would have the analysts prepare an interim report on each of the four priorities, but not release them until the end of the meetings on the four priorities. Then we could discuss as a committee all of them at the same time. Then I would think we would issue an interim report on the four priorities at that point.

I see the thumbs up.

Once again, I think that's not exactly what I was talking about before, but I think it's a good idea. As long as we haven't lost sight of the fact that we have this mountain of interim evidence we have received from many witnesses who took time out to come to our committee from February until the end of 2020. I still think we have to get that evidence summarized. Perhaps that's a larger project to do after we do this.

I think Mike's suggestion is a good one. It's fair to all the parties. It will be released at the same time. I also think it pays respect to Tony's idea on mental health, but also respects the other parties' priorities.

● (1330)

**The Chair:** Thank you, Mr. Davies.

Mr. Van Bynen, please go ahead.

**Mr. Tony Van Bynen:** Thank you.

I agree with what Don has said. The intent would be that each one of these segments, as we've identified them, would a be a chapter in the overall study. I think the recommendation and the amendment Mike is proposing is a good one because it allows us to consider each one of these chapters and the effect of the overall study more effectively.

I appreciate that amendment and I would be supporting it.

**The Chair:** Thank you, Mr. Van Bynen.

Ms. Rempel Garner, please go ahead.

**Hon. Michelle Rempel Garner:** I'm not sure anyone's clear on what's being proposed here.

This is how I would like to proceed. The analysts do their job, as they've been admirably doing. They're reviewing the material that's coming in. They're preparing a draft report. Since this amendment doesn't really have any date on which we would be reviewing that, we're kind of just proceeding normally anyways.

I'm not comfortable with wording on an amendment that could potentially be used to weasel out of one of Conservative-selected meetings on vaccines. The amendment has now been amended so many times that I think the Liberals should have gotten their ducks together and actually formally crafted this. Maybe they should've just picked up the phone and given me or any one of our colleagues a call ahead of time.

I would like to move to adjourn debate.

**The Chair:** Thank you, Ms. Rempel Garner.

The motion is to adjourn debate. There is no debate on that.

(Motion negatived: nays 7; yeas 4)

**The Chair:** We go now to Monsieur Thériault.

[*Translation*]

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

I would like to point out that, by definition, an interim report is just that: an interim report. The problems around vaccination will probably continue until we submit our final report. At any rate, the issue will remain until we reach herd immunity.

The committee did not decide to hold only four meetings on the topic. Depending on the situation, we could add meetings. The committee is free to determine its own schedule, in a united and sovereign manner.

One thing is certain: we will not work on the report until we have studied the priority topic of each party. At this point then, the member's argument does not make sense. If ever the need arose to hold more meetings, there is nothing stopping us from doing so.

Be that as it may, methodology-wise, I think it's extremely important to have a document that shows where we are. For that reason, I support the motion.

● (1335)

[*English*]

**The Chair:** Thank you, Mr. Thériault.

I should remind the committee that we are operating under the terms of Mr. Davies' motion of November 13, or so, which is that if we wish to do more than four meetings on any given topic, we require unanimous consent to do so.

Mr. Fisher.

**Mr. Darren Fisher:** I hear Luc and it makes sense; I hear Don and it makes sense; and I hear Mike and it makes sense. I think we're going to get to a place where I hope the whole committee wants to get. Nobody wants to weasel out of anything. Everybody wants to get this work done.

I'm not sure. I guess the next step would be to finish out debate and then move to the vote on the amendment, but I get the sense that what Mike is proposing and what Don is saying and what Luc is saying are all in that same ballpark. I certainly hope that's the case, because I think that's a reasonable way forward.

**The Chair:** Thank you, Mr. Fisher.

Mr. Davies, go ahead.

**Mr. Don Davies:** It's really important that we're all clear on what we're saying, and Michelle's comments left me with some concern that maybe we're not.

To make sure that I have it right, what we're talking about is hearing all the meetings on the first priority. We've already done four on mental health, we're going to do four on vaccine, and then we have the Bloc's priority. We have not determined how many meetings, what that will be, up to and including four, and then we have the NDP priority, up to and including four on whatever our priority is.

The motion is to instruct the analysts throughout the process to prepare an interim report on each of those topics. At the end of all those meetings, we will schedule our meetings to go over the reports all in one shot and we'll issue, hopefully, one interim report on all four priorities.

The reason I want to clarify that is because Michelle tended to be concerned that we would be taking up meeting time of our priorities, but that's not how I understand it, given the order, and I see a lot of heads nodding. I think what I expressed is what we are getting at.

If that's the case, taking a meeting or two at the end of the first round of priorities to assess the interim report and issue that interim report before we then start the round of second priorities of parties I think makes sense. It usually takes a couple of meetings to go through a report. I don't think we need to take more than two meetings to do that.

If I understand it properly, then I'm in favour of what I just said, if Mike and Tony are okay with it.

**The Chair:** That's my understanding as well.

We'll go now to Ms. Rempel Garner, please.

**Hon. Michelle Rempel Garner:** Thank you, Chair.

Given the fact that it would be tough for me to trust the government, because sometimes they say some things and do different things, I wonder if Mr. Kelloway could read the motion exactly how it would be as amended, just to make sure that what is being said is actually what is being prescribed in the motion.

**The Chair:** Just as a point of clarification, you're not being asked to trust the government. You're being asked to respect the members of the committee before you, who—

**Hon. Michelle Rempel Garner:** Point of order, Mr. Chair. Actually, Mr. Fisher does have a government appointment and has been part of debate and is part of committee. I'm assuming that as a quarterback of the Liberal side, he's speaking on behalf of the government.

● (1340)

**The Chair:** Be that as it may....

We have Dr. Powlowski next.

Following that, Mr. Kelloway, if you wish to restate your amendment, I'll invite you to do so.

Dr. Powlowski, please go ahead.

**Mr. Marcus Powlowski:** In response to Don's point, I think that if we took a meeting or two after completing everybody's round of their topic, I think this is a good idea to summarize things, but it would also be an opportunity to at that point decide that we may need to revisit some of these issues. This is going to be a couple of months down the line. Maybe the situation with respect to vaccines will have changed, and we will want to bring it back to have more discussions on vaccines, but I think that would be a good opportunity to figure out where we are and where we ought to be going.

**The Chair:** Thank you, Doctor.

**Mr. Don Davies:** Could I just have a point of order, Mr. Chair? It's really more of a point of clarification.

I didn't mean to suggest that we have a meeting after each priority. It's that the meeting where we discuss the report would be after all four priority meetings are heard. I see that Marcus is okay.... Thank you.

**The Chair:** I'm going to ask Mr. Kelloway to restate his amendment, but I'm also going to encourage us all to wrap this up quickly, because we're very quickly going to get booted from this room for the next group.

Mr. Kelloway, if you please, go ahead.

**Mr. Mike Kelloway:** It is, "instruct the analysts to prepare an interim report for each of the topics of study as we conclude their meetings and from them to be reviewed at the end of the first round of topics".

**The Chair:** Is everyone clear now? Are we ready to vote on Mr. Kelloway's amendment?

(Amendment agreed to: yeas 7; nays 4 [*See Minutes of Proceedings*])

(Motion as amended agreed to: yeas 7; nays 4 [*See Minutes of Proceedings*])

**The Chair:** Thank you, Mr. Clerk.

Ms. Rempel Garner, I understand that you wanted to take up some procedural matters. We are really running out of time. I know that you're concerned about the time we spend during the preamble of each meeting. I should advise you that the clerk has given me an indication that he's going to tailor those scripts a bit, depending on whether or not we have members in the House.

Is this something that you absolutely need to raise now or is it—

**Hon. Michelle Rempel Garner:** I do, because, Chair, I think the average amount of time that you're taking to read housekeeping items at the front of each meeting, which are repetitive, actually takes a full question round away from members. I think that needs to probably be changed so that it's more efficient. I think most of what you're reading is known operating procedure and could be emailed to members and also advised to witnesses prior to the start of committee meetings.

The other thing I would say is—I've said this many times—that witnesses should be sound-tested before the start. When a meeting has really already started, especially when we're doing two tight panels....

I move that, in an effort to maximize witness testimony and MP questioning time, the clerk and the committee communicate to all witnesses and members all protocol, procedure and technical information prior to a meeting to ensure that this information does not need to be repeated during a meeting.

● (1345)

**The Chair:** Thank you, Ms. Rempel Garner.

Mr. Davies, please go ahead.

**Mr. Don Davies:** I support what Ms. Rempel Garner's saying, and I also want to raise the issue that Mr. Thériault is repeatedly struggling with.

I think witnesses have to be instructed that they have to have a headset, because that seems to be the problem. If they don't have the headset, then the interpreters can't get the audio. I think Mr. Thériault's holding back. I think there are more interpretation issues and he's graciously trying to not interrupt the meetings, but it's completely unfair that he has to be put in a position of interrupting.

I don't think any witness should be allowed to testify unless they have the proper headsets or arrange them, or in the case of Dr. Bogoch, I think he had an acceptable...looks like he had a pretty skookum microphone there.

The interpretations have to be ironed out before the meeting starts. I understand there could a glitch here and there, but it shouldn't be an equipment-based one, because equipment can be worked out in advance.

The other thing I want to serve notice on, just to get my colleagues thinking about, I will probably move a motion on this coming up. We have these superb witnesses coming. We just had two powerhouse panels of some of the best witnesses maybe in the world, and we could barely scratch the surface. Giving them five or six minutes to talk and then six minutes of questions is not enough.

I know we're constrained by the motion from the House in some respects, I would like to have us all think about how we can maybe change this. It would be nice to have maybe four witnesses for the two hours so we can give them a full 10 minutes, and then we have second rounds of questions.

Also, I know that certain members I speak to have not been able to ask questions because we only get the first round.

Again, I know we're dealing with the House motion but maybe this committee can change that, or we can go back to our whips and maybe amend that motion somehow, because hearing eight witnesses in this time period, in this format, does not do justice to them nor to us.

I just wanted to throw that out. I would be interested in my colleagues' thoughts on this at a future meeting.

**The Chair:** Thank you.

I should point out that the clerk makes extraordinary effort to get people headsets and so forth, and to go through technical stuff. That's why he needs several days' notice.

As for the Minister of Health from Saskatchewan, for example, we only knew he was going to be able to make the meeting 10 minutes before the meeting started. There was no opportunity to get him the headset and make sure it was available.

I would certainly encourage everyone to get their witnesses together on any given meeting very soon so the clerk has ample time to locate them, to communicate with them, and make sure they have the headsets and so forth.

The House of Commons is ready, willing and able to send out headsets to everybody, but they just need time to do that.

I think we're running out of time here.

Mr. Van Bynen, you have your hand up.

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

The point that you've raised is a point that I wanted to raise as well. We need to make sure that all this equipment is in everybody's hands and so we need adequate notice.

I think this may require some further discussion, further consideration, so I would move that we adjourn debate to the next meeting.

**The Chair:** Once again, we have an adjournment to a date certain. This would be an adjournment until after the ministers' meeting on Friday.

There is no debate on this. I will ask the clerk to conduct the vote.

(Motion agreed to: yeas 7; nays 4)

**The Chair:** Thank you, Mr. Clerk.

This debate is adjourned until after the ministers' appearances on Friday.

That concludes our business. It was a good meeting. There were interesting discussions.

We'll see you on Friday.

Thanks, everybody.