HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

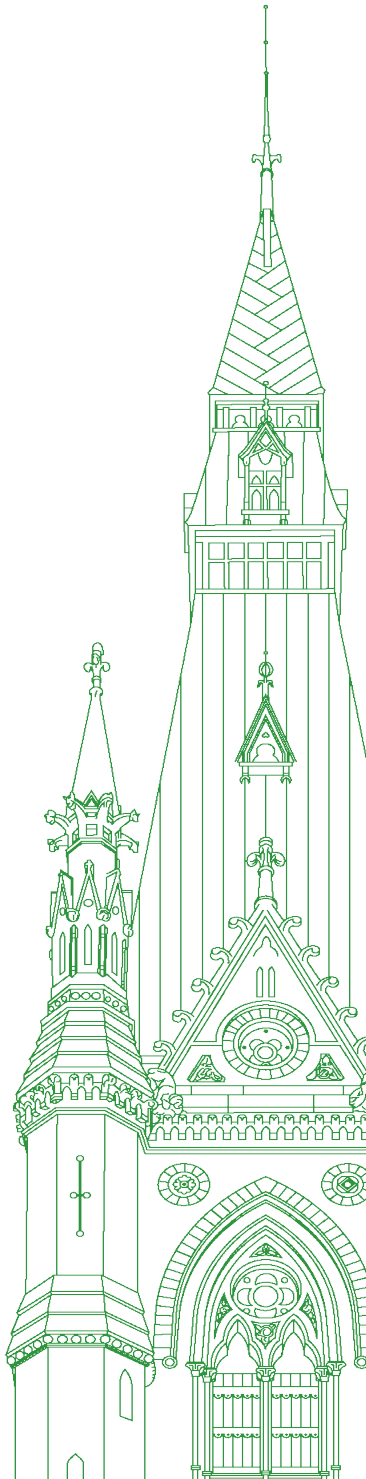
43rd PARLIAMENT, 2nd SESSION

Standing Committee on Health

EVIDENCE

NUMBER 028

Monday, April 12, 2021



Chair: Mr. Ron McKinnon

Standing Committee on Health

Monday, April 12, 2021

● (1100)

[*English*]

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

Welcome, everyone, to meeting number 28 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 COVID-19 pandemic and, most specifically for this meeting, the collateral effects of the pandemic.

I would like to advise the committee that the witnesses we requested last week for the meeting have confirmed availability for Friday.

I would now like to welcome the witnesses for our meeting today. From the Calgary Airport Authority, we have Carmelle Hunka, vice-president for people and risk and the general counsel. From the Centre for Future Work, we have Dr. Jim Stanford, economist and director. Finally, from Share Family & Community Services Society, we have Ms. Claire MacLean, chief executive officer. Welcome to all of you.

Before we get to the witnesses, we may have some business to take care of first.

Ms. Rempel Garner, did you want to move your motion at this time?

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): What motion, Mr. Chair? I don't think you're at liberty to talk about motions that have been put forward. Is that correct?

The Chair: You have informed the committee of a notice of motion. I'm—

Hon. Michelle Rempel Garner: Mr. Chair, I put to you, before you say what you're going to say, that when a motion submitted to the clerk in confidence is disclosed without the mover putting it forward, there is a breach of privilege.

The Chair: I haven't actually disclosed the motion. I just noted that you filed one. The members of the committee are all aware of the fact that you have filed one.

I take it that you do not wish to move the motion at this time.

Hon. Michelle Rempel Garner: I find that your raising this matter in this manner is inappropriate.

The Chair: Well, thank you. I'll take that as a no.

That being the case, we will carry on with our business.

We will start with our witnesses. Witnesses, you will have seven minutes for a statement. We'll start with Ms. Hunka, vice-president of people and risk and the general counsel for the Calgary Airport Authority.

Please go ahead, Ms. Hunka, for seven minutes.

Ms. Carmelle Hunka (Vice-President, People, Risk and General Counsel, Calgary Airport Authority): Good morning, and thank you, Mr. Chair.

Honourable members of the committee, thank you for inviting me to speak with you today.

My name is Carmelle Hunka. I am the vice-president, people, risk and general counsel at the Calgary Airport Authority.

Airports play a critical role in ensuring the safety and health of countless travellers, thousands of employees, and the communities we serve. I'm here today to provide an update on our efforts, to call on government for increased collaboration with industry on a national approach to testing, and to support innovations aimed at ensuring the safe return of air travel.

I am pleased to answer any questions you might have.

The Calgary Airport Authority is an enabler to the economies of Alberta and Canada, generating billions to provincial GDP, and employing, directly and indirectly, thousands of Albertans. The YYC Calgary International Airport has proudly played a vital role in Canada’s air transportation ecosystem, and since the onset of the pandemic, YYC remains one of four Canadian airports designated to receive international travellers.

As you know, COVID-19 has had a particularly devastating impact on airports, air carriers, and the thousands of complementary businesses that rely on Canada’s air transportation system. The pandemic decimated demand for travel, erasing almost 25 years of passenger growth at our airport, and bringing us back to the same number of guests we last saw in 1995. Our airport revenues declined 60% year over year, and we’ve taken on an additional $68 million in debt in 2020 in order to maintain our operations.

Despite this, we remain committed to prioritizing the health and safety of passengers and employees. This commitment was recently reflected in YYC’s participation in the international border testing pilot program, in the screening program now offered to our employees, and in our vision for the future.

The international border testing pilot program was implemented to test inbound international travellers at YYC from early November of 2020 to late February of this year. The pilot program offered travellers entering Canada from international destinations an opportunity to reduce the 14-day quarantine following two negative COVID-19 tests. One test was taken at the airport upon arrival, and another six or seven days later. In the event the first test came back negative, travellers could shorten their quarantine, so long as they remained in the province and followed other restrictions.

Alberta's chief medical officer of health considered the pilot project to be a vital tool in identifying variants of concern coming into the province. Overall, health officials determined a positivity rate of 1.37% for the first test, and 0.69% on the second test. We share the view that this data collection has been a success and that airport testing was an effective measure in containing the spread of the virus, notably by providing an important early warning system.

Additionally, the first report of the Minister of Health's COVID-19 testing and screening expert advisory panel includes the deployment of rapid testing for screening as one of its recommendations.

Having witnessed the value of testing and screening, we've implemented voluntary COVID-19 testing for employees and select partners working at the airport. The on-site, 20-minute rapid antigen testing program provides an extra layer of protection for our employees and reduces the risk of asymptomatic transmission.

We are asking our government to collaborate with us and to enable technological advancements in screening protocols, including testing at airports, the effective use of data systems and the implementation of modernized screening infrastructure. We are also following closely on the progress of domestic and international efforts, notably by our G7 partners and the EU, in creating recognized documentation that would facilitate the movement of people across borders while the pandemic is ongoing. In the immediate term, a thoughtful, data-driven and tailored approach to restarting domestic travel is critical. We welcome the government's participation in such collaborative efforts.

In summary, a unified approach to modernized passenger screening measures and the effective use of robust data systems are vital for restoring confidence in air travel as well as for maintaining the health of air transportation employees, passengers and the communities we serve. We hope to see the government contribute to such efforts.

Thank you for your time, and I look forward to answering any questions you might have.

● (1105)

The Chair: Thank you, Ms. Hunka.

We'll now go to Dr. Stanford. I'm advised by the clerk that we have five to six minutes per witness.

Please go ahead, Dr. Stanford.

Dr. Jim Stanford (Economist and Director, Centre for Future Work): Thank you, Mr. Chair and committee members.

I'm grateful for the opportunity to meet with you today and I'm grateful for the work you are doing in trying to help Canada through this incredible moment.

I'm Jim Stanford, economist and director of the Centre for Future Work, which is a labour economics think tank with offices here in Vancouver and in Sydney, Australia.

As a labour economist, I will address the impacts of COVID-19 mostly in terms of work, workers and workplaces. I will draw on, in particular, a major report from our centre called "10 Ways the COVID-19 Pandemic Must Change Work For Good". If any of you or your staff are interested in following that up, it's on our website, centreforfuturework.ca.

There are many overlaps, of course, between the COVID-19 pandemic and work. Workplaces were and remain a major site of contagion. This means the people who work there and the customers and clients they serve are vulnerable. That vulnerability stems not just from where we work; it's clear that some industries and some kinds of workplaces are particularly vulnerable to contagion, largely based on the spatial configuration of those workplaces and how closely people have to work with their colleagues or their customers.

There is also an overlap with how we work. In particular, there is an interaction between employment relationships and the risks of contagion as a result of the prevalence of non-standard or precarious work arrangements leading to vulnerability to disease. The growth of precarious or non-standard work arrangements in which people are not working in regular, full-time permanent positions with normal employment benefits has led to COVID being experienced in a number of ways.

First, workers in non-standard positions typically do not have access to paid sick leave, which means there is an economic compulsion on them to continue working even when they should be isolating.

Second, people in non-standard work situations are more often trying to make a living by cobbling together income from multiple jobs by holding two, three or even four jobs at the same time. This means they're working at multiple workplaces, which naturally enhances the risk of their sharing the virus among different locations. We saw how catastrophic that was in the roles of workers in non-standard situations and precarious employment relationships in spreading COVID across multiple long-term care facilities in the earlier stages of the pandemic.

The general absence of stability and permanence in work arrangements, the lack of training and skills acquisition in precarious work situations and the lack of channels through which workers in those jobs could express their concerns and needs also contribute to a greater vulnerability.

In terms of the impact of the pandemic on employment, we have seen the pandemic greatly exacerbate the inequality in employment outcomes that was already visible before the pandemic.

There was an incredible concentration of loss of employment hours and income in the initial months of the pandemic in particular sectors of the labour market, including particular industries—the face-to-face industries that had to be shut down immediately, such as retail, hospitality, arts and recreation, personal services and many transportation functions. There were also the demographic and gender groups: Young people experienced much worse job losses and women experienced more job losses than men.

Also, of course, there was the type of job, the level of work. Employment losses for part-time workers and temporary workers were four or five times greater than job losses experienced among permanent staff. In fact, there are many staff in relatively good jobs who were able to do their jobs from home and didn't lose any income as a result of the pandemic.

In this way, the pandemic has greatly exacerbated the consequences of inequality. In my judgment, it will impose lasting economic, social, health and fiscal costs on Canada unless our post-COVID policy response is fundamentally directed at helping those who need it most.

In terms of what we do to ensure a stronger labour market, stronger employment and safer jobs coming out of the pandemic, I will refer you to the full study. We have a 10-point agenda, which includes reconfiguring spatial relationships in workplaces; the provision of paid sick leave, which is an essential step; measures to enhance stability and well-being when working from home; and of course measures to address this overarching problem of precarious employment and how that contributed to a negative health outcome.

● (1110)

I would recommend the full study for a deeper view.

Fixing work after COVID is going to be a substantial, long-term task. It will have to involve all stakeholders: federal and provincial governments, employers, regulators, unions, educational institutions, and more. In my judgment, it is essential. The pandemic was a wake-up call that exposed fractures in our labour market and our employment relationships that were visible before the pandemic, but now we realize those are harmful not just to the workers affected but also to public health. In order to make work better, but also make public health safer, we have to fix work coming out of the pandemic.

I'll leave it at that, Mr. Chair. Thank you, again, and I look forward to our discussion.

● (1115)

The Chair: Thank you, Doctor.

We'll go now to SHARE Family & Community Services Society, and Ms. MacLean.

Ms. MacLean, please go ahead. You have five to six minutes, please.

Ms. Claire MacLean (Chief Executive Officer, SHARE Family & Community Services Society): Thank you very much, Mr. Chair and honourable members of the committee. It's really a pleasure to be here this morning.

My name is Claire MacLean. I'm the chief executive officer of the SHARE society.

SHARE is a registered charity. We are somewhat unique in terms of social service agencies in that we don't serve just one demographic, such as seniors, or one area of need, such as autism. We really are here to support members of our community during times of vulnerability. It is our deeply set belief that if we can wrap our services around people during those times of vulnerability, they can come out on the other side with better outcomes.

As a result of that belief, SHARE delivers a wide range and different buckets of services. We have services that address financial vulnerability, such as the food bank, a rent bank, employment programs and affordable housing. We have services that support the vulnerability of mental health, including counselling and addiction services. We have services to support the vulnerability of aging, including social connection services for our seniors and transportation to medical appointments. We have services that address the vulnerability of disability, including services for children and youth with special needs. We have services that support the vulnerability associated with being a newcomer or a refugee to our country. Finally, we have programs that support the vulnerability of early and middle childhood, including parenting programs.

Through this wide range of services, SHARE supports about 22,000 people each year in the cities of Coquitlam, Port Coquitlam, Port Moody, New Westminster, Anmore and Belcarra.

When the COVID-19 pandemic hit in 2020, SHARE was one of those classified as an essential service provider. Our food bank has not missed a single day of food hamper distribution. Across all of our programs, our staff have done a really amazing and admirable job at coming up with creative solutions to ensure that the people in our community could continue to access the supports they needed.

I know the committee has already heard expert testimony around the disproportionate impact of the COVID-19 pandemic on vulnerable members of our community. I can add my voice as further witness to that fact.

We cannot talk about the impacts of this pandemic without talking about the financially vulnerable members of our community. These are folks who are at higher risk of contracting the virus. They lack paid sick leave and therefore are more likely to attend work if they have symptoms or have to work alongside someone doing the same. The financially vulnerable are more likely to live with roommates or extended family, thus expanding the contacts they experience on a day-to-day basis. These members of our community are often employed as casual or part-time workers with multiple employers at multiple locations, again expanding their contacts.

In addition to being at higher risk of just becoming sick, the financially vulnerable members of our population are also at a higher risk for the collateral damage of this pandemic. They are the ones more likely to have been laid off by struggling businesses, and they do not have the same access to mental health supports, child care, domestic supports, recreation services or even nutritious food. You cannot talk about the emergency situation facing Canadians as a result of the COVID-19 pandemic without talking about financial vulnerability.

However, there is good news on this aspect. Some of the government's actions during the height of the pandemic were very effective at helping to mitigate the impacts on financially vulnerable people. We heard from the community members that SHARE serves that the CERB payments were critical to ensuring the well-being of their families. In addition, the funding supports for food banks were incredibly impactful. With a food bank that serves over 2,000 people every month, I can tell you that the funding SHARE received allowed us to feed more households and get them the nutritious food they needed. We appreciate these efforts and thank the government for its actions.

As we look ahead, I would implore this committee to consider two specific recommendations:

The first is that these supports be continued. Just as the financially vulnerable members of our community were hit harder by this pandemic, they will take longer to recover. This cannot be measured in months; rather, it will take years. Sustained government funding for food banks and programs that continue to put money directly into the hands of those in need in our communities is effective and necessary.

The second is that desperately needed infrastructure funding be provided to the community services sector. While attention and funding is justifiably focused on primary care and emergency care hospitals and services, it is the community-based services, such as those delivered by SHARE, that complete the cycle of support for our citizens.

A baby girl born at 26 weeks of gestation is sent home from her local hospital with a feeding tube and dire predictions for her long-term developmental and academic success. It is the speech-language pathologists, the physiotherapists and the occupational therapists at SHARE who work with her parents so that she can learn to drink from a bottle, take her first steps and say her first words.

● (1120)

It is through the work of SHARE and her family that she arrives at kindergarten, never having set foot back in the hospital since her infancy.

Similarly, for the senior who's using alcohol to manage his loneliness and depression and had to visit the emergency room after a particularly bad fall one evening, it is the SHARE counsellors who helped him find a better way to cope. SHARE's legal advocacy and housing teams help make sure that he doesn't get evicted and end up homeless or make more frequent visits to the ER.

Our nation's health care system does not work without social service and community-based organizations such as SHARE, yet we are consistently denied any type of basic infrastructure support and funding for IT or administration needs. To continue to starve this sector of supports places the health and well-being of all Canadians at risk.

Honourable members of the committee, as someone who has done this work and had the privilege of working in the field of community services for over 20 years, and has done work in B.C., Ontario and Alberta, I can tell you that these stories are not unique to the Tri-Cities or to SHARE. The need to support the most vulnerable members of our communities spans our entire country. The solution of direct financial support and sustained and conscious infrastructure funding for the community services sector is one that could be applied nationally.

The Chair: Thank you, Ms. MacLean.

We will start our rounds of questions at this point. We will begin with Ms. Rempel Garner.

Ms. Rempel Garner, please go ahead for six minutes.

Hon. Michelle Rempel Garner: Thank you, Chair.

I'll start with questions for Ms. Hunka from the Calgary Airport Authority.

Ms. Hunka, if I'm not mistaken, you have your AGM coming up this week. Is that correct?

Ms. Carmelle Hunka: Yes. It's on Wednesday at 9 a.m. Mountain Time.

Hon. Michelle Rempel Garner: You mentioned to us that in the last year, you've amassed about $68 million in debt. What do your financials look like in terms of cash flow for the next few months? What will you be telling folks at your AGM this week, in the context of what you can and can't say?

Ms. Carmelle Hunka: For our cash flow position, we will be advising of a $23-million deficit in 2020 as a result of the pandemic. Our revenues were down about 60%, as we indicated. Our expenses were down about 38%. As you can appreciate, an airport has significant infrastructure, and while we've taken decisive action and reduced significant capital programs, we need to expend regular resources on things like keeping our runways clear when there's snow. We can only reduce our expenses so much. What we will be advising is a cash flow deficit of $23 million.

Hon. Michelle Rempel Garner: What does that mean? How long do you guys have to operate with that type of a deficit projection?

Ms. Carmelle Hunka: Our projection is that we will probably need to borrow, in addition to the $68 million, $200 million over the course of the next two years in order to remain cash positive. If we have to continue to borrow and we see the same types of situations, we may be cash flow negative and our liquidity will run out sometime in 2023.

Hon. Michelle Rempel Garner: Essentially what you're saying is that if things don't turn around, there is a risk of insolvency for the Calgary International Airport sometime in 2023.

Ms. Carmelle Hunka: We will certainly need to—and we are committed to this—maintain and take on additional debt as we need to. That's not the direction we would like to go. We are hopeful that we will find a way to fund recovery and bring back our operation.

Hon. Michelle Rempel Garner: In terms of what could fund recovery, you mentioned a lot about the Calgary border pilot program. When that was cancelled, were you given any evidence or rationale for why that cancellation was needed for public health outcomes?

Ms. Carmelle Hunka: We were advised that the pilot program was being cancelled as a result of the new testing that was being implemented Canada-wide.

● (1125)

Hon. Michelle Rempel Garner: Were you shown any evidence or data that showed that the new system was more effective than the old system for public health outcomes?

Ms. Carmelle Hunka: We were not provided with that evidence or information. We participated in the change as a result of the order in council. We participated in the switchover and supported the government.

Hon. Michelle Rempel Garner: Essentially, you are in a situation of having to look at significant borrowing because of measures that were put in place without any clarity on why they were needed for public health outcomes or any clarity on when they were going to end.

Ms. Carmelle Hunka: Certainly we support any testing that is being done at the airport, whether that's for domestic travellers, which is what we would like to see, or for arriving passengers. We do believe that the pilot program provided significant and strong data and information with respect to what the risk was from travellers arriving. We continue to support that.

Hon. Michelle Rempel Garner: Have you been given any information on when, say, the Alberta pilot program might come back into place, or any benchmarks for when some of the restrictions that you've been operating under might be lifted?

Ms. Carmelle Hunka: We have not received any of that information at this point. We continue to support—

Hon. Michelle Rempel Garner: Have you asked for it?

Ms. Carmelle Hunka: We have not gone and asked specifically for that information. We continue to participate in conversations and telephone calls with Transport Canada and otherwise with respect to the continued restrictions that are in place—

Hon. Michelle Rempel Garner: But Transport Canada has not provided any information in terms of benchmarks on when restrictions might be eased.

Ms. Carmelle Hunka: No, they have not provided those directly to us. As I indicated, we have asked to participate in testing and have indicated that we are prepared to participate in as much testing at the airports as possible in order to enable and support recovery.

Hon. Michelle Rempel Garner: Sure. If things keep going the way they are right now under the current system, would it be fair to say that the airport authority is in major trouble in about a year's time?

Ms. Carmelle Hunka: We certainly are looking at our forecasts over the course of the next year. We are actually forecasting for 2021. We will be advising at our AGM that we're forecasting 5.1 million passengers compared with 5.7 million passengers in 2020. The 5.1 million is the same level of passengers as in 1995. With those low levels of passengers, certainly we have—

Hon. Michelle Rempel Garner: Just quickly, with the time I have left, the April 21 OIC ends in 10 days. You're telling me that the government has told you nothing in terms of what might happen at that point in time. We're 10 days away.

Ms. Carmelle Hunka: We have not received any indication. We continue to plan for supporting the continued testing, should it be required.

Hon. Michelle Rempel Garner: Thank you.

The Chair: Thank you, Ms. Rempel Garner.

Mr. Kelloway, please go ahead for six minutes.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thanks, Mr. Chair.

Hello to my colleagues.

To the witnesses today, thank you so much. I had a few questions prepared for this morning, but I sort of erased them because of the testimony given today, which I found very, very important. Whether we're talking about food security or food banks or sustainable funding, I hear you. I've been there. On the need to build on the 25 million rapid tests that we have out there now, it's a lot, but we need more. It's an important work-in-progress.

Dr. Stanford, I'm going to focus on you. I want to thank you for your testimony today. As a community developer, I've always found that economists like you are fundamental in helping to provide insight in how we can move communities forward and the country forward.

As you know, our government implemented a number of support measures for Canadians through the pandemic, most notably the CERB. For me, anyway, in essence it's been acting as a basic income for those who need it the most. I've been an advocate for basic income in my riding in the Atlantic region.

I'm wondering if you can speak to your thoughts around a basic income. Do you think a national basic income framework is something that could help Canadians as we enter into our post-pandemic recovery?

Dr. Jim Stanford: Thank you, sir, for the question and also for your very generous remarks about economists at the beginning. We don't usually come off that well in people's estimation. More often I hear an economist described as someone who's good with numbers but doesn't have the personality to become an accountant.

Mr. Mike Kelloway: It all depends on the economist.

Dr. Jim Stanford: Right. Your remarks are very much appreciated. Thank you.

The federal government's very fast and very powerful injections of income support last year were absolutely vital to our traversing this crisis as well as we did. Obviously, despite that, it's still been a very painful, disruptive experience for millions of Canadians. The CERB, in particular, was vital to helping Canadians imagine how they could get through with the job losses and income losses that they experienced. The money was delivered very quickly and the qualifying requirements were relatively accessible, which was vital. The traditional rules of the employment insurance system before the pandemic would have left most Canadians out in the cold without any support whatsoever.

In this regard, the pandemic highlighted the flaws in our previous income security system. The CERB, because of its encompassing nature, had some of the characteristics of a basic income. I think many observers have noted that and noted how important that was. The level of the CERB, $500 per week, did seem to be an amount that was sufficient to meet the basic necessities of life for people in most households if they didn't have special needs of some kind, so the analogy to a basic income-type system was obvious. I think that was, in a way, a positive experience. On the other hand, it also showed that universal payment of a benefit like that would be very significant in terms of its fiscal implication.

I don't have a clear judgment one way or the other on basic income as a specific policy goal. As a direction to head towards, the concept that every Canadian should be entitled to a standard of living that meets their basic necessities of life is an absolutely valid one. There are ways to get at that principle, to advance that principle, that don't necessarily involve one big package of a universal basic income. We see this happening already through things like the Canada child tax benefit, the proposed disability benefit that has some of the indications of a basic income for people with disabilities, and the improvement in the EI system so that more people can qualify. In a way, those are all different directions to get towards a basic income situation without necessarily having the one big silver bullet, if you like, to try to address that problem.

I tend to think that that's ultimately going to be more effective than trying to imagine a great big redesign of all of our social programs, particularly because there are some programs today that offer more than a basic income would be providing, and necessarily so, for people who have particular needs.

To sum up, I would say that the concept and the principle of a basic income—that every Canadian should have the necessities of life—should be a guiding light in our social policy design, but there are many ways to get at that goal, ultimately.

● (1130)

Mr. Mike Kelloway: Thank you, Dr. Stanford. It's a very interesting conversation. I think we need to have a deeper one as a country.

I'll stick to the reality on the ground. In my riding over the past 12 to 13 months, we've seen a lot of folks come back from different parts of the country to stay in Nova Scotia because it's a safe place to be. It's also, in many ways, home; it always will be home. We've seen a lot of people who were working in downtown Toronto coming to Cape Breton or other parts of Nova Scotia.

I find the dynamic of virtual learning, virtual work and remote learning—whatever you want to call it—really key here. I'm wondering if you could briefly summarize your work-from-home findings for the committee. What do you think needs to be done to ensure that working from home occurs in a safe, sustainable and fair manner until we're able to send folks back to their regular workplaces when it's safe to do so? I think the Canadian public would be interested to learn your findings on that aspect.

Dr. Jim Stanford: That's a great question.

Working from home, of course, has exploded during the pandemic. Over five million Canadians are working from home now, over a quarter of all people who are employed. I don't expect it to stay at that level once the vaccines are out and people have taken them, hopefully, and we get the contagion under control, but it will certainly remain elevated compared to where it was before the pandemic.

It isn't a no-brainer. There are many issues that have to be addressed. You can't just work on your couch. You have to have a proper set-up. You have to have good ergonomics, lighting and safety. You have to have proper rules regarding hours of work so that your job doesn't spill over into a 24-7 type of arrangement just because you have the material at home. You also have to have fair arrangements around compensation for extra costs from working from home.

Another one I'll end this with is protection against undue monitoring and digital surveillance by employers of people who are working from home. If we put those types of protections in place, then working from home can be a great permanent solution.

● (1135)

The Chair: Thank you, Dr. Stanford. Thank you, Mr. Kelloway

[*Translation*]

Mr. Thériault, we now go to you for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

Can you hear me clearly? I could hardly hear you, but that's okay. The next time you speak, perhaps you could turn up the volume.

The Chair: All right.

Mr. Luc Thériault: Thank you.

My first question is for Ms. MacLean.

Throughout the first and second waves of the pandemic, and now, as we unfortunately enter the third wave, everyone we have heard from has talked about the health and social service system. The realities you described earlier stem from the underfunding of health care and, above all, social services. Social services are always shortchanged when health care funding is being handed out.

All the experts have told us that the pandemic has highlighted the chronic underfunding of one of the determinants of health—prevention. The first thing medical students learn in any faculty of medicine is that prevention is the first determinant of health. It's as though that lesson was never even taught, because the focus is always on putting out fires. The health and social service system was already strained, and as you mentioned, the pandemic brought to light all the deficiencies and weak links within the social service network.

Contrary to what the government is claiming, it should immediately and substantially increase funding, and provide the $28 billion being requested by the provinces to bolster health transfers. Do you not agree, Ms. MacLean? That way, we could start overhauling the system now and provide a sustainable response to the pandemic.

The government's current position is that it must wait until after the pandemic to determine what actions it should take, but service providers need to know now what's coming so they can plan accordingly. The provinces and Quebec—the jurisdictions responsible for providing the care—have to develop tailored programs and expand their range of services.

Where do you stand on that?

[*English*]

Ms. Claire MacLean: Thank you very much for the question.

The social service sector is a nimble sector, and I think we are ready. With additional funding, we can ramp up very quickly. We saw that happen when the opportunity arose during the height of the pandemic's first and second waves. We're seeing it now. I think with additional funding, we could absolutely be a very quick part of the solution to this issue.

[*Translation*]

Mr. Luc Thériault: The government said it would address the need for increased health and social service funding, but I gather you would like the funding now to ensure the response to the pandemic is sustainable.

Another priority is fixing the problems that had never been fixed. In other words, some 30 years of chronic underfunding had put a significant strain on the system. Fixing that means setting new priorities. The priority right now is health, and it has to be with all the collateral damage that's been done to the economy. Mr. Stanford and I can talk about that later.

Is that what you are asking for?

[*English*]

Ms. Claire MacLean: Absolutely. I think the funding is urgently needed, and we could use it immediately.

Something to keep in mind as well—as kudos to the economist at the table today, Dr. Stanford—is that in our organization, for example, 80% of the people we employ also live in our community, so investing in social services is also a fantastic way to invest in the economy of local communities as well. We tend to employ a significant portion of women, of working moms. This is something that gives back to local economies as much as it also sustains their social and health infrastructure.

● (1140)

[*Translation*]

Mr. Luc Thériault: Absolutely. Thank you, Ms. MacLean.

I don't have much time left, so I'm quickly going to move on to Ms. Hunka.

Ms. Hunka, where do you stand on a vaccine passport or an international vaccine certificate? A similar document could be required for attendance at large events.

What is your position on such a document? Do any challenges come to mind? I'd like to hear your views.

[*English*]

Ms. Carmelle Hunka: Certainly, the airport authorities do support the opening of safe travel corridors and the use of a vaccine passport or some type of notification that could identify vaccines. We feel that vaccine passports, in conjunction with continued testing, would enable the travelling public to gain confidence in us to provide a safe travel experience, so we would support such activity.

[*Translation*]

Mr. Luc Thériault: Would checking or validating vaccine passports or certificates pose any particular administrative challenges?

[*English*]

Ms. Carmelle Hunka: That would be an absolutely critical and important piece to the vaccine passport. We have seen that there has been very good enforcement with respect to the pre-departure PCR testing. We would consider that to be very important in order to ensure we have critical alignment with the vaccine passports, perhaps with people's own passports from Canada or elsewhere.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Davies, please go ahead for six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair, and thank you to all the witnesses for being here today.

Dr. Stanford, I will start with you.

In a January 16 op-ed in the Toronto Star, you wrote the following:

> Anyone concerned about the economy should be pleading for fast, powerful lockdowns, not demanding a return to business-as-usual. The correlation between controlling contagion and economic recovery is clear across Canadian provinces: those with fewer COVID cases have achieved the strongest employment results since the pandemic hit.

Could you expand on that? Do you have any specific recommendations to give us, as federal politicians, for how we can implement that concept?

Dr. Jim Stanford: In that commentary, I was confronting the argument that has been heard from some provinces and some premiers that we cannot intervene to try to stop the contagion with effective measures because it would be too damaging to the economy. The evidence is clear, both interprovincially in Canada and internationally, that this view has it exactly backwards. The recovery of the economy absolutely depends on a fast and powerful effort to stop contagion, and that is what creates the conditions for a sustained reopening. This idea that we should just tolerate COVID in our communities in order to keep restaurants open and stores open and so on is very short-sighted. Internationally, that evidence is very clear.

I mentioned at the beginning that I do some work in Australia as well, where there has been a very strong and effective COVID response. The Australian economy is largely open now and back to pre-pandemic levels of activity. The same goes for other countries like New Zealand, South Korea and Taiwan.

In Canada's case, there are many different factors that affect the degree of contagion in different locations, but in the places that said, “No, we have to go easy on the shutdowns, because it's bad for the economy”, that approach has not panned out at all. If anything, their economic and employment results have been worse.

The health response is largely a provincial responsibility, so I guess the federal role here would be to support the provinces in trying to take the effective actions that are required, including income support measures and supports for small businesses that are affected and so on. That's how the federal government could facilitate the provinces in taking the stronger actions that are essential, if in fact we're going to protect both public health and the economy.

● (1145)

Mr. Don Davies: In the Public Policy Forum you wrote:

> In retrospect, both employers and regulators took the safety of many workers for granted when the pandemic first erupted. There were many occupations — from taxi and ride-share drivers, to meat-packing workers, to workers in crowded oil sands and farm labour camps — for which the risk of infection was obvious, but little was done until devastating outbreaks occurred.

What steps can the federal government take to ensure workers are better protected in the future?

Dr. Jim Stanford: Thank you.

First of all, I think it is definitely the case that the health response to the risk of workplace contagion was inadequate from the beginning. There was a considerable attempt initially to minimize the risks.

Perhaps among the worst possible examples is an instance such as that of the Cargill meat facility in Brooks, Alberta, or that of the Amazon warehouse in Brampton, Ontario. You don't need to be an occupational health and safety expert to understand that those were going to be very dangerous places during the pandemic, but regulators either wilfully ignored or soft-pedalled the sorts of steps that would have been required to protect the workers and their families and ultimately whole communities in those places.

The federal government has a limited responsibility for direct health and safety within the federal jurisdiction, so that's important. You can set a role model there with absolutely top-of-the-class workplace health and safety standards around contagion. Then again, you can facilitate the provinces in doing a better job, including through income supports. This will neutralize the false economy-versus-health trade-off that is still circulating.

Now we're in the midst of a third wave that obviously could have been handled much better if we'd been stronger on limiting contagion from the beginning. I think the federal government, by providing income support as well as regulatory guidance, has an important supplementary role to play in that effort.

Mr. Don Davies: You've mentioned comparative examples. You also wrote that “formally structured voice mechanisms are on the wane in Canadian workplaces” and went on:

> Elsewhere in the world, providing workers with regular, protected channels for voice and input is considered a basic democratic right, protected by law. In many European countries, for example, firms must establish works councils composed of elected employee representatives, who participate in certain workplace decisions and monitor local conditions and practices.

How does Canada rate in this regard, and do you have any suggestions to give the federal government for how we can improve our record in that regard?

Dr. Jim Stanford: This question gets at a remark I made in my opening remarks about the overlap between insecure and precarious forms of employment and enhanced risk of contagion in workplaces. In very insecure jobs, workers come and go. They are not treated as a lasting asset; they are treated as a disposable productive input. They're hired and fired on a just-in-time basis.

In that type of workplace, you do not get the stability, the training, the knowledge and the information flows that are necessary if all members of a workplace are going to respond to a challenge such as this pandemic. In this way, the conditions of precarious work make the problem worse. Even in permanent jobs, however, in Canada we have undeveloped structures for communication, input, guidance and voice between workers and managers and employers.

One exception to this, interestingly enough, is in the workplace health and safety area. All jurisdictions, including the federal jurisdiction, compel employers above a certain size to establish joint health and safety committees in their workplaces, precisely because they recognize that facilitating knowledge and communication is crucial for better safety outcomes. Those lessons could be applied and extended in the case of contagion, and indeed to other pressing workplace topics as well.

The Chair: Thank you, Mr. Davies.

We're almost out of time. I think we'll try to shoehorn in a very fast second round. We'll go forward with two minutes for each party.

We'll start with Mr. Barlow, please, for two minutes.

Mr. John Barlow (Foothills, CPC): Thank you, Mr. Chair. I appreciate the opportunity.

I want to go back to Ms. Hunka.

You were talking about the success of the pilot program for testing at the Calgary International Airport. My colleague mentioned that the order in council on hotel quarantines is going to be ending on April 21.

I want to give you a chance to explain that a bit more. You could have a massive change in what your airport is going to be asked to do in nine days. Do you not have any information on whether that order in council is going to be extended and whether the pilot testing program will be reinstated?

● (1150)

Ms. Carmelle Hunka: We are continuing to support the testing program that will be at the airport, and we are actually utilizing the same testing facility that we are using for our employees. We will therefore continue to have that facility available. We have been incredibly resilient in providing for testing and being able to ramp up or ramp down.

We don't have any information as to whether it will be continuing. On the basis that we don't have that information, we are proceeding as if it will be continuing.

Mr. John Barlow: Were any concerns raised, Ms. Hunka, prior to the cancellation of the pilot test program? Everything I heard was that it was extremely successful, and you've talked about the test numbers, 0.69% on the second test and 1% on the first test. Everything I've heard of this testing program is that it was extremely successful. Do you see any reason for it to be cancelled? I know that this was a national issue, but were there any concerns raised with that program prior to the cancellation?

Ms. Carmelle Hunka: All indications were that this pilot program was successful, including the Public Health Agency of Canada's acknowledgement of the success of the program. As far as we were concerned, it was a highly successful program, but for consistency with the rest of the country, it was ended.

Mr. John Barlow: I guess we could have taken that pilot program and put that across the country instead of imposing hotel quarantines, but thank you very much for your time, Ms. Hunka.

Ms. Carmelle Hunka: Thank you.

The Chair: Thank you, Mr. Barlow.

We go now to Dr. Powlowski. Please go ahead for two minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): My questions are for Dr. Stanford.

We talked a bit about Australia and how Australia seems to have done better than Canada. In Ontario, the ICUs are overflowing. We just instituted a stay-at-home order. What did Australia do differently in terms of implementing increased measures requiring social isolation? What did they do that we didn't do?

Second, in Canada, it's obviously a matter of provincial jurisdiction. Is it the same in Australia, with each state having to decide which measures to implement, and was there any federal oversight?

Dr. Jim Stanford: Those are great questions, Mr. Powlowski. Thank you.

On the jurisdiction issue, in Australia it's similar to Canada. The main health response was led by state governments, and they were in charge of all of the different features around distancing, lockdowns, testing, etc. The federal government did one thing: They closed the borders quite effectively early in the pandemic. In retrospect, that was a good thing to do. I know it was a hard decision.

Then it was up to the states, and they included border closures within the country that were much stricter than anywhere in Canada, other than in the Atlantic region. They've endured some really serious lockdowns. In Melbourne, Australia, there were 99 days when you were required to stay within five kilometres of your house and only very limited reasons you could leave it. It was stricter than anything we experienced, but it worked. Now they have the benefits of that sacrifice in other states as well. The Australian evidence is very clear: A forceful, powerful response to contagion is the best thing you can do for the economy.

Mr. Marcus Powlowski: Do I have any more time]?

The Chair: You have two seconds left. Thank you, Doctor.

[*Translation*]

Mr. Thériault, it is now over to you for two minutes.

Mr. Luc Thériault: I'd like to stay on the same topic and carry on the discussion with Mr. Stanford about what other jurisdictions did. In Canada, the inclination has been to open borders and relax the rules at the first opportunity.

You told us that Australia instituted much more stringent lockdowns in terms of movement between regions, which may be due to its continental situation. You recommend a cautious approach, saying we should be very careful because opening things up at the first opportunity can ultimately do more to hurt the economy than to keep it going. Can you elaborate on that?

You also spoke about rethinking workplaces. Can you give us some specific examples?

● (1155)

[*English*]

Dr. Jim Stanford: The Australian case shows that the faster and more comprehensively you shut down interactions, the better your chances of stopping the contagion from taking hold and spreading. I mentioned the severe lockdown in Melbourne's case, but the rest of the country learned from that.

Every time they get an outbreak now—and it does happen from time to time—they very quickly put the whole city down under another lockdown order for three, four or five days. Yes, we get the usual complaints from business groups that they're going to suffer from lost business, but they're being done a favour, because by stopping the contagion that quickly, you're allowing those businesses to reopen. This is where you need government to take a forceful, long-term view and do what's right for the whole community.

The Chair: Thank you, Dr. Stanford.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies for two minutes, please.

Mr. Don Davies: Dr. Stanford, your long-time work in championing the Canadian auto industry is well known. I'm curious about what you see in a macro, post-COVID economic perspective in terms of national self-sufficiency. We saw earlier on that Canada didn't have self-sufficiency in PPE and essential medical supplies. I'm wondering if you have any suggestions to give the federal government on how we can position the Canadian economy for greater national economic security in the future.

Dr. Jim Stanford: This is certainly a moment when we have to think about our role in the global economy after the pandemic. There's no doubt that some industries are going to change forever because of this pandemic. New industries are going to grow and some industries are going to face challenges for years, obviously. As we heard, the aerospace and air transportation sectors are going to take years to recover. I'm an advocate of a very forceful, engaged sector development strategy from both the federal and provincial governments engaging other stakeholders, private businesses, educational institutions, unions, and so on, and there are lots of opportunities for Canada to leverage its technological know-how, skilled workers and strong social inclusion in Canada into successful industries of the future.

Examples of that obviously would be around renewable energy and all the inputs and downstream benefits that come from that. Health technology is obviously going to be a huge one. We know we can't do vaccines all by ourselves—no country can do that—but we can certainly have a much better foothold in the global supply chain of modern medicine and modern medical equipment than we have now. That requires planning, public investment, co-investment and active policy rather than just sitting back and thinking that the markets will take care of it.

I think there is an opportunity after the pandemic to think more about public sector leadership in all areas of the economy, including industrial and sector development.

Mr. Don Davies: Thank you.

The Chair: That brings us to a close on our round of questions. I would like to thank all the witnesses for sharing their time with us this morning, and for their expertise. Your testimony is most helpful to us. With that, we will suspend to bring in our next panel.

● (1155)

_____(Pause)_____

● (1200)

The Chair: We are now resuming meeting number 28 of the House of Commons Standing Committee on Health. We are meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic and, most specifically at this point, the collateral effects of the pandemic.

On this panel we have Ms. Linda McQuaig, journalist and author, as as individual. From the Canadian Association of Radiologists, we have Dr. Michael Barry, president; and later we may have Dr. Gilles Soulez, vice-president. From the Fitness Industry Council of Canada, we have Mr. Scott Wildeman, president; and from the Tri-City Transitions Society, we have Ms. Carol Metz, executive director, consultant and leadership coach.

Thank you all for being here today.

We will start witness statements with Ms. McQuaig. You have six minutes, please.

Ms. Linda McQuaig (Journalist and Author, As an Individual): Thank you very much, Mr. Chairman. I appreciate this opportunity to address the committee today.

I would like to talk about Canada's lack of domestic vaccine production facilities, which I think has been one of the key problems in Canada's slow vaccine rollout.

Last month the Trudeau government attempted to correct this problem by investing $415 million in the French pharmaceutical giant Sanofi. The idea was to help Sanofi expand its vaccine production facilities in Canada.

In my opinion, this is not the answer. This is not the solution to the problem of our limited vaccine capacity. On the contrary, I would go so far as to say it's a reckless use of hundreds of millions of dollars of public money.

In announcing the investment, the federal industry minister said that Ottawa was currently in negotiations with Sanofi over a contract that would give Canadians priority access to Sanofi's vaccines during a future pandemic, but hold on—surely it would have been better to postpone that $415-million announcement until after Sanofi had agreed to the government's terms to give Canadians priority access. Without that key term being nailed down, we really are just keeping our fingers crossed that Sanofi will deliver for us. I think in some ways this reveals just how vulnerable Canada is now that we no longer have a domestic vaccine capacity that we control.

Of course, we once did have that capacity. We had Connaught Labs, a Canadian publicly owned enterprise that was one of the world's leading vaccine producers. For seven decades, Connaught developed and produced a range of vaccines. It provided those vaccines to Canadians at cost. It provided them to other countries at affordable prices. Connaught operated without government financial support, yet it even made profits, which it reinvested in medical research. Connaught's research scientists were among the best in the world. They contributed to some of the key medical breakthroughs of the 20th century, including insulin, penicillin and a polio vaccine. Connaught even played a vital role in the World Health Organization's global vaccination campaign to rid the world of smallpox, yet despite this remarkable record, Connaught was privatized by the Mulroney government in the 1980s.

The Connaught facilities still operate today in Toronto, but they are now owned by Sanofi. In fact, Ottawa's $415-million investment in Sanofi is going to expand the old Connaught facilities, but Canada no longer has control over what happens there.

There is, of course, much to lament about the sell-off of this spectacular Canadian company and Canadian enterprise, Connaught Labs, but that is history. That is history. The key point now is that it's not too late to create a new version of Connaught. That would be a publicly owned biotech company that could produce vaccines and other medications and could be counted on to put Canada and Canadian needs first, which was what Connaught always did. Rather than investing $415 million in a private company that we don't control, we could invest that money in a company that we do control.

Next week's budget would be a perfect opportunity to announce the launch of a new publicly owned biotech enterprise. I realize that may sound ambitious, but it wasn't too ambitious for the visionary Canadians who created Connaught in the early 20th century. Let's see if we can't own that podium again.

● (1205)

Thank you.

The Chair: Thank you, Ms. McQuaig.

We go now to The Canadian Association of Radiologists. Dr. Barry, please go ahead for six minutes.

Dr. Michael Barry (President, Canadian Association of Radiologists): Thanks, Mr. McKinnon, and thank you very much to the committee.

I'll be as quick as I can to work through the statement.

I want to thank you all for all this work that you're doing in this difficult time, and it is a difficult time. Although we're not through COVID-19 yet, we will be soon, we hope, and it's because of work like yours and the people in the front trenches that we'll get there. However, now is a time to plan our reopening and what Canada's health care system and our country will look like after COVID-19.

As many of you know, imaging, radiology and high technology are the centrepiece of a medical system in the 21st century. Every branch of medical care in Canada and worldwide is reliant on a comprehensive radiology imaging program to look after our preventive care and our active care. We are the single most important infrastructure investment in the health care system. Much like roads, bridges, seaports and airports are to our transportation networks, we are an investment and not a cost centre.

I'd like to share some observations from COVID-19 and some of the effects.

Initially, imaging wait times because of COVID-19 left hundreds of thousands of people in the long wait-list that was already quite long. We have found there's probably been about a 50% reduction in medical imaging and screening services, non-urgent ones in particular, that we've neglected because of COVID-19, through no fault of anybody. It's just a fact of the matter. Cancer doesn't wait for COVID. It's created a real sense of urgency and caused an overwhelming backlog in medical imaging services from coast to coast.

Before the pandemic, patients in Canada were waiting an average of 50 to 82 days for CAT scanning and 89 days for MRI. These are between 20 and 52 days longer than recommended from the OECD wait-lists, and because of the COVID-19 impact, the wait-lists are even longer. This is especially concerning for cancer patients, for breast screening and colorectal screening, and just diagnostic screening for people who are waiting at home and afraid to go to the hospital because of the first wave, second wave, and now the third wave.

I've spoken to the committee about an initial case that came through our hospital here in Saint John, New Brunswick, where I have practised for 30 years. I can remember when a young man in his 30s came in about six or eight weeks after his initial symptoms and found out he had a high-grade glioblastoma. He was too afraid to come in because of COVID, so he waited for his treatment. By the time he came in, he had a high-grade glioblastoma. It was a late intervention, and he did not do well, needless to say. That was concerning.

We have a lot of patients who present at the emergency room with obstructions of their bowel, colon obstruction. They have rectal bleeding, but they're afraid to go to the hospital. We see that, unfortunately, every day.

The Maritimes hasn't been as impacted as the rest of Canada, but I can assure you that nationally we're hearing stories on a daily basis from our colleagues from coast to coast. We had a recent report from the CMA about clearing the backlog and the cost to return to wait times at pre-pandemic levels.

Wait-time delays do cause an additional economic cost to the system. Waiting 52 days for an MRI scan costs our health care and economic system approximately $377 million a year. CT scans, waiting 33 days, cost us approximately $377 million on a yearly basis. According to Deloitte, the procedures that have the highest funding requirements are MRI and CT scans. They make up about 75% of all procedures across Canada.

That gets to our point and is close to our ask. I've spoken to a number of you before in person and on Zoom about The Conference Board of Canada report published in 2019, which talks about how far behind Canada is in capital equipment. We're by far the worst off, with 75% of our capital equipment being almost at end of life. We've had the request on the table to all parties for an immediate commitment of $1.5 billion over the next five years. That was a pre-COVID ask. That was an attempt to bring our national wait-list to a more acceptable standard. There are still many patients waiting for months and unable to work. We have estimates from The Conference Board that the cost to the economy was upwards of $5 billion in 2020.

● (1210)

Our response to COVID-19 has been fast and rapid, based on our being able to pivot and change our health care. We're already very virtual in radiology, as many of you know, but it's imperative that the diagnosis of injury, chronic illness in particular, and acute illnesses not wait. We have actually pivoted very quickly in of our ability to work at home when the time came, as well as in the hospital, to get our wait-list in order, but we still continue to fall behind.

There are many technical requests that go into this ask, which include artificial intelligence and new updated equipment to make our turnaround times faster and enable us to address this tremendous backlog.

In closing this part of it, the CAR is asking for $1.5 billion over the next five years to support Canadians, ensure capacity and integrate technology such as AI to help run the system more efficiently. This is an investment, not a cost. It will get people back to work, look after our sick people and chronically ill people, and get our cancer screening back to what it should be and beyond.

It is not unprecedented for the federal government to take charge in this. As many of you know, there was a targeted investment in 2005 and 2006 by the Paul Martin government. It put $2 billion into equipment targeted for imaging and reduced our wait times significantly. I think a number of you have seen our radiology report from The Conference Board showing the impact of that investment, which really has tapered off since 2013. Now we're back to where we were in 2004 and 2005.

Our second ask is to strike a federal task force to look at the health human resources and infrastructure components, such as waiting rooms, workspace, air ventilation and consulting areas to support new equipment, because we'll have to be much better prepared in the way we practise medicine in 2021 in a post-COVID world with a possible further pandemic .

That's it, Mr. Chair. I could go on forever, but I'm available for questions. I'll stand by for questions.

● (1215)

The Chair: Thank you, Doctor.

We'll go now to the Fitness Industry Council of Canada and Mr. Wildeman, president.

Please go ahead for six minutes, Mr. Wildeman.

Mr. Scott Wildeman (President, Fitness Industry Council of Canada): Thank you for the opportunity to speak to you all today.

The Fitness Industry Council of Canada represents over 6,000 fitness facilities, ranging from single boutiques to large regional and national chains. We employ over 150,000 Canadians coast to coast to coast, and we serve over six million members.

We've been decimated by the closures and the restrictions arising from COVID-19. To give some context, if a facility is able to be open, they are operating at around 50% of pre-COVID levels. If they're forced to close, they're operating at 0% to 10%, depending on their online presence.

We still have fixed cost bases. We applaud the federal government for the CEWS program and the CERS program. They have been very well received and appreciated. However, there are still other costs that we incur.

Little consideration has been given to new start-up businesses that opened in January or February of 2020. With regard to regional chains with multiple locations, the fact that their CERS is capped means they're still on the hook for the balance of their rent. At the end of the day, after government supports, facilities are still losing between $15,000 and $30,000 per month. We have asked the provincial governments for industry-specific support.

I'm here today to talk about how we, as an industry, can be part of the collective health and wellness of Canadians and do our part to help with the national recovery. We're not here to ask for a bailout; we're here to be part of the solution.

We know that exercise has a multitude of benefits. It reduces hypertension by 33% to 60%. It reduces diabetes and cardiovascular disease. It reduces risks of stroke and colon cancer, of breast cancer and Alzheimer's, and it reduces the impacts of anxiety and depression. We also know that COVID-19, unfortunately, has significant impacts for those who have one or more of these chronic conditions.

How can we be part of a solution? Post-COVID, we're looking to ask the federal government and PHAC to expand the Prescription to Get Active program across Canada. For those who don't know about the program, it's based out of Alberta, and it links primary care—your physician—with the fitness and recreation options in your community. We have no-cost and low-cost options. We have fitness facilities. We have remote options for those who are in rural or rural remote areas or are simply not interested in joining a facility.

We want to expand this program. It is turnkey, but it is also flexible to accommodate various geographical regions of Canada. For example, northern Ontario is much different from downtown Vancouver.

We are also asking the federal government to have fitness expenses—fitness memberships and services—considered a medical expense. On your federal tax return, you could include fitness as a medical expense. We have the ability to provide attendance reports for auditability. We have professionals from coast to coast to coast who are ready, willing and able to serve Canadians, to help build sustainable behaviour change to ensure that we create healthy and active lifestyles.

The infrastructure already exists. This truly is a stroke-of-the-pen change that we're asking for. We believe that with this change, we can provide the government with a significant return on investment, over 500%, in terms of reducing the overall burden on the health care system. We can move somebody with a chronic condition from sedentary to physically active, inspiring Canadians to take proactive steps toward their own health and wellness.

We will get many of our young people back to work. Our industry employs many young people. We have college and university programs across the country that do a fabulous job of creating fitness professionals. They will have a viable industry to enter, and we'll get many of our folks we've had to lay off back to work. We will rebuild our industry.

As I mentioned earlier, we have incurred significant amounts of debt. Many operators are now well over $200,000 to $250,000 in debt. By adding fitness as a tax deduction, we believe we can get more people into our industry to help us pay back those debt amounts.

In summary, we're here today to be part of the solution. We'd like to partner with government, and we look forward to answering any questions you may have.

● (1220)

The Chair: Thank you, Mr. Wildeman.

We go now to Tri-City Transitions Society and Ms. Metz Murray, the executive director. Please go ahead for six minutes.

Ms. Carol Metz (Executive Director, Consultant and Leadership Coach, Tri-City Transitions Society): Thank you, Mr. Chair.

Honourable members, I'm delighted to be here today with you to talk to you about the impacts of COVID-19 in the world of domestic violence, intimate partner violence or violence in relationships, whatever title you wish to give it.

I appreciate being invited to the committee.

Tri-City Transitions is a 46-year-old organization serving women, children, youth and men. We began as a women-serving organization. In the early 2000s, we saw that we could help women, children and youth all we wanted, but band-aids were running out, so in 2006 we began to provide services to men because domestic violence is not just a community and women's issue but also a men's issue. There are generally two parties to domestic violence.

In the world of COVID-19, our services changed somewhat from what we were offering earlier. Our services include a transition house for women and children fleeing domestic violence. We also offer counselling services for women. We offer counselling services for children, ages three to 18, and their caregivers, whether they are parents, grandparents, foster parents or whatever the caregiver definition includes. We also offer a victims service program for women, children, youth and men who are impacted by domestic violence, as well as when domestic violence becomes a criminal matter. We are also offering a mentor relationship program for men. All of these services have been impacted as a result of COVID-19.

We serve between 1,500 and 2,000 families a year. Most of our employees are local, and women make up the majority of our workforce. At the beginning of COVID, we decided to help the broader community. We opened up our phone lines to provide emotional support to whoever might need it. In addition, we very quickly moved to virtual services, whether by phone, Zoom or other technology.

What we discovered, when we originally had staff work from home, was that staff asked to come back to work in our offices. Our services were deemed essential. Our main office is such that we were able to physically distance. We have safety protocols in place. We also realized, for the health and welfare for our staff, that it was important that everybody be in the same building. We have been very successful in remaining COVID-free this whole time period.

Part and parcel of what we saw this past year, and continue to see, is the impact that COVID and the lockdowns have had on families. As I listen to everyone else speak this morning, we speak looking at the environment, but the key in all of this is family, regardless of whatever that dynamic may be.

What we saw here at Tri-City was an increase in sexual assaults. Sexual assaults involved not only adults 19 and older; we saw an increase in youth and children. That's not a surprise, given the fact that families found themselves suddenly at home together and unemployed. Perhaps both partners were unemployed, having to educate children. If there were any issues within a relationship, they would surface very quickly.

● (1225)

What that has also meant for people is that it has stopped women from reaching out for services. Perhaps they will reach out via email, but they won't reach out via phone because their partner is in the home or in the same room. We know that there has been a lot of domestic violence happening where people haven't been reaching out for services.

In that whole process of reaching out, one of the biggest things we saw was the lack of funding for services related to sexual assault, so we moved forward to find ways that we can find funding to help people directly when they are impacted by sexual assaults. As we move forward, we truly want to be part of the solution, because families, whatever that dynamic may be, make up the fabric of Canada.

One of our asks is to remove the barriers when we're looking at domestic violence—to remove those barriers that limit us from funding men's programs. Men, too, need to have services in order to decrease domestic violence.

With that, I conclude my presentation.

The Chair: Thank you, Ms. Metz Murray.

We will go to our rounds of questions now, starting with Mr. Maguire. Please go ahead for six minutes.

Mr. Larry Maguire (Brandon—Souris, CPC): Thank you, Mr. Chair.

I thank all our witnesses today for their presentations.

First I want to go back for a moment to Dr. Barry from the radiologists association.

It's good to speak with you again. I know the ask of $1.5 billion was something we had put on the table in the last election, but to purchase MRIs and CTs, you're very short. You're making a very good point that many of those—I think you used the number of 75%—are near their end of life as far as that equipment goes. Even though you're still doing a lot of work from home, you're still well behind in the types of scans that you're able to do.

Can you elaborate on that and perhaps tell our committee how long it takes to put that type of equipment in place and whether there are any roadblocks from regulations that we could look at as well?

● (1230)

Dr. Michael Barry: Thanks for the question, and again, thanks for the opportunity.

Dr. Soulez has arrived. Thank you, Gilles, for making it.

I'll make a few comments on the wait-lists and whatnot.

The equipment is readily available in the marketplace. The investment turnaround time in the last cycle, 2005-06, was about three years. It ramped up and it made about a seven- to 10-year improvement in the wait-lists on CT and MRI, cardiology, interventional radiology and things of that nature.

In terms of the targeting, a lot of the screening done, particularly mammography, has been reduced. For our mammography screening, it's less than 50%, because of COVID and the intimate location you have when you're screening with mammography. The technologists in particular are very exposed to a patient, so they were reduced to about 10% of their workload at that time. Then, just basically, when a COVID patient comes into our CT scan or our MRI, it takes fully one hour to turn it around. There's a COVID protocol based on ventilation and cleaning with Lysol. Then the room has to sit for an hour afterwards.

I was on call a few weekends ago when we had a COVID patient at the Saint John Regional Hospital emergency area. We fortunately have two scanners. I had to use the older scanner, which was about nine years old. It was routine. You wouldn't really compromise diagnostic capability to keep the trauma scanner open, but once we did that patient, which took 15 minutes, it took 15 minutes to clean it, and then we had downtime of about an hour, as the room had to ventilate. If you're in a smaller centre than ours, you could shut down the whole scanner for the whole day.

If you're having people coming through the hospital on a daily basis, you could see how the wait-list would get extended just based on the COVID patients, and then the reduction in volumes that could go on—

Mr. Larry Maguire: That relates to the second part of your ask, as well, with regard to the rooms and the types of facilities that you need to work in.

I just want to go back to the cancer issue. You were mentioning that we have a huge backlog here, hundreds of thousands—I think it's 330,000—of situations that need to be dealt with right away, elective surgeries and that sort of thing, but more in the diagnostics area, the extended.... Can you just refer again to the extensions for the cancer patients? Is it a situation of getting the equipment into areas that need it more? Are there areas in Canada that are at greater risk or that have a vacuum of equipment that could be dealt with, or is there technology today to be able to take those scans and move them into another area where a radiologist doesn't have to be there with the person when the imaging is being done?

Dr. Michael Barry: There is. It's a complex question, but where there are people, there's cancer, and where there's cancer and people in communities, there are imaging departments in hospitals. Most people are prepared to travel to some degree, 50 or 60 miles or an hour or longer, but not much more than that. In New Brunswick and the Maritimes, most people have a CAT scan or an MRI done within about an hour, but in other communities, not so much.

If people in northern communities need imaging, we do that already, because we have the bandwidth to transfer without too much difficulty. It's basically getting up-to-date equipment in a rapid fashion, getting this backlog of hundreds of thousands of patients scanned, and getting existing.... We're talking about rechecks for cancers of lungs and colons that haven't been done, as well as the patients. The six-month protocol may have been extended to 12 months.

Again, I can go in a million directions, but I don't want to take up all of the committee's time.

Mr. Larry Maguire: Thank you.

I want to ask a last question with regard to whether some provinces have done a better job of adjusting their diagnostic imaging departments to the pandemic and keeping their wait times as short as possible. Are there examples that we could use there and follow up on? What's your best knowledge, just to finalize that? Do you know of any COVID outbreaks happening in diagnostic imaging in Canada? You made a very good case that things are being well controlled, but are there areas of concern?

Dr. Michael Barry: I know that Alberta just put put a whack of money into wait-lists for imaging, which we were pleased to see, because they have been hit hard. I'm not as familiar with Quebec and Ontario, which have also been hot spots, but I suspect when the dust settles in this third wave, that.... I talked to people last week in the Hamilton area, and as they head back into the third wave with the variants and lack of vaccinations, their volumes are down 50% already. It's really a moving target.

All I know is that we were quite badly off before this started. We started to stabilize, and then we went into the second wave. Now here we are. It's such a moving target. It's not better—I can assure you of that—and I suspect it'll be a lot worse.

● (1235)

The Chair: Thank you, Mr. Maguire.

We'll go now to Ms. O'Connell. Ms. O'Connell, please go ahead for six minutes.

Ms. Jennifer O'Connell (Pickering—Uxbridge, Lib.): Thank you, Mr. Chair.

Thank you, everyone, for being here. I have questions for all of you, but I'm not sure if I'll get through them, so I'll try as quickly as I can.

Dr. Barry, I might as well start where you left off. Certainly I hear your point about the need for equipment pre-COVID and about wait-lists, but you also mentioned in your testimony that Atlantic Canada, for example, isn't hit as hard. Is that because they've had a zero-COVID mentality or a near zero-COVID mentality and that the provinces have put in place restrictions to really limit COVID?

Where I come from in Ontario, we're seeing places like SickKids hospital actually preparing beds to be ICUs and the direct correlation with doctors' warnings back in February that if reopening happened too quickly too soon, we were going to see hospital rooms and ICUs fill up. You mentioned in your testimony Atlantic Canada, the example, and the direct correlation that not getting COVID contained is going to have long-term health impacts outside of just COVID. We're going to see, as you mentioned, issues around screening, prevention and treatments in other areas, so the focus should be around containing COVID to ensure that everybody is able to access health care in the ways that we are seeing in other jurisdictions.

Dr. Michael Barry: I couldn't have said it better, Ms. O'Connell. You hit it right on the head.

As a direct correlation, in the Maritimes—New Brunswick, Nova Scotia and Prince Edward Island—we're at about 93% of last year's volumes in radiology, and not so much in Ontario, Quebec, B.C. and Alberta. Not to waste your time and the committee's time, but you nailed it; you're right on. It's a direct correlation.

Ms. Jennifer O'Connell: Thank you. I'm going to move on to Ms. Metz and domestic violence.

Thank you for being here and sharing the impacts you're seeing with COVID and describing what's been happening. I understand the need for support and the lack of reporting or of people reaching out.

What are some areas where you find successes that we can help support, for example? We need to understand what's happening. We need to know whether it's sexual assault or domestic violence and who that's impacting so we can get supports to those people.

Is there a way that we can help reach out to people? I come from a semi-rural riding, and I know we try to do some different outreach, versus just having clients come to us in the local organizations. Is there something we can do to help find out who these victims are and how to get them support? Also, as you mentioned, we need support for men so that these abuses are not happening in the first place.

Could you maybe elaborate on some ideas there?

Ms. Carol Metz: Thank you very much for the question. That's a broad question.

When I look across Canada and how we can reach out to people, the rural communities are much more challenged in reaching out to victims of domestic violence just because of the remoteness. One of the things I notice when I'm looking at the remote communities is the need to have bandwidths that are up to date so that people can call. Another thing—just thinking back to rural communities, because I was raised in a rural community—is also having services available in the local communities, perhaps in partnership with another organization, so that someone doesn't have to travel for 50, 60 or even 20 kilometres when they are fleeing domestic violence.

When it comes to services for men, one of the things, as I've said, is that we have started to offer the mentor relationship program and we continue to look for funding in a variety of different places to be able to offer that program. That program is a huge success. If I had the time, I would share stories with you, as I have seen men transform their lives. They too want to make a difference. They too want to be part of their family.

● (1240)

Ms. Jennifer O'Connell: Thank you so much. We're getting a lot in a short amount of time.

If I have time for one more question, I will ask Mr. Wildeman quickly about his ideas. Thank you for sharing them with us. Certainly fitness and health are going to be critical for recovery.

In terms of fitness expenses, would you have some proposal for some type of accreditation similar to massage therapists, for example, with personal benefits or employment benefits? I would think there would be concerns even to your industry and your membership if people all of a sudden started claiming they were personal fitness instructors and flooding the industry. Do you have ideas to help prevent that for your members in terms of the rebuild, and would there be some check and balance in place for the government to review?

Mr. Scott Wildeman: As an industry, we are self-regulated currently. There are a number of registries in place, so folks who have a fitness certification can be identified. The public can search the registry to see if their fitness professional is accredited.

As an industry association, we work with all the different certification agencies. We are looking at ensuring that the public know where to go to find a qualified fitness professional.

Australia has a very good model, with a tiered certification program. We hope to emulate that. We have great certification agencies from coast to coast. We can definitely leverage them.

I think there does need to be a check and balance and some sort of proof of purchase and proof of certification. That does exist today. Those registries are in place.

The Chair: Thank you, Ms. O'Connell.

[*Translation*]

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

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

Thank you to the witnesses for their opening statements.

I would like to begin with Dr. Soulez and Dr. Barry.

Thank you for agreeing to take part in this meeting on the collateral effects of the pandemic, in general, including on non-COVID-19 patients. The pandemic has created two categories of patients: those with COVID-19 and those without COVID-19.

There can be no medicine without diagnosis, and your specialty is hugely important in diagnosing patients. You said the government needed to invest roughly $1.5 billion in equipment. Tell me, if you would, whether your requirements would be met if the government were to make a massive investment in health transfers, sooner rather than later.

● (1245)

Dr. Gilles Soulez (Vice-President, Canadian Association of Radiologists): That's an excellent question. As Dr. Barry clearly explained, Canada was already behind in capital equipment investment before the COVID-19 pandemic. Investments were already needed pre-pandemic, with our equipment assets significantly below the average among countries in the Organisation for Economic Co-operation and Development.

At the height of the crisis, the rate of imaging and screening dropped drastically, and we have yet to return to pre-pandemic levels. At best, we are at 90% to 95% of where we were pre-pandemic, and in most cases, that figure is 80%. We are digging ourselves into a deeper and deeper hole.

The $1.5-billion ask covers not just the purchase of equipment, but also things like human resources—which matter a lot. Different provinces have different needs. Some are in desperate need of equipment, such as the Atlantic provinces and Alberta. Other provinces are more in need of human resources. We have to maximize the use of all equipment, even running machines overnight where possible. That means finding ways to train the technologists who run the machines and to keep the technologists in those communities, something that isn't always easy.

Investing in information technology is also essential. Right now, most provinces don't even have a central inventory for wait lists, so patients can't be referred to appropriate IT platforms. There's no way to find out in real time how serious cases are or determine which ones are truly urgent, meaning, the ones that can't wait. That information is extremely important.

I want to draw your attention to one last thing regarding IT investment. Making sure we choose the right tests for patients is crucial. IT systems are now available to support clinical decision-making, helping to guide front-line workers, such as family physicians. The technology provides assurance that the test fits the needs of the patient, thereby ensuring testing is 100% useful.

Mr. Luc Thériault: Wait lists were already a problem prior to the first wave. Procedures were postponed when the first wave hit, and the backlog was not cleared before the second wave hit. The same thing happened during the second wave and will happen during the third wave. People are going to suffer the consequences of being put on the back burner.

As we speak, people are not being diagnosed. That's clear, is it not? Could that not end up costing the health system more? Am I wrong?

Dr. Gilles Soulez: You raise a good point.

I'll give you a brief overview of what we are dealing with at the clinical level.

Patients have been broken down into four priority categories. Category one—sometimes called P1—patients have to be seen the same day; in other words, they are emergency cases. P2 patients have to be seen within a week.

Disaster strikes when we are dealing with P3 patients, who are supposed to be seen within a month. An example of a P3 case would be someone with unspecified abdominal pain. It's important to find out what it is. Nearly 90% of those types of cases turn out not to be serious, but 10% can be linked to cancer. Even though P3 patients are supposed to be seen within a month, the current wait time is three to six months.

An example of a P4 case would be someone waiting for an orthopaedic surgery, a hip or knee replacement. Normally, those patients are seen within three months, but the current wait time is almost a year, sometimes more. Patients who are waiting for surgery cannot work and they suffer in pain. They do not have access to the treatment they need. What's worse, they sometimes have to be examined over again because too much time has elapsed since the diagnosis, so they have to go through two examinations.

Mr. Luc Thériault: Isn't it true that a delayed diagnosis of certain types of cancer can make things worse? It can end up costing a lot more to treat the patient, can it not?

Dr. Gilles Soulez: Yes, you're absolutely right.

A month is a reasonable time frame. When we strongly suspect a patient has cancer, we have to speed up the process as much as possible. The problem is that we can't confirm the patient has cancer until they undergo medical imaging. Most patients who fall into the P3 category will have to wait three to six months, instead of one month. That gives the disease time to progress to another stage, so instead of performing curative surgery, doctors can merely treat patients with radiation and chemotherapy. The mortality risk is inevitable.

● (1250)

Mr. Luc Thériault: Quebec and the other provinces are the ones who have to provide that care. They need predictability. The government claims it has to provide health care support on an as-needed basis to get through the crisis, saying it will adjust health care transfers once the pandemic is behind us.

Given what we've just talked about, do you think that's a mistake? Shouldn't the government massively reinvest in health care right now?

A total of $28 billion is needed to restore health care funding to an adequate level.

Dr. Gilles Soulez: As someone who works in a tertiary and quaternary care hospital, I can tell you that, right now, non-COVID-19 patients, on the whole, are really suffering because of the pandemic. Clearly, they need very serious attention. The health care system is already underfunded, grappling with staff and equipment shortages.

As things stand, we could see higher mortality among patients whose condition is unrelated to COVID-19 than among those who contract the virus. That is a possibility.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, please go ahead for six minutes.

Mr. Don Davies: Thank you, Mr. Chair, and thank you to all of the witnesses for being here today.

Ms. McQuaig, I think it's a fair comment to say that one of the most profound problems our country faced in terms of vaccine rollout was our lack of domestic production capacity. As you pointed out, the current Liberal government is negotiating a private model relating to domestic production. Why do you have so little confidence that Ottawa and Sanofi Pasteur can negotiate a contract that would give Canadians priority access to the vaccines and medication that we need?

Ms. Linda McQuaig: You know, it's not even that I have little confidence; it's that when we're dealing with hundreds of millions of dollars of public money, we have to have more than just confidence. We have to have certainty. We have to have real rules in place.

What alarms me so deeply about this $415-million investment the government is making in Sanofi is that there seem to be no restrictions. There seem to be no strings attached. They say they're negotiating this contract with Sanofi. Hopefully, it will mean that we'll get what we want and we'll get that priority access for Canadians, but without that being really clarified and clearly nailed down, it's just dreaming. That's a tremendous amount of money to be dreaming about.

I would also add that I think this whole way of thinking is based on a fundamental misconception that we often see on the part of people in government—that is, that the interests of government and private business are fundamentally the same. That is just wrong. The interests of government and business are really quite different. The top priority of business is profit maximization for the company. The people running the company ultimately answer to their shareholders, who want to be made richer, and I'm not even saying this to criticize private companies; this is what they're all about. On the other hand, government answers ultimately to the people, to the voters. If they don't defend the public interests that the voters want, they will end up getting defeated and kicked out of government.

My whole point is that there's a different set of interests involved. The way the Trudeau government is approaching this, throwing $415 million at Sanofi, is just way too trusting. It's based on some notion that they have the same interests that we do. They do not have the same interests. We have to be much more careful.

Even more important, we'd be much smarter to not go this private route and to instead go the public route. As we saw with Connaught, we were able to control what happened with Connaught. It turned out to be a wonderful situation. This was an enormously successful company that provided vaccines for Canadians at cost. They used their profits to reinvest in research. This was a spectacular example. I think the point is that we should be more aware of that history and more excited by what was achieved with it and more interested in investigating whether we couldn't try that again.

● (1255)

Mr. Don Davies: You anticipated where I was going, which was to move to Connaught Laboratories. As you pointed out, it appears that it's pretty common ground that it was a huge success. It was pivotal in producing vaccines for diphtheria, polio and diabetes as well, providing those medicines at affordable prices for millions of Canadians and in fact selling at a cheap cost to the rest of the world.

In 2021, what steps should we take, or you would recommend that we take, to replicate that success today in moving forward?

Ms. Linda McQuaig: There are two key things that I think we should keep very much in mind. You described the success of Connaught. There was a reason Connaught was so successful. One of those reasons was that it was very explicitly, right from the beginning, committed to the public good. It stated its goals very clearly as making medication affordable and available to all who needed it. Now, that's a public interest definition. That's very different from what private pharmaceuticals do. I think that inspired loyalty in its staff and in scientists.

The other thing I'll just say quickly is that Connaught was based at a university. It was based at the University of Toronto. It expanded way beyond that. That meant it could draw on the expertise of the university, the scientific expertise. In fact, they could share research with private pharmaceutical companies. There tends to be an unwillingness to share any proprietorial information with other scientists. Connaught wasn't like that at all. They were constantly contributing to other medical advances. They became a hub for scientific inquiry. I think it's very important that if we go back to recreating Connaught, we once again replicate that model as a real hub of scientific innovation and collaboration with other scientists.

Mr. Don Davies: Thank you.

It appears I'm out of time.

The Chair: Thank you, Mr. Davies.

That brings our rounds of questions for this panel to an end, and I believe that concludes our business for today.

I thank the witnesses for your time and your expertise and for sharing your insight with us—

[*Translation*]

Mr. Luc Thériault: Mr. Chair, if everyone consents, we could have a second round of two minutes, as we did earlier, since we still have a bit of time.

[*English*]

The Chair: Sure, we could do 30-second shots if everyone wants.

We'll start with Mr. d'Entremont for 30 seconds, please.

Mr. Chris d'Entremont (West Nova, CPC): Thank you. My question is for Dr. Barry or Dr. Soulez.

We know that we're already backed up in wait times when it comes to diagnostic imaging. Just how far back has COVID brought us?

Dr. Michael Barry: If you look at patients—and I think Gilles has dealt with that, particularly the P3s—I suspect that more than 380,000 people are backlogged in the system, but that's one raw number. Nova Scotia and New Brunswick are probably in better shape than the rest of the country. I think the economic cost is upwards of $5 billion a year, with not letting people get back to work, being at home and off the payroll and with all the social issues around staying at home and not being productive.

Certainly it's more than 380,000. We'll know more about how to quantify it as we study it again after this third wave.

The Chair: Thank you, Mr. d'Entremont.

Ms. Sidhu, please go ahead for 30 seconds.

Ms. Sonia Sidhu (Brampton South, Lib.): My question is to Ms. Metz.

As we have said, the federal government has been there to support Canadians, providing eight out of every 10 dollars. Did you notice the impact of the support on Canadians?

● (1300)

Ms. Carol Metz: In the last year with COVID, there certainly was an increase in support from the federal government. Where we noticed the biggest support was through the Canadian Women's Foundation. That came from federal dollars. That certainly has helped us over the past year. That support has also helped us to boost the services for sexual assault victims.

[*Translation*]

The Chair: Mr. Thériault, you have 30 seconds. Go ahead.

Mr. Luc Thériault: Dr. Soulez, talk, if you would, about the importance of overhauling how appointments are booked and investing in artificial intelligence?

Dr. Gilles Soulez: As you know, most provinces in Canada don't really have a central booking system or a system to prioritize appointments appropriately.

A number of systems have the ability to ensure that all the examinations requested at the primary care level are appropriate. However, improving the patient experience is absolutely crucial. You've probably all received a letter in the mail or by fax indicating that an appointment had been scheduled for you, only to realize that it's during your workday. It's absurd not to have an online system where people can book appointments at times that suit their schedules, a system that gives them access to contraindications and instructions to prepare for the examination. We are way behind the curve on that.

We really need to do a lot more to leverage information technology and move the process online. It would then be possible to analyze the workflow and streamline the process from beginning to end.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Davies, please go ahead for 30 seconds.

Mr. Don Davies: Thanks.

Ms. McQuaig, Canada seems to be opposing the move at the WTO to override private patent rights for COVID vaccines so poor countries can get access to COVID vaccines. What's your comment on that?

Ms. Linda McQuaig: I think it's such a terrible position for Canada to be taking. Canada is essentially siding with big pharma, which wants to protect their patent rights, and frankly it's quite out of line with what Trudeau would normally be expected to do. He's very interested in his image as a progressive.

I think what this speaks to is the fact that the Trudeau government is very anxious to do what the big pharmaceutical companies want, because Canada feels so vulnerable when we don't have a vaccine supply of our own. I think this is just exactly the kind of problem that we would be correcting when we recreated something like Connaught Labs. We shouldn't be so much at the mercy of the big pharmaceutical companies, which is what we are.

The other thing that the big pharmaceutical companies are very anxious to push on the Canadian government—and I can see Sanofi trying to use the negotiations with Ottawa over this—is to push for Trudeau to back off from the changes he's announced to the patented medicines regulations, changes that are designed to reduce the price of drugs by billions of dollars for Canadians.

Let's not end up getting a vaccine supply through a private supplier, like Sanofi, in exchange for giving up the right to bring down drug prices in Canada. That would be a terrible trade-off.

The Chair: Thank you.

Mr. Thériault, I see your hand is raised. Do you wish to speak or have you already done so?

Mr. Davies, I see your hand is up.

Mr. Don Davies: Yes, thank you—

[*Translation*]

Mr. Luc Thériault: I had my hand up before he did, Mr. Chair.

[*English*]

The Chair: Yes. Sorry. Mr. Davies; we'll go with Mr. Thériault.

Mr. Thériault, go ahead.

● (1305)

[*Translation*]

Mr. Luc Thériault: It was just to talk about the work plan going forward, Mr. Chair.

This morning, we had two notices of motion. At Friday's meeting, we won't be discussing the motion relating to Standing Order 106(4). We were supposed to do that by April 7 and we didn't. We need to know what the plan is for Friday. We have witnesses to invite.

Do you have an idea of what's planned for the next few meetings?

[*English*]

The Chair: As I mentioned at the beginning of the meeting, we have confirmation of witnesses who we had wanted to have for our meetings last week. They are confirmed for Friday, so we will have that meeting on Friday.

We will then carry on with our schedule as we had previously decided, which will be to carry on with the Bloc portion of the COVID-19 study, and at some point in the next month we will schedule the minister for estimates as well.

Does that answer your questions?

[*Translation*]

Mr. Luc Thériault: Sorry, Mr. Chair. From the interpretation, I understood that we would not be hearing from witnesses on Friday, so that was why I asked.

Thank you.

[*English*]

The Chair: Mr. Davies, please go ahead.

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

I think you answered, but I just want to clarify. Will all of the witnesses we were supposed to schedule for last week be scheduled for this Friday?

The Chair: I'll actually have to ask the clerk about that. I understand that both ministers are available, as well as Dr. Quach-Thanh. Dr. Quach-Thanh and at least one of the ministers were not available last week.

Mr. Clerk, could you advise?

The Clerk of the Committee (Mr. Jean-François Pagé): I was not aware the minister will have.... I have not received any confirmation from my contact in the department, so I don't know....

Last week, I was told that—

Mr. Don Davies: Fine.

The Clerk: In terms of the ministers, Minister Anand was available, but I haven't received any confirmation from the health department, from the minister, so I don't know.

I will ask and I will.... Go ahead.

Mr. Don Davies: If my memory serves me correctly, I believe we requested five witnesses. They were Minister Hajdu, Minister Anand, Mr. Stewart, Dr. Quach-Thanh and Dr. Tam. I think those were the five.

If we're scheduling for Friday, again I think we need to know pretty quickly whether some or all of those witnesses are going to be attending.

The Chair: We'll verify that as soon as we can and get back to the committee.

Ms. Rempel Garner, please go ahead.

Hon. Michelle Rempel Garner: Why wasn't the meeting scheduled, as stated in the motion? I understand that the ministers can choose to appear or not, but why didn't you schedule the meeting?

The Chair: The motion was for us to invite the ministers and other witnesses for a meeting on that day. We did so. The ministers were not able to attend. Dr. Quach-Thanh was not able to attend. I therefore felt it was not appropriate to hold the meeting on that day. I felt that it was more the will of the committee to hear from these witnesses than to have a meeting just for the sake of having a meeting.

Hon. Michelle Rempel Garner: Mr. Chair, you unilaterally decided to overrule a motion by the committee. I understand that people might not show up, but direction was given to you by the committee to hold a meeting. What you just said is that you felt, based on your feelings, that you couldn't avail yourself to schedule a meeting that the committee ordered you to schedule.

The Chair: I believe the motion was to invite the ministers and other witnesses for a meeting on a specific date, and we did that.

Hon. Michelle Rempel Garner: You felt that you didn't have to schedule the meeting. You felt...feelings.

The Chair: I believe I fulfilled the terms of the motion.

Hon. Michelle Rempel Garner: I don't think we had the meeting, so I beg to differ, but I guess your feelings prevail.

● (1310)

The Chair: That's not exactly what I said. I said that as far as I'm concerned, we fulfilled the terms of the motion, which were, in fact, to invite the ministers and other witnesses for a meeting on that date. We did that. The ministers, of course, were not able to make it, and neither was Dr. Quach-Thanh. I believe there was also potentially a problem with television coverage for such a meeting last week.

In any case, we will do our best to have this meeting on Friday. Hopefully, we can resolve the questions and get the information that is hoped for from the ministers and other witnesses at that time.

Ms. O'Connell, go ahead.

Ms. Jennifer O'Connell: Thank you, Mr. Chair.

With regard to her comments about your feelings, Ms. Rempel Garner is absolutely wrong. The committee passed a motion requesting the appearance of officials and ministers on a specific date. They weren't available. You, as chair, fulfilled the committee's request, which was to hold a meeting with those ministers and officials.

Her feelings are hurt because she didn't get the date she wanted, but the business of this committee and Canadians moves forward despite what she wants. I think having testimony from the ministers and officials is far more important.

If there are any feelings at play here, I suggest that the member opposite get on with doing the committee's work, as you have so appropriately done, Mr. Chair, and I look forward to the meeting on Friday.

The Chair: Thank you, Ms. O'Connell.

Mr. Davies, please go ahead.

Mr. Don Davies: Given that we have witnesses here, we probably should defer this conversation to another time. I do, however, believe that we need to have a discussion about the proper protocol going forward.

I don't agree, with great respect, with what Ms. O'Connell said, or frankly, Mr. Chair, with what you said. We passed a motion that gave one week to have a meeting within one week, and we invited five witnesses. I don't think the obligation is to simply send out invitations, and if no one shows, not have a meeting. I believe the proper approach there would have been to schedule the meeting. We could have then, at that meeting, decided what the next step would be.

We have the tail wagging the dog. Witnesses don't control this committee. Witnesses appearing or not appearing doesn't determine whether this committee sits. This committee determines when we sit. We passed a motion by eleven votes to zero, including the Liberals, to hold a meeting within one week with those witnesses.

I also find it passingly coincidental that five out of five witnesses could not appear on the same day at the same time, including Ms. Tam, Ms. Quach-Thanh, Mr. Stewart and the two ministers. Frankly, what if witnesses never want to appear? Do we never sit?

I also think it's an important accountability mechanism. If we call this meeting and no witnesses show up, it gives us a chance to question why.

I would also point out that this committee received not a word of notice from the chair at all, until the eleventh hour. After one week, at six days and 23 hours, we were notified that the meeting wouldn't take place. There was no attempt to notify the members of this committee of the witnesses' response so that we might have made an adjustment. Perhaps we could have met on Thursday or Friday of last week, but we weren't given that chance because of the unilateral decision of the chair.

I think, then, that we need to have a conversation about this. This is not about feelings on anybody's part; this is about respect for this committee. When this committee passes a motion to hold a meeting, that motion should be respected. If witnesses do or don't appear, then it's up to the committee to determine how that situation is handled.

That's my two cents' worth. Perhaps we can have a special meeting at which we can make sure this doesn't happen again, but I think it's important to set the record straight on this issue.

The Chair: Thank you, Mr. Davies. I take your point about the witnesses.

I would really like to thank the witnesses for their attendance here today. Please feel free to withdraw, if that is your wish.

I would also say, Mr. Davies, that I did not say that all five witnesses could not come on Wednesday. I know that at least one or both of the ministers, as well as Dr. Quach-Thanh, could not attend.

Anyway, I'll turn the floor over to Ms. O'Connell.

Please go ahead.

● (1315)

Ms. Jennifer O'Connell: Once again, Mr. Chair, I understand the position of Mr. Davies in wanting to discuss this, but frankly, the rules around what a chair can and cannot do are established, and it is the job and the role of a chair to call meetings based on the direction of the committee. The chair acted exactly in that fashion. If members of this committee don't like those rules, then they should take the matter up procedurally at PROC or within the House. Those are the Standing Orders, and the chair has the authority to do this.

In addition to that, I've never seen a committee which, if members asked for specific witnesses and they were not available, would hold a meeting and all just sit there. If that were the direction of the motion—that, if witnesses were not available, the meeting be held anyway—then the drafters of the motion should have written that in.

You can't, however, go back on a poorly written motion or a motion that didn't encompass all of the things you wanted and now blame the chair for not being able to read your mind into an understanding of what should happen in the event that witnesses are not available. We can invite witnesses, but we cannot control their schedules.

If the intention, then, was to have a meeting despite not having witnesses, that should have been included in the motion and—coulda, woulda, shoulda—you'd have had to come forward and have that stipulated, because the chair followed the direction of the motion as written, and the Standing Orders are the rules that govern the responsibilities of the chair.

If those rules are something you want to review, then there is an appropriate way to do so. Blaming the chair for fulfilling his role, however, is not appropriate, and blaming the chair for something that's not written as part of the motion is also not appropriate.

The Chair: Thank you, Ms. O'Connell.

I also would remark, regarding the matter of notice, that I did not hear definitively that the ministers could not attend until Tuesday, and the committee was informed as soon as possible thereafter.

We have Ms. Rempel Garner. Please go ahead.

Hon. Michelle Rempel Garner: Mr. Chair, to be clear, there were witnesses who were able to attend, per the outline in the notice. That's what you said: some were able to attend.

The Chair: I didn't say that. I said that I only have knowledge that the ministers—or at least, one of the ministers—couldn't attend, as well as Dr. Quach-Thanh. I don't know whether the other witnesses were able to attend or not.

Hon. Michelle Rempel Garner: Did you ask them?

The Chair: The clerk reaches out to the witnesses and—

Hon. Michelle Rempel Garner: Clerk, did you ask the other witnesses on the list?

The Clerk: Yes, of course.

Hon. Michelle Rempel Garner: Were they able to attend?

The Clerk: They didn't say no. I just got an email saying that Dr. Tam and Mr. Stewart were available this Friday, the sixteenth. They didn't say no, but they said they were only available next week, the week after.

Hon. Michelle Rempel Garner: It seems that the story has changed here, Mr. Chair. At first you said the ministers weren't available and you weren't going to call the meeting; however, in your response to Mr. Davies, you said there were some people available. It sounds as though you really didn't press to get an answer, and if somebody was available, I'm not sure why you unilaterally decided to not have the meeting. It seems curious to me.

I will just say this. Per the Standing Orders, chairs have to follow directions given by a committee. I think there's a bit of a changing story here.

If I had to surmise, I think this is what happened. I think the ministers decided they didn't want to attend, per the terms of the motion. I will note that the ministers did find time to speak on a political panel at the Liberal committee last week. They were both there at the same time, so that was a priority. I think that's interesting.

I think they probably said they couldn't attend, and then it was, "Let's not have the meeting at all", because they didn't want to face the political consequences of not showing up to a meeting, given the gravity of the matter that was compelled.

Mr. Chair, I think it's very interesting that you decided not to hold the meeting. Also, given that your story has changed a couple of times here, it's disappointing. I think we deserve better. I find it odd.

That's all I'll say on that. I'm very disappointed.

● (1320)

The Chair: Ms. Rempel Garner, you're putting words in my mouth. The story has not changed.

Hon. Michelle Rempel Garner: I'm happy to check—

The Chair: I said that at least one of the ministers and Dr. Quach-Thanh could not appear. I made no assertion regarding the other witnesses for last week's proposed meeting.

Mr. Davies, please go ahead.

Mr. Don Davies: Thank you.

I find myself unclear as to what's being said as well. I have some remarks, but first I want to ask the clerk. Did any of the witnesses get back to you to say that they could attend the meeting on Wednesday of last week?

The Clerk: No. Dr. Quach was not available, and all the three names I gave for the sixteenth and the ministers were not available. I got an email saying that they could not make it for the seventh.

Mr. Don Davies: Did all five people get back to you to say that none of them could make the seventh?

The Clerk: Dr. Quach could not attend, nor could the ministers. For Dr. Tam and Mr. Stewart, I didn't get an email saying they could not come; I just got an email saying they were available on the sixteenth.

Mr. Don Davies: This is confusing to me. We passed a motion one week earlier that said we wanted to call these five witnesses to a meeting on or before the 7th, and you're saying that witnesses got back to you and said, "I can come on the 16th." It's funny. We've had Ms. Tam come before this committee 10 times in the past three years, I would say, and she has never been unavailable.

I have to also say that we gave these witnesses one week's notice, a full week's notice for all five of these people. I understand about the ministers, by the way. For ministers, I understand that their schedules are much tighter, although I am a bit troubled by the fact that only one minister got back to us and said she couldn't make it. Did Ms. Hajdu get back and say that she could or couldn't make it? When we have bureaucrats like Mr. Stewart and Dr. Tam, my experience has been that if we ask them to appear before this committee on one week's notice, they can generally do that.

Anyway, this is water under the bridge, but I do think that this committee does need to understand what the proper protocol is going forward. I for one would have appreciated having the meeting anyway and having a report back from the chair and the clerk about what happened, because you have to remember that the motion did say that we would have this meeting or on before the seventh.

To respond to Ms. O'Connell, if we're going to get extremely denotative and literal about motions, there is nothing in that motion that says the meeting can happen after the seventh, so how the chair is taking it upon himself to unilaterally schedule the meeting for this Friday coming up when the motion clearly said that couldn't happen is also beyond me.

We need to figure out how we're going to do this. I for one would rather that we say we'd have the meeting. Then we could have determined what the best way forward would have been. It may have been to proceed with one of the witnesses or two, or to maybe pick another time to schedule.

That's my only point about this, but I think it's better if we move as a committee with these situations. I understand that these things do happen and I understand that the clerk and the chair were doing their best to carry out the point of the motion, but my suggestion is that moving forward, we have a better approach to involve the committee in this decision.

The Chair: Thank you, Mr. Davies.

We'll go to Mr. Van Bynen, please.

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

I'm hearing a lot of language around how we should respect the committee, and perhaps respecting the committee also involves making sure that we have all our witnesses available when we call a meeting. I don't think there's any positive outcome in speculating on or even imagining a scenario that has a surreptitious outcome or a surreptitious motive.

I think this committee is committed to finding solutions. This committee is committed to going forward and making sure there's a productive use of our time—all of the committees—and I think that's the respect we should have. Some of this partisan posturing is counterproductive. I would suggest that maybe all of us take the time to read the book entitled *Teardown: Rebuilding Democracy from the Ground Up* by Dave Meslin.

This partisanship is so counterproductive to all of us. Why don't we focus on finding good solutions? I think there are procedures in place, but procedural gymnastics are unproductive. Let's settle on the intent of having a positive outcome in going forward. It's really disappointing to see that we're even having this discussion.

● (1325)

The Chair: Thank you, Mr. Van Bynen.

Is there any further discussion?

Seeing none, I therefore declare this meeting adjourned.