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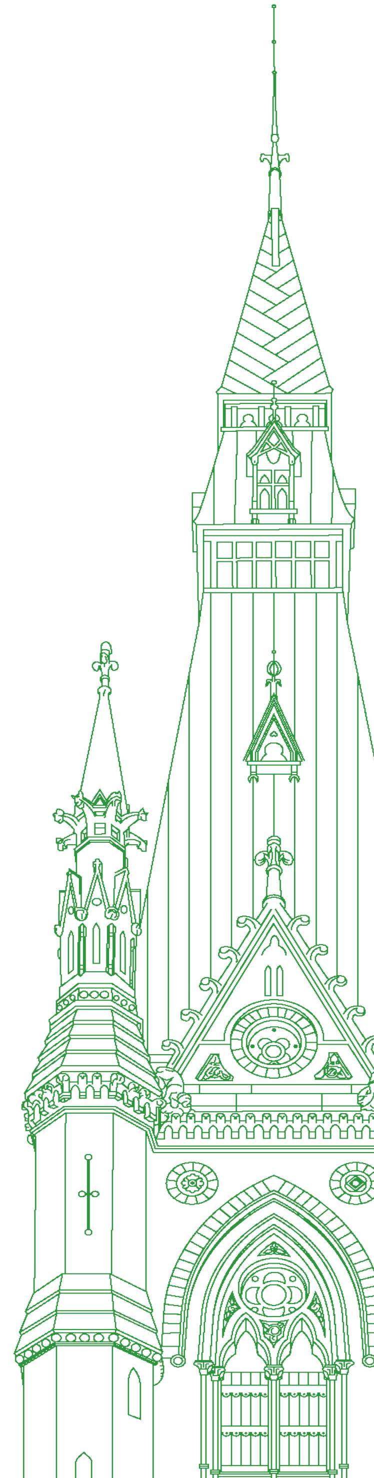

Chair: Mr. Ron McKinnon

Standing Committee on Health

Friday, April 16, 2021

● (1305)

[*English*]

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

Welcome, everyone, to meeting number 29 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.

I would like to welcome the Honourable Patty Hajdu, Minister of Health, and the Honourable Anita Anand, Minister of Public Services and Procurement.

I'd also like to welcome senior officials joining us today. From the Department of Health, we have Dr. Stephen Lucas, deputy minister. From the Canadian Institutes of Health Research, we have Dr. Michael Strong, president. From the Department of Public Works and Government Services, we have Mr. Bill Matthews, deputy minister; and Mr. Michael Vandergrift, associate deputy minister. From the Public Health Agency of Canada, we have Mr. Iain Stewart, president; Major-General Dany Fortin, vice-president, vaccine rollout task force, logistics and operations; Dr. Theresa Tam, chief public health officer; and Dr. Matthew Tunis, executive secretary for the National Advisory Committee on Immunization.

We will start with witness statements. I will invite Minister Hajdu to begin. Minister Hajdu, please go ahead, for seven minutes.

Hon. Patty Hajdu (Minister of Health): Thank you very much, Mr. Chair. I'll just give my remarks in English to go easy on the interpreters, given this virtual environment. I will say that I'm very happy to be here with you all, and I thank the committee for the opportunity to share an update on our work to protect Canadians against COVID-19.

Of course, many people have used the word “unprecedented” to describe this pandemic. In fact, around the world, we've talked about the unprecedented nature of a global pandemic of this sort. Besides being unprecedented in its scope, it is obviously also unpredictable, as the virus has changed and shifted and as we've attempted to keep ahead of our knowledge on how best to protect people from COVID-19.

As we see case numbers rising across the country, Canada and indeed the world have worked hard to manage COVID-19 and to protect our citizens in each of our jurisdictions. Every step of the way, since January 2020, our government has responded and adapted to information as it has evolved. Information is coming to us in real time. On many fronts, we learn as we go, and I want to take a moment to thank the scientists, the researchers and the public health officials who have worked non-stop to better understand this virus, to better understand measures to protect against this virus, and to better understand how it's affecting the many communities in our country.

Mr. Chair, it's important to establish that context as we address the important questions before us today. All levels of government are racing to ramp up vaccination, to suppress the rapid spread of variants of concern and indeed of the virus itself, and to help bring the pandemic under control. As of April 16, more than 12 million vaccines have been distributed to the provinces and territories, and we delivered over 10 million doses by Easter weekend, which exceeded our initial goal of six million doses for the first quarter of this year.

As of now, more than nine million doses of COVID-19 vaccines have been administered in Canada; 81% of people 80 years of age and over have received their first dose, and 10% have received both doses. The Government of Canada is going to continue to do its job to make sure more and more doses are delivered throughout the country, and will also be there for provinces and territories for any additional support or resources they might need.

We're also going to continue to provide advice to Canadians about vaccination and about how to protect themselves against COVID-19 as we see the virus accelerate in many jurisdictions across the country. We work with real-time data, and Health Canada carefully reviews any new information that becomes available so that our advice continues to evolve and be based on the best and latest science.

As the vaccine rollout continues, we continue to work with partners in industry and the not-for-profit sector to increase testing and screening capacity across the country. Testing and screening continue to be the foundation of slowing the spread of COVID-19, although of course it's very important that provinces and territories also manage people well and in a supportive way who have tested positive for COVID-19. Mr. Chair, it's important to know if people are sick, and it's important to support them when they are. That's the best way to stop the spread of COVID-19.

On testing, as of April 8, 2021, more than 25 million rapid tests had been shipped to provinces and territories. That's 25 million, Mr. Chair. When combined with the federal allocation, over 41 million rapid tests have been distributed across the country. Not only have we delivered those tests, but we've also been working with provinces—

● (1310)

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Sorry, Mr. Chair.

I also want to apologize to the minister.

I'm really sorry, but I'm having a sound issue. Even though I turned on the French channel, I can hear the minister's remarks as loud as the interpretation. I can't understand what's being said.

I don't know what procedure to follow in this situation, but I've had a similar issue before. I resolved it by leaving the meeting and coming back. I'd like to try this method. I hope that I won't miss too much of the minister's speech. You may want to wait for me.

What's your decision, Mr. Chair?

The Chair: Thank you, Mr. Thériault.

We'll wait for you.

[*English*]

We will suspend briefly while Mr. Thériault fixes his problem.

● (1310)

_____________________(Pause)_____________________

● (1310)

The Chair: Minister Hajdu, thank you for your patience. Please continue from where you left off, if you can.

Hon. Patty Hajdu: I'll begin at the testing section and talk about testing.

As the vaccine rollout continues, it's important that we continue to test and contact trace, support people who have been infected with COVID-19, and isolate in order to contain the spread of the virus as we do that important work. The government has been working with partners in industry and in the not-for-profit sector to increase screening and testing capacity across the country.

As of April 8, 2021, more than 25 million rapid tests had been shipped to the provinces and territories. When combined with the federal allocation, over 41 million rapid tests have been distributed across the country. We've supported the provinces and territories, along with the private sector, to ensure that rapid testing can help identify the spread of COVID-19 in essential workplaces and in congregate living settings. In fact, in pandemic spending, eight dollars out of every $10 spent on our national response have come from the federal government.

Recently, the Province of Alberta announced that more than two million rapid tests will be available for businesses in Alberta, and this is an expansion of a program that has already successfully rolled out more than 1.2 million rapid tests to long-term care facilities, schools, hospitals and homeless shelters. In this next phase of Alberta's program, test kits will be provided to employers and service providers, with priority given to organizations that work with vulnerable people. This will give employees a sense of security and comfort when they go home to their families at night after working with the public all day.

There's no silver bullet to fighting COVID-19, but adequate rapid testing and appropriate contact tracing and isolation are layers of protection to keep essential workers safe as they stay on the front lines for all of us. From border measures to mandatory quarantines to digital tools to the establishment and funding of safe isolation sites, the Government of Canada has been working with the provinces and territories every day to keep Canadians safe. We're going to continue to use all the tools at our disposal to help the country through the pandemic. We will do whatever it takes, for as long as it takes, to protect Canadians.

I would like to conclude with a few words about the report recently published by the Office of the Auditor General of Canada.

As you know, it raises issues concerning the Public Health Agency of Canada's response to the emergence of COVID-19. We have accepted every recommendation from this audit, and work is under way to respond to these recommendations. We have to keep the health and safety of Canadians our top priority across government.

That's why the Government of Canada has provided significant funding and resources. As I said, eight dollars out of every $10 in the pandemic response has come from the federal government. This includes, recently, $690.7 million in the fall 2020 economic statement to strengthen the Public Health Agency of Canada's response and surge capacity.

The agency has grown tremendously. It has expanded by more than 1,000 new employees to bolster our capacity to have more people able to support and protect Canadians across a number of areas. The agency continues to grow to support our response to COVID-19. In October, the agency implemented a national COVID-19 public health data portal to support data collection, sharing and management, something we know that we need to get better at all across the country. Also, I've asked for an independent review of Canada's global public health surveillance system, commonly referred to as GPHIN, and a final report and recommendations are expected later this spring. These measures will help us improve Canada's pandemic preparedness and response capacity.

There have been financial supports for Canadians through the CERB and the CRB, wage supports for businesses through the CEWS, and wage top-ups for health care workers. Through my portfolio, there have also been things like safe isolation sites for communities; Canadian Red Cross personnel, field epidemiologists and other experts; contact tracers; and mental health supports that are free and directly deliverable to Canadians through Wellness Together Canada. This is along with $19 billion through the safe restart agreement; supplies and resources, fully paid, for the provinces and territories to test, track and treat COVID cases; treatments for COVID-19; and millions upon millions of vaccines. Every step of the way we have stopped at nothing to support the provinces and territories to deliver on their responsibility to provide health care to Canadians in their jurisdictions.

● (1315)

As we see this third wave threaten so many lives, we know we have to keep working together, with all hands on deck. This is a team Canada moment. We have to keep working together and working with our partners, because Canadians want us to do that. They need us to do that. They need us to continue to be collaborative and to look for ways to help. They want us to know that they need us to work together and that we are going to get through this together.

To my colleagues here today, I hope that you will use your platforms, your ability to communicate as leaders in your communities, to encourage Canadians to get tested, to stay home when they're sick, to wear face masks, to isolate when they're close contacts, to restrict their movements and indeed to get vaccinated when it's their turn. It's very important that we are all speaking from the same page on this.

Thank you very much. I look forward to your questions.

● (1320)

The Chair: Thank you, Minister.

We'll go now to Minister Anand.

Minister Anand, I invite you to make your statement. Go ahead, please, for seven minutes.

Hon. Anita Anand (Minister of Public Services and Procurement): Thank you so much, Mr. Chair.

I want to thank the committee for inviting me to speak here today—

[*Translation*]

Mr. Luc Thériault: Sorry, Mr. Chair.

I can't hear the interpreter properly. There seems to be a volume issue on the interpretation channel. When a new interpreter takes over, the volume isn't at the same level. This isn't the first time this has happened. I think that we should pay attention to this issue.

The issue is that if I turn up the volume on my computer like I usually do, when the other interpreter takes over, it will be much too loud. I've been participating in video conference meetings for a year and a half now and my hearing is starting to go. I would like this comment to be taken into consideration. Not only is the hearing of the interpreters at risk, but also my own.

Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

I will ask the clerk to bring that forward with the interpretation people and see if we can address that. I myself notice that when the language switches to English, there's a lag before the volume is restored.

However, let's forge ahead.

Please keep us informed, Mr. Thériault. We'll do the best we can.

[*Translation*]

Mr. Luc Thériault: The issue still isn't resolved, Mr. Chair.

I don't want to raise my volume to a level that would harm my eardrum. I'm sorry, but the issue isn't resolved. I think that the issue is in the interpreters' booth.

The clerk must give instructions regarding this matter now. I'll be spending three hours with you, and I don't want to go through this for three hours. I'd like to get this issue resolved.

I'm sorry. I know that this is unpleasant, but I've been dealing with this reality for the past year and a half.

Thank you.

[*English*]

The Chair: Thank you, Mr. Thériault.

I see that the clerk has gone to talk to the people in the interpretation booth.

We will briefly suspend. Thank you.

● (1320)

_____________________(Pause)_____________________

● (1325)

The Chair: Thank you, Mr. Clerk.

Mr. Thériault, thank you for your patience. We'll do our best.

Hon. Patty Hajdu: Mr. Chair, I've arranged my schedule so that I can stay until 3:15 p.m. as well.

The Chair: Thank you, Minister. I appreciate that.

With that, we will resume.

Thank you for your patience, everyone. Translation is sometimes difficult.

I would invite Minister Anand to resume.

Hon. Anita Anand: Thanks so much. I was just actually thanking everybody for having me here. I look forward to taking your questions.

I also wanted to thank the translators, who I know have been working so very hard during this whole pandemic and in various committee meetings.

I would like to also acknowledge that I'm meeting you from the territory of many first nations, including the Mississaugas of the Credit, the Anishinabe, the Chippewa, the Haudenosaunee and the Wendat peoples.

[*Translation*]

I understand the sense of urgency with which this meeting has been convened. The government has been dealing with this crisis for over a year now. Canada is in the third wave of the virus, and my department, Public Services and Procurement Canada, has been working around the clock since the beginning—

[*English*]

The Chair: I'm sorry, Minister. Pardon me.

In English, we're now getting the translation and the original voice at the same level. I wonder if we could have the translators take a quick look at that.

Please, carry on, Minister.

● (1330)

[*Translation*]

Hon. Anita Anand: Public Services and Procurement Canada is working 24 hours a day, seven days a week, to secure the goods and services needed to help Canada get through the pandemic.

[*English*]

Our primary goal at PSPC has been to meet the needs established by the Public Health Agency of Canada and Health Canada as they worked—and continue to work—with the provinces and territories to support Canada's health care professionals on the front lines.

Early on, we focused on buying urgently needed PPE in what proved to be a hyper-competitive global market, with huge international demand for a finite supply of goods. My team accelerated procurement processes, and in some instances established completely new international supply chains to ensure that Canada had access to the most vital PPE from overseas as well as right here in Canada.

Indeed, we tapped into the ingenuity of Canadian companies. We put in place contracts with those who answered our call to action and stepped up to deliver what they could.

[*Translation*]

At the same time, our government made significant investments in domestic production of much-needed personal protective equipment, or PPE, helping several Canadian companies retool and expand their production lines.

To date, my department has now procured some 2.5 billion pieces of equipment, which we are continuing to receive, with a substantial amount of that equipment being made right here, at home.

We have also procured other vital supplies and services on behalf of the Public Health Agency of Canada, such as rapid tests and medical equipment.

[*English*]

As the members of this committee well know, our focus now is on vaccines—getting them into Canada and into the arms of eligible Canadians as soon as possible. We are also supporting the Public Health Agency of Canada and all provinces and territories with the supplies necessary, including the low-dead-volume syringes.

Moving to vaccines, Mr. Chair, our work from the outset has been to follow the advice, in our procurements, of the Public Health Agency of Canada and the COVID-19 vaccine task force. On their advice, we began by building a diversified portfolio of vaccine candidates as soon as they began to show promise. As soon as we received the advice of the vaccine task force, we began signing agreements in principle with potential suppliers. That was as early as July 2020.

[*Translation*]

Our objective was to place Canada in a solid position to take delivery of doses as soon as vaccines were deemed safe and effective—and that is precisely what we have done. We gained access to more than 400 million doses of potential vaccines from eight different manufacturers, resulting in one of the most diverse portfolios in the world.

[*English*]

This diverse portfolio is giving Canadians some security in what continues to be a volatile marketplace for vaccines, and it is thanks to this diverse portfolio that we are seeing inoculations happening across this country. We have four approved vaccines. We have received more than 12 million doses in this country since December. Millions more are arriving on our shores every week. We are working directly with our suppliers to keep them coming.

At the same time, we continue to negotiate for earlier deliveries from vaccine suppliers. Indeed, the Prime Minister and I just announced that we have secured the delivery of an additional eight million Pfizer vaccine doses. The first four million additional doses are scheduled to arrive in May. Two million doses a week are coming to Canada in May. That is double the amount of Pfizer doses that we had previously expected.

Indeed, in June we will also see more than two million doses arriving per week. Then, in July, there will be two million more doses, so Mr. Chair, Pfizer has really stepped up in order to ensure that we get vaccines into Canadians' arms as soon as possible.

All of this means that from April until the end of June, we are set to receive at least 24.2 million doses of Pfizer and, by the end of September, Canada will have received 48 million Pfizer doses. This is in addition to the other shipments of vaccines that are coming in from Moderna, AstraZeneca and Johnson & Johnson.

● (1335)

[*Translation*]

This is tremendous news for Canadians. It means more Pfizer vaccine doses sooner, on top of the millions of other vaccines we already have coming.

I can also now provide an update on our anticipated deliveries of Johnson & Johnson's vaccine.

[*English*]

We expect an initial shipment of approximately 300,000 doses during the week of April 27, with more substantial deliveries coming in the latter part of this quarter and into the third quarter.

For AstraZeneca, Canada is scheduled to receive 4.1 million doses from various sources by the end of June, with further deliveries in the third quarter.

In total, prior to the end of June, Canada will receive between 48 million and 50 million doses of vaccines.

Mr. Chair, as we have said many times, by the end of September, we will have more than enough doses so that every eligible person in Canada will be able to be fully vaccinated.

[*Translation*]

Once again, this is good news for Canadians, but it doesn't mean our work is done. Our government continues to work with suppliers and our international partners to ensure the steady flow of vaccines into this country, and we are continuing to push for earlier delivery of vaccines from our suppliers.

[*English*]

Mr. Chair, this is the most important work that I have ever undertaken in my professional career. Like many of you around the table and Canadians across this country, I am worried about the third wave, and I am working—

The Chair: Pardon me, Minister.

I don't know if it's your microphone or whether it's generally heard the same, but the last minute of your remarks was very choppy, very static.

Was the committee able to hear those final remarks?

Ms. Rempel Garner.

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): Mr. Chair, I move that the committee now proceed to questioning rounds.

The Chair: We have an agenda, and we have invited the other witnesses to give statements as well. We will continue on with those.

Hon. Michelle Rempel Garner: Point of order, Chair.

There is a motion on the floor that needs to be dispensed with.

The Chair: There is not a motion on the floor. You cannot move a motion on a point of order.

Hon. Michelle Rempel Garner: I didn't move a point of order. You acknowledged me without my saying point of order.

The Chair: In any case, we will carry on with the agenda as—

Hon. Michelle Rempel Garner: I challenge your ruling.

The Chair: The question is, shall the decision of the chair to carry on with the agenda and the witness statements be sustained?

(Ruling of the chair overturned: nays 6; yeas 5)

The Chair: Very well, the committee has made its decision. We will not carry on with the statements from the other witnesses.

We will therefore start our round of questioning. We will begin with the Conservatives.

Ms. Rempel Garner, I expect that would be you.

Hon. Michelle Rempel Garner: That's correct. Thank you, Chair.

My question is for Major-General Dany Fortin.

How many doses of Moderna vaccines will arrive in Canada between today and the end of the month of April?

● (1340)

Major-General Dany Fortin (Vice-President, Vaccine Roll-Out Task Force, Logistics and Operations, Public Health Agency of Canada): Mr. Chair, there will be 650,000.

Hon. Michelle Rempel Garner: How many doses of Pfizer vaccines will arrive in Canada between today and the end of the month of April?

MGen Dany Fortin: Between now and the end of April, there will be two million.

Hon. Michelle Rempel Garner: How many doses of Moderna vaccines will arrive in Canada between May 1 and May 15?

MGen Dany Fortin: Mr. Chair, I do not know at this time.

Hon. Michelle Rempel Garner: How many doses of Pfizer will arrive in Canada between May 1 and May 15?

MGen Dany Fortin: Mr. Chair, from May onwards, we expect approximately two million a week.

Hon. Michelle Rempel Garner: Okay, and that has been confirmed, so there will be four million Pfizer doses between May 1 and May 15.

MGen Dany Fortin: Yes, Mr. Chair, there will be two million a week, every week.

Hon. Michelle Rempel Garner: Thank you.

Mr. Tunis, when do you expect to reach a decision on whether to change NACI's recommendations on the use of the AstraZeneca vaccine in persons under age 55?

Dr. Matthew Tunis (Executive Secretary, National Advisory Committee on Immunization, Public Health Agency of Canada): Mr. Chair, the National Advisory Committee on Immunization, or NACI, has been meeting this week to discuss the evolving situation and the conclusion of Health Canada's assessment. They are working very quickly to try to update any recommendations on that to provide advice to the Government of Canada and to provinces and territories.

We would expect something in the coming weeks from the committee.

Hon. Michelle Rempel Garner: How many weeks will it be on that?

Dr. Matthew Tunis: It will likely be next week. The committee is working right now to deliberate.

Hon. Michelle Rempel Garner: Thank you.

Dr. Tunis, this question is also for you. The United States has paused the distribution of the Johnson & Johnson vaccine. Is NACI preparing similar advice for Canada, or will the rollout proceed under current advice as scheduled, at the beginning of May?

Dr. Matthew Tunis: NACI has not yet issued advice on how the Janssen vaccine should be integrated into public health programs in Canada. It is authorized, of course, in the country, but the committee has been deliberating and has been waiting as more information comes forward. Obviously, we have seen the evolving situation in the U.S.

The committee has been discussing the Janssen vaccine and is expecting to provide advice before doses arrive in the country. They are moving to provide us advice this month. That's the expectation from the committee.

We don't know at this time what the conclusions of their deliberations will be and where they will see to fit Janssen into the public health programs recommended to provinces and territories.

Hon. Michelle Rempel Garner: When will that advice be ready?

Dr. Matthew Tunis: Mr. Chair, they're working on it now. The expectation of the committee is that the advice will be ready before the doses arrive, so before the end of the month.

Hon. Michelle Rempel Garner: Thank you.

Minister Hajdu, has the federal government made a formal request to any other country or aid organization for critical care workers in the event that provinces request surge capacity in coming weeks?

Hon. Patty Hajdu: Mr. Chair, we work really closely with the provinces and territories on their anticipated health human resource requests.

I will turn to Deputy Lucas to talk about those conversations he is having with other deputy ministers across the country.

Hon. Michelle Rempel Garner: Deputy Lucas, the question was as follows: Has the federal government made a formal request to any other country or aid organization for critical care workers in the event that provinces request surge capacity in the coming weeks?

Dr. Stephen Lucas (Deputy Minister, Department of Health): We are in discussion at the officials level with provinces in terms of anticipated needs for both health human resources and medical equipment and other supplies. On the basis of those, we'll address them in terms of federal assets and supports from other provinces—

Hon. Michelle Rempel Garner: Deputy Lucas, have you asked any other country or aid organization for critical care workers?

Dr. Stephen Lucas: No, we have not.

Hon. Michelle Rempel Garner: Deputy Matthews, Reuters reported that deliveries of Moderna COVID-19 vaccines are on track to meet the number of doses it promised the European Union this month, but that there are no disruptions—that is, there are no disruptions for the European Union—and yet Canada has seen its supply of the vaccine disrupted from the manufacturer. Was any form of remedy negotiated into our contract with Moderna if they missed a quarterly delivery target?

Mr. Bill Matthews (Deputy Minister, Department of Public Works and Government Services): The deliveries by quarter from Moderna, Pfizer and all other vaccine companies are targets. We're working with Moderna to make sure they do their best to meet the Q2 target. We are aware that Canada and some other countries are having a dip in the next delivery—

Hon. Michelle Rempel Garner: They're targets. They're not firm delivery requirements in the contract at the end of the quarter.

● (1345)

Mr. Bill Matthews: Mr. Chair, I'm not going to speak about the confidential nature of the contracts.

Hon. Michelle Rempel Garner: Well, you just said they were targets. Is there a difference between target and firm contractual obligations?

Mr. Bill Matthews: I'm sorry, Mr. Chair. I can't elaborate more on that, at this stage.

Hon. Michelle Rempel Garner: Was any form of remedy negotiated into our contract with Moderna?

Mr. Bill Matthews: Again, Mr. Chair, I will not elaborate on the confidential nature of the contracts, at this stage. We are in discussions with our suppliers about taking some transparency measures related to the contracts, and that work is under way.

Hon. Michelle Rempel Garner: Thank you, Chair.

With that, I will put the following motion on notice: that in relation to the committee's study, “Emergency Situation Facing Canadians in Light of the COVID-19 Pandemic”, the committee do summons Patricia Gauthier, Canada country manager for Moderna, to appear and testify by April 30, 2021, for no fewer than two hours.

Thank you, Chair. That concludes my questions.

The Chair: Thank you, Ms. Rempel Garner.

Mr. Kelloway, please go ahead for six minutes.

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

Hello to the ministers and the rest of the witnesses. Thank you for coming today.

Minister Hajdu, as Canadians we're fighting this virus together. I believe COVID-19 is not a political war, but I think we should look to other provinces and territories to learn what has worked and what hasn't worked when it comes to keeping Canadians safe from the virus. Here in the Atlantic, the provinces banded together early on to tackle COVID-19. Our premiers truly took a team Atlantic approach.

In your opinion, why has the Atlantic region been so successful in slowing the virus?

Hon. Patty Hajdu: It really speaks to the different experiences that provinces and territories have had.

I have to say it's been a pleasure to work with all the health ministers from the Atlantic provinces, who have been extremely supportive of the other provinces. Even recently, the ministers and the Premier of Newfoundland were suggesting they would be there for Ontario. You're right that this demonstrates that provinces and territories acknowledge that we really are in this together. No Canadian is safe until all Canadians are safe.

One of the things I've noticed with the Atlantic provinces—really speaking bluntly here—is that those provinces did not wait to take action when there were outbreaks in communities. In fact, the measures they imposed probably felt very stringent, as an Atlantic member, when there were potentially very few cases in these outbreaks—five or 10 cases, in some cases. However, these premiers and health ministers made a decision to act very quickly on very few cases and to do the really hard work of contact tracing and isolation. The population itself understood that even though they were few in number, it was better overall to make a collective sacrifice to keep the region safe.

There's been a real focus on protecting and supporting people who are sick, and on isolating them appropriately so that they can indeed stay home. It seems easy to say to people, “Stay home when you're sick,” but isolation is actually really challenging. You can't leave your house. You cannot leave to get groceries. Oftentimes, if you don't have Internet or digital access, you are cut off from the world. Of course, if you're single or living in poverty, there are other barriers.

When I think about east coasters and the way they band together in general, it's true testimony to working together and collective action to fight a significant threat.

Mr. Mike Kelloway: Thank you, Minister, for that. I appreciate it.

I'm going to switch gears just a bit. Everyone around the world and within our country is eager to get vaccinated. Everyone is eager for this pandemic to end. My heart goes out to many in Canada, particularly those in the hot spots.

We hear stories and a variety of misleading claims that these vaccines can't be trusted or can't be safe because of the speed with which they were developed. What do you have to say about those promoting vaccine hesitancy? Quite frankly—and I know it's a million-dollar question—how do we combat that? We've talked about it in previous health sessions, but I continually see it on social media in different forms. How do we combat that, and what do you say about that?

Hon. Patty Hajdu: Vaccine disinformation is not new. We've seen anti-vax types of information and disinformation sown in communities for other health threats, and this does lead to loss of life and to great suffering. Many of you have met Jill Promoli in your travels as MPs. She's the woman who lost her very young child to influenza, and she has been advocating for years for people to be immunized against the flu. When you hear the stories, you realize this is not specific to COVID-19.

Of course, these vaccines were developed in record time, and it's really a testament to the coordinated will and determination of science and researchers working together on a common goal. It's important that Canadians have access to and are pointed to credible sources. I always say to people who are hesitant or unsure that the best source of information for them is a personal health care provider, if they have one. Then of course there are health care websites that are government run and credentialed as such.

Part of it is our responsibility as leaders to make sure we're pointing the people who trust us in the right direction and that we're not giving messages that are meant to sow division. Rather, we should give people access to accurate information so they can make the best decision for themselves with a foundation of credible information. It isn't about trying to force people to accept vaccinations; it's about making sure they have the right information and credible information.

I'll end with this, MP Kelloway, because it's important. The risk from COVID-19 far outstrips any risk from vaccination. We know this. If you allow it, MP Kelloway and Chair, I'd love for Dr. Sharma to talk a bit about the technical end of what goes on at Health Canada to make sure these vaccines are indeed safe.

● (1350)

Mr. Mike Kelloway: Yes, by all means.

Dr. Stephen Lucas: Perhaps I'll speak. Dr. Sharma is not a witness on the panel this afternoon.

Health Canada has a very rigorous, independent regulatory organization. It has very high standards for safety, quality and efficacy. We published our standards for this in the fall, and they're aligned with those of other leading regulators.

The review process involves teams of scientists from a variety of disciplines. We put in place an interim order to accelerate the reviews, without sacrificing any of the intense scientific analysis required to evaluate the vaccine submissions relative to those standards. This was enabled through a process of rolling review—that is, being able to look at the submission as it was provided—and by having multiple teams of reviewers associated with each submission. That way, they could work around the clock with the information provided, and, in collaboration with other leading regulators, ensure that every aspect of the review was looked at and decisions were taken in a timely fashion.

The Chair: Thank you, Mr. Kelloway.

[*Translation*]

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

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

Not only am I trying to understand, but I am also trying to put myself in the shoes of taxpayers wanting to understand how Canada negotiated its vaccine supply. Yesterday, we found out that, according to Pfizer's CEO, a third vaccine dose would probably be needed six to 12 months after the initial round, followed by a yearly booster. You negotiated with Pfizer for a vaccine that was supposed to be 95% effective against the virus with two doses. Did you get the same type of deal we see in those TV commercials, "buy two and get the third one free"?

How does this new information affect your negotiations, because it certainly changes things?

What are the scientific implications, and what do you plan to do?

Are we going to be at the mercy of pharmaceutical companies suddenly taking advantage of the situation to fill their order books?

How much will all this cost?

Are you going to skip your turn when it comes to getting the third dose of Pfizer?

I would like Ms. Anand and the NACI representative to answer.

● (1355)

Hon. Anita Anand: Thank you for your question.

Personally, I'm still waiting to get my first dose.

Bear in mind that we will follow the advice of Health Canada.

Mr. Luc Thériault: What, then, does Health Canada think?

What instructions do you follow when a game changer like this occurs? After all, this does change the game as far as vaccine procurement goes. Don't you agree?

Hon. Anita Anand: Right now, we are negotiating with suppliers to make sure our contracts offer the flexibility we need to purchase other doses. The negotiation process is not over, however, because we have to wait for Health Canada's advice.

Mr. Luc Thériault: With all due respect, Minister, it seems the need to be flexible applies only to the government, the purchaser. The situation has changed. We started with two doses, and now, a third has just been added; meanwhile, the time frame between the first and second doses is still under review.

How does this change affect the supply of other types of vaccines?

Are you going to prioritize other types of vaccines, instead of pursuing a third dose that is going to cost three times as much?

What do you say to that?

Hon. Anita Anand: May I answer now?

Mr. Luc Thériault: Yes, but you can also answer in English, because you seem to have trouble articulating your thoughts clearly in French.

Actually, it's fine if the interpretation is good. The reason I suggested it is that your answers are somewhat perfunctory, Minister.

Hon. Anita Anand: Thank you, but I will answer in French.

Let's be clear. The scientific research is ongoing, and the testing phase is only in its infancy, but we are not sitting idly by. The first COVID-19 vaccines were approved just three months ago.

Mr. Luc Thériault: You have nothing to say on the subject, then. That's fine.

Now I will turn to the health minister. The harder it is to vaccinate people, the more people who will die. The longer the pandemic goes on, the more hospitals have to triage patients. The more they triage, the more the condition of non-COVID-19 patients worsens. Representatives of the Canadian Association of Radiologists told the committee that non-COVID-19 patients could end up dying because of delays in getting their conditions diagnosed and treated before it's too late.

What do you plan to do about that?

[*English*]

Hon. Patty Hajdu: We've been quite clear that we'll be there for provinces and territories now and into the future to, first of all, get through this pandemic together. Regardless of what it takes and regardless of what it costs, the federal government will be there for Quebec and Quebeckers. We continue to be there financially, with equipment, with vaccines and indeed with people.

After we manage to get the country in a more stable health situation, the Prime Minister has been clear that he will be more than happy to have a conversation about what enhanced health transfers could look like at that point.

[*Translation*]

Mr. Luc Thériault: Excuse me. I realize that's what your plan is, but I have a solution for you, Minister.

You could transfer the $28 billion to the Quebec and provincial governments now so they can start addressing the triage problem and know how much breathing room they have as this third wave gets under way. You could do that, instead of thinking that the problem will get fixed later, as though it were already possible to anticipate post-pandemic requirements. We haven't even gotten through the pandemic yet.

We will have gotten through it once we've dealt with all the patients who have suffered the consequences of triaging, patients who will have paid the price during the pandemic. The destruction caused by the pandemic will include all those patients who get left behind, Minister. Why won't you give Quebec and the provinces the breathing room they need to care for patients now?

● (1400)

[*English*]

Hon. Patty Hajdu: Thank you, MP Thériault.

This year alone, Quebec has received the direct transfer of $13 billion: $9.7 billion in health transfer dollars and $3.07 billion in the safe restart agreement.

We also deployed the Canadian Red Cross. We have paid for and delivered 4.7 million rapid tests, over 2.8 million vaccines and 76 federal contact tracers. The Prime Minister has been clear, MP Thériault—

[*Translation*]

Mr. Luc Thériault: That's not what I am talking about, Minister.

Despite the ad hoc investments the government is currently making, the provinces, territories and Quebec need predictable funding so they can provide care to people and fix their health systems. That means you need to act now and grant those transfers. You know as well as I do, the provinces and Quebec need $28 billion more than what the government has provided thus far on an ad hoc basis.

The Chair: Thank you, Mr. Thériault.

[*English*]

We will go now to Mr. Davies.

Mr. Davies, go ahead, for six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you to the ministers for being here.

Minister Hajdu, as Minister of Health, are you the minister responsible for the Public Health Agency of Canada?

Hon. Patty Hajdu: Yes, I am.

Mr. Don Davies: PHAC's website says that PHAC is Canada's lead agency responsible for public health, emergency preparedness and response, and infectious disease, control and prevention.

Is that your understanding of one of PHAC's mandates?

Hon. Patty Hajdu: Yes. We obviously work with partners across governments, but yes.

Mr. Don Davies: You are familiar with the concept of ministerial accountability, are you?

Hon. Patty Hajdu: I would hope so, after five years.

Mr. Don Davies: On March 25, the Auditor General tabled what I think can only be described as a scathing and comprehensive indictment of PHAC's preparedness for the COVID pandemic.

The report found that PHAC failed to test or update its readiness plans prior to the COVID-19 pandemic, in direct violation of the agency's internal standards and recommendations stemming from the H1N1 pandemic.

Minister, do you accept responsibility for that failure?

Hon. Patty Hajdu: I accept responsibility for receiving the Auditor General's report, and I have been clear that we accept all the recommendations in the report.

Mr. Don Davies: The Auditor General's report also found that PHAC failed to resolve shortcomings in Canada's health surveillance information and data systems first identified by the Auditor General in 1999, 2002 and 2008.

Minister, do you take responsibility for that failure?

Hon. Patty Hajdu: I have been clear since the beginning of the pandemic, and as a public health professional in my prior employment, that it is very important that we invest not only in health care, but also in protection and promotion of health, which is public health. I continue to say that we need to make those investments. In fact, that's why the fall economic statement commits hundreds of millions of dollars to bolstering the capacity of the Public Health Agency of Canada.

Mr. Don Davies: The Auditor General's report found that PHAC failed to "assess the pandemic risk" posed by COVID-19 or the "potential impact were it to be introduced into Canada". As a result, the Auditor General found that the agency "underestimated" the potential danger of COVID-19 and continued to assess the risk as low until after the World Health Organization had declared a global pandemic. By then, Canada had already recorded over 400 confirmed cases, and community spread was under way.

Minister, do you take responsibility for that failure?

Hon. Patty Hajdu: Every step of the way, as you know, MP Davies, we have been guided by public health advice, science and research. We have responded to the pandemic with strengthened measures every step of the way.

I have been clear: We accept all recommendations of the Auditor General. No Canadian would argue with the need to invest in public health, and certainly that is the commitment of our government. We will ensure that the Public Health Agency of Canada has the funds and the resources it needs to continue to strengthen its response.

Mr. Don Davies: The report also notes that GPHIN, which was established in 1997 specifically to provide early warning of a threat such as the one posed by SARS-CoV-2, was not properly used when an outbreak of viral pneumonia in China was detected in late 2019 and early 2020. The report also documents that PHAC rescinded analysts' authority to issue alerts in 2018.

Minister, do you take responsibility for that failure?

● (1405)

Hon. Patty Hajdu: As the member opposite knows, I was not the minister of health in 2018, so it was a surprise to me as well when I heard the report in The Globe and Mail, which is why I ordered the independent investigation. Of course, we have an interim report from the independent investigators, who have concluded that although the alert was not issued, it in fact did not stop the beginning of our response and that our response started very quickly, as Dr. Tam had internal information and convened a committee of public health officers across the country on January 2.

Mr. Don Davies: The Auditor General's report found that PHAC failed to verify compliance with quarantine orders for two-thirds of incoming travellers and did not consistently refer travellers for follow-up who risked not complying. That happened under your watch, Minister.

Do you take responsibility for that failure?

Hon. Patty Hajdu: Certainly we've learned a lot through the process of working with our provincial and indeed local partners to strengthen enforcement when people are required to quarantine as per the Quarantine Act. I will say that we want to thank all those partners for their ongoing and strengthened response. This is a team Canada approach, and we need to work together at all levels to ensure that we're protecting the health of Canadians.

Mr. Don Davies: Minister, if you aren't responsible for PHAC's comprehensive failure to prepare for or effectively respond to the COVID-19 pandemic, who is?

Hon. Patty Hajdu: MP Davies, I'd like to take a moment to thank Dr. Tam, who has been working seven days a week around the clock, and, in fact, the thousands of PHAC employees, who have also been working around the clock seven days week doing their absolute best to respond to a global pandemic that is unprecedented. In fact, Canada's experience has been better than in some countries and worse than in others, but I will tell you that we should be extremely proud and grateful for the hard-working Canadians who have put their lives on the line and on pause to protect each other.

The Chair: Thank you, Mr. Davies.

That brings round one of questions to a close. We'll now start round two.

My understanding is that the opposition parties have made some arrangements to switch around their time, so we will start round two with the NDP with five minutes, please.

Mr. Don Davies: My questions are for Minister Anand.

Minister Anand, when you appeared before the committee on February 5, I asked if you would disclose the confidentiality clauses contained in Canada's vaccine contracts. In response, you said:

> That's a very good question, and I will take that back to determine whether that would be possible within the confines of the legal parameters of the agreements.

On February 17, I followed up by sending you a letter requesting a timely response to that commitment. I have received no response to date. Given that you've had over two months to consider my request, will you or will you not table the confidentiality clauses of the vaccine contracts to this committee?

Hon. Anita Anand: The confidentiality clauses are themselves contained in the contracts. The entire contract is subject to a confidentiality clause. Therefore, I am unable to table the confidentiality clauses alone. However—

Mr. Don Davies: Thank you.

Hon. Anita Anand: May I just continue?

I believe that our conversation the last time was about not only confidentiality clauses, but the contracts as a whole.

Mr. Don Davies: Actually, with respect, Minister, I have limited time, and it was a pretty specific question. Thank you for answering; I appreciate it.

This week, B.C. health minister Adrian Dix said, “The real issue with vaccines is the amount of vaccine we have. If we could get a million more doses, we have the system in place, we have the capacity in place to deliver that...quickly.” He also said, “Despite the unpredictability of deliveries, we are administering the Moderna vaccine as efficiently as supplies allow.”

Saskatchewan premier Scott Moe says that erratic deliveries are challenging his province's vaccination program. The City of Ottawa announced that it's looking to fill a gap in its COVID-19 vaccine supply. The City of Toronto announced that a vaccine shortage is to blame for the fact that local clinics in COVID-19 hot spots in the city have had to close. Also, Dr. Isaac Bogoch, who sits on Ontario's vaccine distribution task force, said, “It's obvious we don't have enough supply.”

Minister, do we have enough vaccine supplies in this country right now?

● (1410)

Hon. Anita Anand: In a very competitive global environment in which all countries are seeking access to the precise, same product, Canada has been able to procure vaccines despite the fact that we do not have, at this time, domestic production. In fact, we're the second in the G20 for the rate of vaccinations, in terms of daily doses administered on a seven-day rolling average. We are fourth in the G20 for total doses administered per 100 people.

We have much work to do and we have more doses to bring into this country, but we announced today, in fact, that we're doubling the number of Pfizer doses coming into the country in May and June. We're working, then, as hard as we can to bring more and more doses into the country. This is, indeed, information that we make public to Canadians through the Public Health Agency of Canada as soon as we get it.

We're all in this together. We're going to work with the provinces and territories so that all Canadians have access to a vaccine.

Mr. Don Davies: Well, the numbers I have, and I just checked them about an hour ago, are that as of April 16, Canada is 41st in the world for doses per 100 people and 63rd in the world for people fully vaccinated.

Are you content with those numbers, Minister Anand?

Hon. Anita Anand: We clearly are looking at different numbers, but I'll tell you that my focus every day is getting more and more vaccines into this country. As I said, we stand fourth in the G20 for the total doses administered per 100 people, despite the fact that we don't have domestic production at the current time.

There is more work to be done. We need to bring vaccines into this country as soon as possible, and deputy minister Bill Matthews and I and our team work on this very issue every day. As you can see from this morning's announcement, cumulatively we're going to see between 48 million and 50 million doses coming into the country before the end of June, and that is work we're going to continue to do for Canadians.

Mr. Don Davies: Minister, the source of that is Our World in Data, which is what is being quoted by pretty much every reputable news organization in the western world. That is where those numbers came from.

Major-General Fortin, at your appearance before this committee on March 12 I asked you whether you were confident that all provinces and territories were prepared to rapidly administer vaccine doses as deliveries arrive in Canada. You said, “Provinces and territories have assured us that they have good plans in place and they have the health workforce required to scale up, so...they have no issues with throughput.”

Right now, there's obviously a problem with vaccines in this country. Is that because the provinces aren't ready, or because there's a lack of supply?

MGen Dany Fortin: Mr. Chair, I stand by my previous comment. Provinces have been indicating that they have the resources, that they have the capacity, that they have on-tap capacity to increase the throughput. It's not equal across the board. It's not necessarily a mobile workforce that can get to all places in the country.

They have repeatedly asked for more line of sight on vaccine doses as they become available. We endeavour to share with them as much as possible on quantities as we have that information

Mr. Don Davies: Thank you, Major General.

The Chair: Thank you, Mr. Davies.

We go now to Dr. Powlowski for five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I have to say that I'm a little confused about the order here.

I wanted talk about the risks associated with AstraZeneca and now Johnson & Johnson. I think a lot of Canadians are anxious about these vaccines and whether they're safe, so I want to address that problem.

Specifically, the concern is with blood clotting, but specifically one kind of blood clotting, called VIPID. That is vaccine-induced prothrombotic immune thrombocytopenia, which is associated with cerebral venous sinus thrombosis. It appears mostly in women under 55. The risk of this in the United Kingdom, where they've given a lot of doses of AstraZeneca, has been estimated at between 1 in 100,000 and 100 in 250,000.

I'm a long-time doctor, and medicine is all about balancing risks and benefits. With that in mind, I want to talk a little about risks and benefits and get a response from the doctors on the panel, for example, Dr. Tam and the person from NACI.

My understanding of the British data is that, up until the end of March, they gave over 20 million doses of AstraZeneca, and there were 79 cases of VIPID with 19 deaths. This is probably causal, because this is a very rare combination, but, as a result of giving those vaccines, it's estimated that the British saved around 6,000 lives. There's always a risk in medicine with almost anything.

If you think about an appendectomy, this is a relatively simple operation, and I've done them myself. If it's your kid, you say, “Okay, you have to have your appendix out”. Well, the mortality is 1 in 100, approximately, from my readings. If they take your gall bladder out, the risk is about 1 in 200. We do CAT scans all the time. As a doctor, you have to explain to people the risks and benefits. If your kid is getting a CAT scan, you tell them, “Well, we're not sure of the risk, but it might be something in the order of 1 in 2,000 who will get cancer from a CAT scan”.

With drugs and antibiotics, I've seen people almost die from reactions to antibiotics. As for vaccines themselves, the measles vaccine has a risk of 1 in 700,000 of getting something called SSPE, subacute sclerosing panencephalitis, which is universally fatal. We give the measles vaccine to our kids all the time. My little baby, whom you may have seen occasionally with me on the panel, is going to be getting it in a couple of months. There is always a risk and benefit. No one is forcing people to have AstraZeneca or Johnson & Johnson. I have to say, the risk with Johnson & Johnson seems to be 1 in a million.

Before the practitioner, nurse or doctor gives you the vaccine, AstraZeneca, they're going to explain the risks and benefits. I would submit there's a very, very small risk from the vaccine. In fact, I calculated that you're seven times as likely to die in a car accident the year after you've been vaccinated with AstraZeneca as you are to die from a blood clot, so the risk is very low. The benefits in terms of protecting yourself from the virus are significant.

I want to ask Dr. Tam or the representative from NACI about the risks and benefits. Obviously, I've outlined my view of it.

Thank you.

● (1415)

Dr. Theresa Tam (Chief Public Health Officer, Public Health Agency of Canada): Mr. Chair, thank you for asking me to be here today. I'll take the question first.

I would say that Canadians should be very comforted in knowing that we have a very rigorous system in Canada for ensuring that the vaccines that they will get in their arms are safe as well as effective. Health Canada, as the regulator, does very rigorous assessments of vaccine safety, and they've been linking with European and other international regulators to get the information we need.

We acted fast when we saw that there was a signal from Europe. With that, the National Advisory Committee on Immunization also took an initial assessment and a precautionary approach in putting a pause on the use of the AstraZeneca vaccine in persons under the age of 55.

Right now, Health Canada, having asked the company, AstraZeneca, for more information, has done its assessment and analysis and concluded that the benefit outweighs any risk of this rare but serious adverse event overall. The National Advisory Committee on Immunization is doing its due diligence in analyzing this information right now. What the committee has to do is not just analyze the risk of this rare side effect but also the balance in terms of the benefits of prevention of COVID-19 in different age groups. The committee is doing this work very diligently right now and will come out with a new reassessment soon, as Dr. Tunis indicated.

Again, Canadians should be very heartened by the fact that our vaccine safety system and how we assess vaccine safety is extremely rigorous.

The Chair: Thank you, Dr. Powlowski and Dr. Tam.

We need to go now to our next question slot, which is, I understand, Mr. Thériault.

[*Translation*]

Mr. Thériault, we now go to you. You have five minutes.

● (1420)

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

In order to maintain the public's confidence and support when it comes to the Public Health Agency's guidelines and messages, the agency has to act in a consistent manner and, as Dr. Tam said, apply the precautionary principle.

The last time we met, three countries had decided to suspend use of the AstraZeneca vaccine. Back then, the agency and Health Canada were saying that it was just three countries, that the cases were not that serious, and that Canada would keep using the vaccine.

I've lost count of all the attempts made to save the AstraZeneca vaccine and keep the same messaging out there. Nevertheless, had we suspended use of the vaccine and waited for the European Medicines Agency to come out with its decision, it would have saved a lot of wasted breath and defensive communications. Not to mention, it would have fostered greater public confidence.

It would have been clear that the authorities were being proactive and applying the precautionary principle. We were not proactive and we did not apply the precautionary principle, undermining the very principle we wanted to uphold. Instead, we went against it. Public fears about receiving the vaccine have emerged. Conversely, when the vaccine was offered to people 55 and older in Quebec, without an appointment, we did see an appetite for it. However, it was thanks to the fact that they did not need an appointment.

Since then, the appetite for the vaccine has dropped significantly. Vaccination clinics are nowhere near full, even when people don't have to have an appointment. It pays to take a cautious approach so as not to produce the opposite effect. A mistake was made, and recognizing that is important.

Dr. Tam, can you explain how the variants work to help us understand what's going on right now? How are we seeing so much variant spread when we are taking so many precautions and when the government claims to be strictly enforcing measures and controls? Do you have any data that would tell us more about the main hot spots?

[*English*]

Dr. Theresa Tam: Canada actually has been at quite a high level compared to other countries in terms of doing our genomic sequencing and surveillance for variants. We are sequencing a lot more virus than any other country, and we have been able to detect the variants across Canada. All provinces and territories are able to detect for themselves or access support from the National Microbiology Laboratory to do this. We have actually quite good visibility as to where the variants are in this country.

Why we are concerned and why we call them “variants of concern” is because they spread more readily. You have to be much more careful with your measures. We know that public health measures work, and we've seen it in the United Kingdom, Ireland and other countries that have had these variants of concern. We know what to do across Canada. The important thing is that, from the local level up, things have to be applied rapidly—as quickly as possible—to control the spread. The method is not different; we just have to be more stringent.

[*Translation*]

Mr. Luc Thériault: Sorry to cut you off, Dr. Tam, but with the borders closed, entry control measures and testing in place, and all the rest, could you please explain why the variants detected in Canada are so virulent?

Do you have any data that helps you to understand what is happening in the main hot spots? What are the causes?

[*English*]

Dr. Theresa Tam: There are different variants in different areas of the country, but the B.1.1.7 variant is present in all provinces. I think there's only one jurisdiction that doesn't have that variant. We have a good understanding that the B.1.1.7 variant is becoming the predominant one, and it is more easily transmitted.

Again, more application of the same tried-and-true public health measures can get those rates down. You're seeing Quebec, Ontario and other places applying some of these measures right now, and that has to be done very quickly. We understand—and we have data from jurisdictions such as Ontario—that some of these variants seem to be causing more severe outcomes. You're seeing that in hospitalizations and ICU visits. The data is there to track and look at the impacts.

To me, the really important thing that you need to do is have what I would call “a final go” at suppressing the epidemic, so that the vaccines can have time to work.

● (1425)

The Chair: Thank you, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: I gather, then, that you have not ascertained the main causes of the virulence and spread of the virus in the main hot spots.

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Ms. Sidhu.

Ms. Sidhu, please go ahead for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you to all the witnesses for being here with us today.

Minister, you and your officials have been working non-stop for well over a year to protect the health and safety of all Canadians.

My first question is to Minister Anand. Can you tell the committee about the update we just received from Pfizer? How will this impact the government's vaccine procurement and distribution plans to provinces and territories?

Hon. Anita Anand: I'd be pleased to share the good news from Pfizer today. We have negotiated the exercise of an additional eight million options with Pfizer, so that means that not only are we purchasing these options, but they're going to be delivered in the very short term.

We expect to have two million doses of Pfizer delivered in May, and 12 million over five weeks in June. In addition to the other vaccines in our portfolio, this means we are going to, cumulatively, have between 48 million and 50 million vaccines in this country prior to the end of June.

I want to reiterate that when we put our contracts into place last summer—and indeed our portfolio is a diversified one, with multiple contracts and multiple suppliers—we wanted to make sure we had access to multiple sources of vaccine supply. We are pulling vaccine now not only from Pfizer but also from Moderna, AstraZeneca and J&J. That is very important.

I would like to clarify a point about our rankings. I was speaking about the G20, whereas my honourable colleague was speaking about all countries in the world. We are indeed second in the G20 for the rate of vaccinations, and fourth in the G20 for the total doses administered per 100 people. Why? It's because of our diversified portfolio, and because we're pulling in vaccine from multiple sources.

We will continue to do that, and distribute those vaccines to the provinces and territories as soon as we receive them. Indeed, Pfizer's go directly to the provinces and territories as it currently stands. We want to make sure we are with Canadians and supporting Canadians right through to the end of this pandemic with our vaccines.

Ms. Sonia Sidhu: My next question is for Minister Hajdu.

Peel now has more than 5,000 active cases. We keep hearing local concern that Peel region is not getting a sufficient supply from the provincial distribution stage for the number of cases.

Yesterday, the mayor of Brampton had a discussion with the Prime Minister, sharing these concerns. Today, the Prime Minister said that the government is ready 24-7 to help Ontario, if such help is requested.

Minister Hajdu, the Peel chief medical officer has a similar concern. Who can he call about the supply to Peel? How does this system work? Is there sufficient supply from the provincial distribution stage? What steps is our government taking to assist hot spots like my home community in Brampton?

● (1430)

Hon. Patty Hajdu: First of all, my heart goes out to everyone working in the Peel and Brampton area and everyone living in the area, because you're right that your region of the province has been very hard hit for, I would argue, a very long time. The appropriate supports have not been in place to help people isolate and stay safe. Our federal government, as you know, has been trying very hard to make sure people have access to, for example, financial supports if they're sick, as well as other kinds of health supports through Red Cross support. I work very closely, as you know, with Dr. Loh, and we've provided isolation housing, for example, in your community.

More needs to be done.

You asked me first about how we could tell who's getting which vaccines, and we can't really. This is the job of the Ontario government to provide that transparency about how they are further distributing vaccines in the province. You heard my colleague speak about Pfizer deliveries going directly to provinces and territories. That's really the only data we have. Data from other vaccines and how they're distributed across the province is owned by the province, and they have not as of yet been transparent with that data, although I believe Dr. Adalsteinn Brown just recently gave some modelling and some updated data on vaccine distribution.

The best approach in terms of trying to understand Peel's allocation of vaccinations from the Province of Ontario is directly with the province itself. Mayor Brown would know that, but of course Dr. Loh would know that as well.

You're absolutely right. We stand by, ready to help the Province of Ontario and indeed local public health units with anything they need. If it would be helpful, I'm happy to speak with Dr. Loh again, or the public health units, just to make sure we haven't missed anything. As I said, we have been providing rapid response supports, including Red Cross workers, isolation housing, contact tracers, epidemiological support to break out where those clusters of outbreaks are happening, and of course the financial supports. It's very important they have someone like you also, MP Sidhu, to advocate for them.

Thank you so much for being a constant voice for your community members. In every meeting I'm at, you are speaking out for the health and safety of the people you care for.

The Chair: Thank you, Ms. Sidhu.

We go now to Ms. Rempel Garner. Please go ahead for five minutes.

Hon. Michelle Rempel Garner: Thank you.

Major Fortin, how many doses of vaccine is Ontario projected to receive between now and the end of May?

MGen Dany Fortin: We are still crunching numbers with the new announcement by Pfizer. With that increase we'll have to come back to Ontario and issue those numbers, and across Canadian provinces.

Hon. Michelle Rempel Garner: Going back to you, Major-General, Ontario just released information saying it would need to vaccinate approximately two million people per week in order to have a hope of bending the curve by the end of May. Is that something that is possible, given current projected supplies to Ontario?

Hon. Patty Hajdu: Maybe I can take this question—

Hon. Michelle Rempel Garner: It was for Major-General Fortin. Thank you.

MGen Dany Fortin: Again, Mr. Chair, I'll have to do the number crunching with colleagues here before I can answer this question in detail, but the projections are that those numbers will increase for all provinces, including Ontario.

Hon. Michelle Rempel Garner: Would you be able to provide that data to committee, perhaps by the end of next week, with regard to projected doses for Ontario by the end of May?

MGen Dany Fortin: We'll take that on notice, Mr. Chair.

Hon. Michelle Rempel Garner: Thank you.

This next question is for Mr. Stewart.

Has the government asked you to provide any advice to update allocations to provinces or any other group based on hot spots, or is it still per capita?

● (1435)

Mr. Iain Stewart (President, Public Health Agency of Canada): Our current approach, as mentioned, is per capita.

Hon. Michelle Rempel Garner: Has the government asked you to look at revising that approach at all?

Mr. Iain Stewart: I have my team continually working on different ways to respond to the pandemic, and different strategies.

Hon. Michelle Rempel Garner: Are you—

Mr. Iain Stewart: It's just the phrasing of your question. I'm not sure what you mean, but we work on this—

Hon. Michelle Rempel Garner: Are you actively looking right now at potentially updating advice on allocations of vaccines from per capita to any other criteria?

Mr. Iain Stewart: It would be very normal for us to do scenario planning like you're saying, yes.

Hon. Michelle Rempel Garner: When would that become public?

Mr. Iain Stewart: This is internal work. That would be for ministers, if this was of interest to them.

Hon. Michelle Rempel Garner: Can you table any documentation that you have on that with committee by the end of next week?

Mr. Iain Stewart: I'll look into what's appropriate to provide and the extent that it's advice that's available to be shared.

Hon. Michelle Rempel Garner: Thank you.

According to CTV reports, Mr. Stewart, Toronto hospitals are reporting that as many as 20% of ICU COVID patients are pregnant women. The Society of Obstetricians and Gynaecologists of Canada is asking government to prioritize women more than 20 weeks pregnant immediately, because of heightened risks to them from COVID. Are you preparing any advice for the government to advocate for prioritizing pregnant women for vaccination?

Mr. Iain Stewart: My colleagues from Health Canada would be better placed, Mr. Chair, to respond to the question. Before any of the vaccines can be used by Dany and our team with the provinces in this way, they would have to be approved for use for that indication.

Hon. Michelle Rempel Garner: Thank you. I'll move to my next question.

This would also be for Mr. Stewart.

The same data that I referenced earlier from Ontario, which was just released, actually, while we were in this meeting, showed that the R0 on the variants is considerably higher than for the original strain; data is showing that our vaccination rate is failing to keep up with variant spread. According to your department's projections, how many Canadians would have to be vaccinated every week to get ahead of the reproductive rate of variants by the end of May?

Mr. Iain Stewart: That's a complex question. I look forward to reading the report. We'll assess it and we'll try to make sense of what they're saying.

Hon. Michelle Rempel Garner: You don't have any information on that or projections right now?

Mr. Iain Stewart: I believe you just said it has just been released. I have not read it, no.

Hon. Michelle Rempel Garner: Does the federal government have any advice on comparing the R0 factors with variants against what the vaccination rate would be in order to “bend the curve”?

Mr. Iain Stewart: Mr. Chair, the measures that are used to bend the curve are usually public health measures. With vaccination, they're not normally applied in that way.

Hon. Michelle Rempel Garner: Why?

Mr. Iain Stewart: I'd have to read the report to see why you're phrasing it this way.

Hon. Michelle Rempel Garner: What do you mean when you say vaccinations aren't used to bend the curve?

Hon. Patty Hajdu: Maybe we can turn to Dr. Tam to speak about—

Hon. Michelle Rempel Garner: No. I direct the questions, Minister.

Hon. Patty Hajdu: Actually, the most appropriate person is Dr. Tam.

Hon. Michelle Rempel Garner: No.

Mr. Stewart, you just said in regard to R0, that you're not using vaccination rates in terms of.... Of course vaccinations bend the curve. Why would you say something like that?

Mr. Iain Stewart: What I said was that public health measures are what we're using to address the spread of COVID to date. You're referring to a report I haven't read yet. It places me in a difficult place to try to respond to your question.

Hon. Michelle Rempel Garner: No, no. Let's talk about this for a second.

Is Health Canada not using vaccination rates in terms of projecting bending the curve?

The Chair: Thank you, Ms. Rempel Garner.

Hon. Michelle Rempel Garner: I have a point of order, Chair. I believe you skipped my round in the last round.

The Chair: No, I didn't. You traded off your first round to the NDP and your second round to the Bloc Québécois.

Hon. Michelle Rempel Garner: No, I did not. The NDP gave their spot to the Bloc Québécois, so there was another CPC round. I was just assuming you were giving me my spot in the second round.

The Chair: I did. This is your second round. It was five minutes. Your time is up, but we'll start the third round of questions with you, Ms. Rempel Garner, for another five minutes, please.

Hon. Michelle Rempel Garner: Thank you, Chair. I appreciate that.

I'd like to go back to Mr. Stewart.

Mr. Stewart, I need to understand this. How are vaccination rates being calculated by Health Canada in terms of using that information to “bend the curve”? I'm just curious. Why did you say we're using public health measures? Are vaccinations not part of that? Are you referring to lockdowns?

Mr. Iain Stewart: Public health measures are protections, like you're saying, such as restricting mobility and so on. That has been what we've been using in this country to, as you say, “bend the curve”. That's what I was trying to say. That's been the approach we've been taking.

● (1440)

Hon. Michelle Rempel Garner: Why aren't we using vaccination rates?

Mr. Iain Stewart: We are vaccinating people, and as has been talked about in this committee, it's a major endeavour and initiative.

My colleague, Dr. Theresa Tam, is probably a better person to ask this particular question, Mr. Chair.

Hon. Michelle Rempel Garner: No, no, no. I'm sticking with you. Thank you, Mr. Stewart.

Earlier, I think it was last week, the Prime Minister said something to the effect that vaccinations on their own are not enough to keep us safe. Then Dr. Tam said that vaccines aren't a panacea. Are you concerned at all, Mr. Stewart, that what you just said might actually cause questions in the Canadian public about vaccines? Can you just put on the record right now that vaccinations will bend the curve in Canada?

Mr. Iain Stewart: I think the question is better answered by my colleague, Dr. Tam.

Hon. Michelle Rempel Garner: But you're the head of Health Canada.

In all seriousness, can you tell Canadians that once we've rolled out vaccines, it will help bend the curve?

Mr. Iain Stewart: We find that as each person gets vaccinated, the number of people in the community who are at risk of infection.... The community becomes better protected as more people are vaccinated. Therefore, we expect the incidence of COVID will go down.

Hon. Michelle Rempel Garner: When do you think you would advise for the public health measures you mentioned, like lockdown, to be lifted? What work are you doing on that? How do vaccinations play into that?

Mr. Iain Stewart: The chief public health officer of the Government of Canada gives us the advice on these kinds of issues. She's here with us today.

It might be more appropriate to direct these questions to her, Mr. Chair.

Hon. Michelle Rempel Garner: I'll ask very quickly. Dr. Tam, do you stand by your statement that vaccines aren't a panacea?

Dr. Theresa Tam: Vaccines are a major contributor to how we're going to get out of this pandemic, but they are not the only thing that will do that.

Right now, to get things under control fast, public health measures must come into play. It's both.

Then, until many people in Canada are vaccinated, vaccines are unlikely to help rapidly for people, but they are an incredible tool.

Hon. Michelle Rempel Garner: How many people need to be vaccinated in Canada by the end of May for us to “bend the curve” with the spread of variants?

Dr. Theresa Tam: You just defined numerous parameters that are at play.

The variants increase your Rt, which means more people will have to be vaccinated, depending on how that evolves. As I say, it's the stringency of the public health measures that's going to help bend this curve while the vaccines are taking hold. We do not know precisely how much vaccines reduce transmission.

Hon. Michelle Rempel Garner: Are you concerned that without having some certainty or information about this in public, that Canadians might not be getting the message on this?

I want people to take vaccines, but statements like “vaccines aren't a panacea”.... As the chief public health officer, when you say that, do you have concerns that it might cause concern among Canadians, or that they might ask, why bother?

Dr. Theresa Tam: Many Canadians want to get vaccinated; you see them queuing up. The uptake's been very high in the priority groups.

Vaccines prevent you from dying and getting into the ICU, which is really important.

Hon. Michelle Rempel Garner: Thank you.

With the time remaining, I have just one question for the deputy minister of procurement.

Are any of the Pfizer doses that were announced today manufactured in the U.S., or are they all manufactured in the EU?

Mr. Bill Matthews: The supply arrangements we have in place, Mr. Chair, allow for Canada to draw from multiple sources. I'm not able to disclose at this time where the actual doses are coming from.

Hon. Michelle Rempel Garner: Why not?

Mr. Bill Matthews: We need to maintain the security of our supply.

The Chair: Thank you, Ms. Rempel Garner.

We go now to Mr. Van Bynen for five minutes.

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

Two things I've heard have really stood out for me: This is an unprecedented pandemic, and the results as we go forward are unpredictable.

I see no value in having our armchair critics who have no medical credentials second-guess what has been done and can't be changed. The real value for Canadians is to provide constructive suggestions for the consideration of people who are professionals.

Mayor John Tory said that you can't make vaccines out of thin air. That is very true.

I'm disappointed that we didn't permit Minister Anand to finish her introductory comments. I'm asking Minister Anand to do so with the balance of my time.

● (1445)

Hon. Anita Anand: I will start off at the end of my remarks. Thank you to the honourable member for asking me to continue.

We began with our procurements in vaccines by building a diversified portfolio of vaccine candidates as soon as they began to show promise, signing agreements in principle with potential suppliers as early as July 2020.

[*Translation*]

Our objective was to place Canada in a solid position to take delivery of doses as soon as vaccines were deemed safe and effective—and that is precisely what we have done.

We gained access to more than 400 million doses of potential vaccines from eight different manufacturers, resulting in one of the most diverse portfolios in the world.

[*English*]

This diverse portfolio is giving Canadians security in what has been and continues to be an extremely volatile marketplace for vaccines. It is thanks to this diverse portfolio that we are now seeing inoculations happening at record numbers across this country, and that we have been able to bring into Canada record numbers of vaccines. Yes, we of course continue to understand that more supply is needed. That is why our team and Deputy Matthews's team are continuing to work around the clock.

The deal with Pfizer that we announced today is just one example of the type of work we are doing. We have accelerated more than 22 million doses already to earlier quarters. This deal with Pfizer today indicates that even more doses are being accelerated to next month. We are doubling the number of Pfizer doses coming into the country next month and in June.

We will continue this work. We will continue to pull vaccines from multiple sources around the world, including from Europe—from Belgium, Spain and Switzerland—from South Korea, from India and from the United States. It is this diversified portfolio of vaccines that we will continue to lean on as we bring vaccines into this country.

In addition, I would like to thank all colleagues around the table for their concern and work on ensuring that our country sees itself through this pandemic together. What we need, now more than ever, is to collaborate together with provinces and with territories, and indeed as parliamentarians.

Mr. Tony Van Bynen: Thank you.

How much time do I have, Mr. Chair?

The Chair: You have about 30 seconds.

Mr. Tony Van Bynen: Minister Hajdu, Health Canada, PHAC and NACI have done a great job in providing regular updates to Canadians, but I think many people still don't have a clear picture of who is responsible for each aspect of the vaccines. When we hear from the officials of Health Canada, PHAC or NACI, our opposition colleagues make an assumption that they're not aligned. I'm wondering if you could inform our colleagues here today on how these various independent experts are working to keep Canada safe.

Hon. Patty Hajdu: I don't think I have much time, given the clock, but I will just say that they are indeed working very closely together. Dr. Tam works very closely with NACI. NACI works very closely with Health Canada.

This advice evolves, as you know, based on the science and research that accumulates on these vaccines. I want to thank everyone for doing that hard work. It certainly is giving a road map for Canadians and for provinces and territories, enabling them to take that advice and then provide those vaccines across the country.

I would just like to say that I have a profound and deep respect for the scientists and researchers and doctors who are leading the way. I would really encourage all members of Parliament to work together now. This is the time, if never before, for a team Canada approach, to support the hard work of our researchers and our doctors and to stop the fearmongering that is indeed harmful to Canadians' safety.

● (1450)

The Chair: Thank you, Mr. Van Bynen.

Mr. Maguire, please go ahead for five minutes.

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

I just want to get some clarification here on some questions I've been waiting to ask in regard to the communications around the government and some of the things they've said about AstraZeneca and some of the vaccine issues. I am wondering if they can clarify the confusion they've put out in people's minds in regard to the mixed messages they've had regarding the usage of AstraZeneca—first of all, not being able to use it for people over 65 and then not being able to use it under 55.

Could you clarify that, Minister?

Hon. Patty Hajdu: Actually, it's a fairly simple concept. As science changes and as research evolves, in fact advice evolves. This is the nature of the scientific approach, that we respond to the new information, commit to transparency to Canadians and evolve our advice based on the research and science that we understand.

As you know, NACI is an independent advisory board—

Mr. Larry Maguire: Madam Minister, I know, but—

Hon. Patty Hajdu: —that can actually provide advice to provinces and territories.

By the way, provinces and territories are free to take that advice or not. In fact, all provinces have accepted the advice of NACI in many different ways. I am glad to see provinces and territories working so closely with the regulatory bodies—

Mr. Larry Maguire: Madam Minister, given my time, I'm just going to interrupt you.

Today in the National Post there is an article that states:

> Officials' mixed messaging more than blood clot risks are undermining COVID vaccine rollout.
>
> A year-plus into the pandemic, “and we’re still having world-class science and medicine undermined by inexcusably amateurish communication.”

How do you respond to that? It has been very confusing for the public, and I am getting a lot of calls and backlash in my constituency from people who don't want to use it. I know we've seen a lot of doctors and others come out and say, “Yes, get your vaccines.” However, these messages are coming from the government.

I'm very concerned about that type of media, the mixed confusion that's coming from different parts of the government, for example, between procurement and health.

Hon. Patty Hajdu: Our government has been very clear that the risks of COVID-19 far outweigh any risks associated with vaccination.

Second, we will be transparent with Canadians as information changes and evolves.

Actually, I think we all have a duty to help our constituents get access to credible information and not to foster fear and sow discontent and confusion. It is very important that—

Mr. Larry Maguire: If you're not fostering confusion, why are you coming out and saying that vaccines are not a panacea?

Hon. Patty Hajdu: Mr. Maguire, it's because they are not. In fact, we need to continue to protect each other through the vaccination process.

Mr. Larry Maguire: That's pretty confusing messaging right there.

Hon. Patty Hajdu: Mr. Maguire, in fact what's confusing—

Ms. Jennifer O'Connell (Pickering—Uxbridge, Lib.): Mr. Chair, on a point of order, the rules state that a member is able to ask a question and the witness is given the same amount of time to answer without interruption. If Mr. Maguire can't control himself, I would ask the chair to enforce that rule.

Mr. Larry Maguire: Mr. Chair, my questions are very short, so I appreciate that.

Don't you talk about what you're going to say and how you're going to affect the uptake on these things?

I just don't understand the circumstances that Ms. Hajdu and Ms. Tam have talked about. What do you think—

Hon. Patty Hajdu: Mr. Chair, my name is Hajdu.

Mr. Larry Maguire: Yes. Well, had you done these things, we wouldn't be in the problem we're in today.

Hon. Patty Hajdu: Mr. Chair, I appreciate the mocking of my last name. It's very appropriate at this time.

I'll say this: It is appalling that we see Conservative members try to sow division and fear. In fact, what Dr. Tam first said—

● (1455)

Mr. Larry Maguire: Oh.

Hon. Patty Hajdu: In fact, what we see is an unprecedented demand for vaccination. Canadians around the country understand that vaccination will save their lives and will contribute to the safety of their community. It is important that we continue to support Canadians to get accurate information in culturally appropriate ways, and that is exactly—

Mr. Larry Maguire: Mr. Chair, she still hasn't answered my question, so I'll go on to the next one.

Hon. Patty Hajdu: —what we have been doing, including a $53-million fund for local community organizations to work with a variety of different under-represented communities.

Mr. Larry Maguire: Mr. Chair, she is much over time.

You also said that the border measures don't work, and that you shouldn't wear masks. There are different things you've said through communications over time.

I just want to ask Ms. Anand a question about the boosters.

Pfizer has indicated very clearly in previous meetings, and I asked the question about boosters a month or so ago and have gotten no reply yet, that they would recommend still that the second shot be within three weeks. The government has gone to 16 weeks in a decision.

Will we see boosters be necessary? That is the question I asked before, and they didn't say they wouldn't be. Now it has come out that they might need that.

Is it because the efficacy of the drug diminishes between the three and 16 weeks that we would need a third booster sometime within six months to a year?

Hon. Anita Anand: That's actually a question that relates to the spacing of doses. I'm the procurement minister trying to get doses to this country, so I would ask my colleague, Dr. Tam, to take the question, if she could.

Mr. Larry Maguire: Well, it was a government decision, if I could just interject—no disrespect to Dr. Tam.

The situation is because of the timing—

The Chair: Mr. McGuire, I'm sorry, your time is up,

We'll let Dr. Tam answer.

Dr. Theresa Tam: We have to look at the science and the data. No matter what the manufacturer says, we can make contingencies for the need for further doses a year beyond this one. We need to have the data to look at the vaccine effectiveness, and to see how people responded to their first and second doses. Then we expect both Health Canada and the National Advisory Committee on Immunization to look at that data in order to provide recommendations.

It is too premature to do that. We have to do epidemiologic studies, look at the variants, and then look at how vaccines may or may not need to be adjusted according to what is circulating at the time.

The Chair: Ms. O'Connell, go ahead, for five minutes.

Ms. Jennifer O'Connell: Thank you, Mr. Chair, and thank you to all the witnesses for attending today.

For the level of concern that the Conservatives brought up in having these witnesses here, the best they had in terms of questioning was mocking an individual's name, one of our colleague's names. That's pretty disappointing.

After a decade of muzzling scientists and ignoring the Public Health Agency and ignoring experts, it's clear that Conservative Party ignorance is alive and well today, when it doesn't even seem to understand the evolution of science and the evolution of data. However, here we are, and I'm just very thankful to all the witnesses who are here to work on behalf of Canadians.

I want to get back in the time I have to the Ontario modelling that was raised. In fact, Ms. Rempel Garner left out a very important part of that modelling that was just released. Ontario, for example, has said it would be capable of doing about 150,000 vaccinations a day if it had the supply. Even in that modelling, even if Ontario did 300,000 vaccinations a day, the trajectory of cases was still on the rise; therefore, as has been said by the minister and the doctors on the panel today, vaccinations alone are an incredibly important tool for keeping Canadians safe.

Dr. Tam said that vaccines prevent death and attendance in the ICU, as well as strong public health measures. If the Conservatives were in power, they said several weeks ago they would open up, ignore science, ignore the experts and ignore the data. Even 300,000 vaccines a day in Ontario wouldn't have helped if Conservatives were in power making those decisions.

The U.K. has very high vaccination rates. Prime Minister Boris Johnson has credited lower case counts to both vaccinations and public health measures. Can we elaborate with regard to those strong public health measures in connection to vaccination rates, and how that is going to help?

Frankly, there's a very important piece that hasn't been touched, and I'm not surprised the Conservatives haven't talked about it, because it doesn't fit with their ill-conceived, wacko science data, conspiracy theory type of questioning. However, in and around our health care workers, they are strained and stressed, so it's not just about keeping Canadians safe and getting them vaccinations, but there is enormous pressure from our health care sector.

Could the minister or a member of our team here talk about why the two measures have to go together hand in hand, and why vaccinations are incredibly important and Canadians are committed them? Why do public health measures matter so much, especially for our public health care workers?

● (1500)

Hon. Patty Hajdu: I'll just say thank you for acknowledging the hard work of the health care workers. You're absolutely right—vaccines save lives and stop the spread, but they are not the only solution. We also have to continue to work hard on disease control.

We see that with other diseases, quite frankly. We have very high rates of vaccination for many other diseases, but it takes hard work on both ends. The public health measures, protecting communities, preventing disease outbreak, and also making sure people are vaccinated are extremely powerful tools in the tool box, but we also need other tools. Those include, for example, having safer workplaces, having financial supports to help people stay at home when they're sick, and making sure people feel they have the appropriate access to health care. All of those kinds of things matter.

Thank you for thanking the health care workers, because—you're right—not only is it hard for people when people get sick, but our health care system, as you can see in Ontario, is surging. When we don't take strong measures to protect our health care system, even more people suffer and sacrifice.

I'll turn to Dr. Tam to talk a bit more about the theory behind that.

Dr. Theresa Tam: Thank you.

I also need to examine the Ontario report, but it was very clearly stated in a sound bite coming from that report that a six-week stay-at-home order along with a vaccination rate of at least 100,000 doses a day is the only way to flatten the curve. Ontario also has the same message, which is that you need both right now.

The United Kingdom has shown—they are ahead of us, of course, so we look to them for data—that despite a very high vaccination rate, they've kept up some very stringent public health measures and are relaxing them very, very cautiously. Israel is another country. We've done a lot of modelling, but we also look at the real-life data. Israel has a high rate of vaccination. The moment they relaxed a little between February and March, they had a resurgence. They had to push back down on the stringent public health measures a bit more, while getting more people vaccinated. That points us towards the kind of strategy we're going to have to have.

That, together with vaccines, is the only way to combat the variants.

Thank you.

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

[*Translation*]

Mr. Thériault, we now go to you for two and a half minutes.

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

I'm going to start with the Public Health Agency of Canada officials.

If I understood Dr. Tam's answers correctly, the basis for the vaccine rollout is to target specific populations.

You've no doubt had discussions about this. When the vaccines arrived, we had a number of hot spots, and one of the biggest was in Quebec. What factors justified the decision to take that approach?

● (1505)

[*English*]

Mr. Iain Stewart: Theresa, would you like to respond?

[*Translation*]

Mr. Luc Thériault: I hope you stopped the clock, Mr. Chair. It's taking a while to get an answer.

[*English*]

Dr. Theresa Tam: The per capita allocation is of course a policy decision made with the provinces and territories together. Partly it is informed by the fact that the highest-risk groups are based on age, so the oldest of our population are among those at highest risk. Even if we look at all the other risk factors, as NACI, the National Advisory Committee on Immunization, did, age is still the key, as is being a member of some of our populations most impacted by health inequities. From all of those calculations, it still worked out that a per capita allocation was the way of moving forward for which there was the greatest consensus. However, I think now that a number of the provinces—Ontario, Quebec, British Columbia and others—are targeting hot spots, it is important to have a look at that data and see what that different strategy might do.

Yes, these are some of the areas of technical analysis that need to take place.

[*Translation*]

Mr. Luc Thériault: My understanding from your answers is this: as long as the virus has not been eradicated globally and everyone has not been vaccinated, thereby establishing herd immunity, the most effective way to curb the spread of the virus is still through the individual health measures.

When people, knowing that there is a vaccine, let their guard down and stop following the public health measures, we see surges and quicker spread. Is that right?

[*English*]

Dr. Theresa Tam: Right now, that's a very important message. No matter whether you've received one dose or two doses, in the midst of a third wave it is very important that we protect ourselves through all those layers of public health measures. Locally, public health will look at how they may apply other community-based public health measures to help plank that curve.

As the vaccine uptake increases, though, I think we will find it much easier to manage any of those outbreaks and surges. That layer of protection will increase over time and that will be really helpful.

Thank you.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, go ahead for two and a half minutes, please.

Mr. Don Davies: Thank you.

Minister Anand, as you are aware, both this committee and the House have ordered production of the vaccine contracts. Have you sent the unredacted vaccine contracts to the law clerk yet?

Hon. Anita Anand: After my committee appearance and with the number of concerns that have been raised relating to wanting to see those contracts, I made sure to go back to our contracts and look at them to—

Mr. Don Davies: Minister, it's a simple question. Have you sent them or not? I have two and a half minutes. It's a yes or no. Did you send them?

Hon. Anita Anand: My apologies. I have not yet.

Mr. Don Davies: Thank you.

Two days ago, you told the Standing Committee on Government Operations that the government has committed to spending up to $8 billion on vaccine contracts.

What is the price per dose that Canada is paying for vaccines—or what is the range?

Hon. Anita Anand: The envelope is $8 billion and the price per dose is covered by the confidentiality clauses in our agreements, as I have previously stated at this committee.

Mr. Don Davies: You can selectively tell us the total amount of money we're paying, but you can't tell us details about it.

Hon. Anita Anand: It's an interesting viewpoint, but incorrect. I am simply citing the $8-billion envelope figure that Treasury Board already released to committee.

Mr. Don Davies: I see. That's fair enough.

Do we pay a premium, Minister, when we have to get extra doses, like the Pfizer doses we just ordered?

Hon. Anita Anand: No, we do not.

Mr. Don Davies: Okay, thank you.

Dr. Tam, what is Canada's national R0 number right now?

● (1510)

Dr. Theresa Tam: It's about 1.1 to 1.2. It's definitely above one, which means the epidemic is growing. In certain areas it's even higher than that.

Mr. Don Davies: Mr. Stewart, when you appeared before this committee on March 12, I asked you to confirm the maximum number of vaccination doses per week that we can administer in Canada nationally. You undertook to provide this committee with that information. It's now been five weeks and we haven't received it. Are you prepared to table those numbers with us today?

Mr. Iain Stewart: Mr. Chair, my apologies for that. We will follow up on that number and provide that.

Mr. Don Davies: Thank you.

Dr. Tam, are we preparing right now for a fourth wave in Canada?

Dr. Theresa Tam: We should always prepare ahead of time, but there is a way to prevent that. We all know what needs to happen, which is to drive the third wave all the way down.

Let's just say that until the majority of Canadians are vaccinated and reinforced with that second dose, any rapid relaxation of public health measures can definitely lead to a resurgence.

The Chair: Thank you, Mr. Davies.

That brings round three to a close. We'll start round four with Mr. d'Entremont.

Mr. d'Entremont, please go ahead for five minutes.

Mr. Chris d'Entremont (West Nova, CPC): Thank you very much, Mr. Chair.

I might as well kick off where my colleague finished up, which was looking at a fourth wave. We're out of control right now in the third wave, by the look of it. The second wave wasn't done before we hit the third wave. What does the modelling say on when the fourth wave might hit?

That is for Dr. Tam.

Dr. Theresa Tam: That's a great question.

The focus of everyone right now should be getting that third wave all the way down. You've seen, with the second wave, what happens when you're two-thirds of the way down and relax things. You can imagine the same thing happening on the way down; if you relax before you get to the bottom, that's what's going to happen.

Mr. Chris d'Entremont: Do we qualify ourselves as being out of control right now? Ontario is projecting somewhere close to 15,000 people. I would suggest that it sounds a little out of control. We're great here in eastern Canada, but if Ontario loses track of things, I think we're in a bit of trouble here.

Dr. Theresa Tam: The situation right now is very concerning, and some of the key indicators are not just that the case rate is escalating so fast with Rt, which another member has already flagged, but also the hospitalizations and ICUs and the fact that the Ontario modelling alone is projecting an overflow of that capacity soon. That is extremely concerning, and jurisdictions need to apply those public health measures fast, as we previously talked about in our modelling.

Mr. Chris d'Entremont: If we talk about variants for a second, we're tracking—give or take—three variants right now in Canada. Because of this uncertainty, because of the distance between the vaccinations and the possibility of a third booster shot, what are the chances of another variant showing up and causing us even more grief?

Dr. Theresa Tam: The virus is always undergoing evolution, and we're monitoring this not just in Canada but around the world. There is a distinct possibility for other variants to occur, although the virus seems to be homing in on a couple of very key mutations that are common to a number of these variants, so we might be seeing the virus settling down on some of those mutations. We just have to keep track, and we are doing all the mutation analysis, the screening and the genomics analysis. We may have to modify the vaccines accordingly. We will have to see about that.

Mr. Chris d'Entremont: As we talk about vaccine supply and vaccines being available, I know, Minister Anand, that you are going to have to be very busy in keeping track of the second dose and the third dose and all that stuff. When are we going to be seeing a domestically produced vaccine available here in Canada?

Hon. Anita Anand: The Government of Canada has put $126 million into the NRC facility in Montreal and has an MOU with Novavax. If all goes well and materializes, there will be domestic production, hopefully, later this year.

● (1515)

Mr. Chris d'Entremont: It's six months away, if everything goes well.

Hon. Anita Anand: This is not my portfolio, however. It's François-Philippe Champagne's, so I defer to him in terms of the status of the negotiations on that front.

Mr. Chris d'Entremont: My final question is for Minister Hajdu.

When it comes to the issue of the other pandemic that's going around, we had the radiologists in here last week, talking about deferred tests and surgeries, with almost 380,000 Canadians waiting for some kind of treatment. How are you dealing with the provinces and your colleagues? Is it a Canadian problem or is it going to be pushed back onto the provinces?

Hon. Anita Anand: Mr. Chair, I'm going to have to step away. Thank you so much for the opportunity to take the members' questions. I really appreciate it. Take care.

The Chair: Thank you, Minister. I appreciate your time here.

I understand that Minister Hajdu has to leave as well, so I would like to thank her as well for her time. We appreciate it.

Mr. Chris d'Entremont: Can we have a quick answer there, just a little answer?

Hon. Patty Hajdu: I'll give you a quick answer, absolutely, MP. Thank you very much. I'll just say that when you mentioned the other pandemic I thought for a moment that you would be talking about the drug overdoses and the crisis that has been going on in this country for so long.

Mr. Chris d'Entremont: All right—the third one.

Hon. Patty Hajdu: We are working on that as well.

Thank you very much, everyone. Have a great evening.

The Chair: Thank you, Ministers.

Mr. d'Entremont, your time is up, although I gave you a little extra time. If you can get an answer to that question, I'll certainly invite anyone who wishes to answer to do so.

Mr. Chris d'Entremont: Does someone have an answer for that?

All right. Thanks, folks.

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

We'll go now to Mr. Kelloway.

Mr. Kelloway, please go ahead for five minutes.

Mr. Mike Kelloway: Thank you, Chair.

My questions will be for Dr. Tam. I had several questions, but I think I'll just focus on one or two.

Early on, Dr. Tam, when you started doing projections, you talked about some of the limitations of the data, because the federal government wouldn't have the same kind of data that the provinces would. Have you been able to address some of the data gaps with the provinces and territories? That's question number one. Also, if not, why are these national modelling projections important?

Dr. Theresa Tam: The whole public health system and other systems need to work together to get the data from the bottom up.

More than $4 billion was provided to the provinces. I was very happy about that, because it's not just about asking for the data. You need the capacity on the ground to do that. Through these investments, if you like, we have been able to get more information to fill in some of the gaps, but doing so requires collaboration across not just public health data but other research.

The modellers have been supported now by another huge investment in the modelling—the academic modelling that works. They thus have to do a lot of research to gather the parameters to fill in their models.

As you've seen, for those models there's collaboration with, for example, McMaster University and Simon Fraser. I believe those models are becoming increasingly robust, although very complex.

Mr. Mike Kelloway: One of the benefits of asking questions later on in the session is that you get to hear a lot of great questions from a variety of folks on this panel to our witnesses. One thing that struck me was around vaccines. I'm wondering whether you or other witnesses can chime in on this.

By the way, my mother is receiving her first vaccine today, at the age of 80, and I have to check on her in a few moments.

We talked about how important vaccines are, and there are words such as “panacea” thrown out and things of that nature. Can you walk through for the Canadian public the importance of the vaccines and then the importance of the other measures? I think this is really important. One of my first questions was around how we approached in Atlantic Canada—and thank goodness it has worked to date—the importance of vaccines and also the importance of measures. Could you walk through that whole process of the importance of vaccine and what it means and the importance of the measures in collaboration with the vaccine?

● (1520)

Dr. Theresa Tam: Mr. Chair, I think the member hit the nail on the head, which is that these are layers of protection. If you think of all of these as layers that you put on to protect yourself and those around you, that's how we look at both public health measures and the vaccines.

Let's go to vaccines first. We have been incredibly fortunate in that we have a suite of vaccines, which we would never have imagined arriving so fast, and that they're safe. The vaccine effectiveness has been great. For our parents and grandparents, the vaccines have been very effective for this part of the population at the outset.

For those in long-term care facilities in particular, it's been very effective in reducing cases, reducing severity of illness and reducing the number of outbreaks in long-term care. That's the population that was most impacted at the start of this pandemic, and we're seeing the vaccines at work right there.

The provinces and territories are now readjusting their measures at those long-term care facilities, still with layers of protection, with the masking, hand hygiene and testing and screening as needed, and people are able to have more visitors, to see more of their family members. That's what vaccines are doing right now.

Health care workers, based on some data from our provinces, are well protected even after that very important first dose. Vaccines are thus definitely at work and are doing well.

As everybody has articulated, we need to ensure that people roll up their sleeves when their turn comes. Particularly at the moment, when the population in that protective layer of vaccines is escalating, public health measures are extremely important when variants are around. They mean that we need to get the cases down in your communities in order to protect everybody. Vaccines alone are not going to be able to do it, but they play a really key part.

I have to say that there are some very good early signals that not only do vaccines protect you against serious illness and death, but particularly some of the mRNA vaccines are demonstrating that you can probably cut down on the onward transmission as well.

We are, then, continually analyzing the data, but it's all really great news.

Mr. Mike Kelloway: Thank you very much, Dr. Tam.

The Chair: Thank you, Mr. Kelloway.

We go now to Mr. Dreeshen.

Mr. Dreeshen, please go ahead for five minutes.

Mr. Earl Dreeshen (Red Deer—Mountain View, CPC): Thank you very much, Mr. Chair. It's great for me to be back here to discuss something that's extremely important to all Canadians.

A little earlier, Dr. Tam said that they look at the science and the data, and no matter what the manufacturer says, they make decisions based on that.

Are we the only ones in the world who are capable of coming up with a detailed analysis of such a circumstance?

Dr. Theresa Tam: I would say that many countries in the world follow the same process.

Mr. Earl Dreeshen: Does that mean there are a number of countries in the world, then, that are delaying the 21 days or 28 days, to push it out to four months? Is that what is happening throughout the world?

Dr. Theresa Tam: I misunderstood your question. I'll just clarify.

The United Kingdom, for example, right at the outset, looked at a 12-week interval for all the vaccines, and our National Advisory Committee on Immunization has been following not just that data but also domestic data from B.C. and Quebec. We are a leader in the world, particularly in terms of the studies in those two provinces, at looking at that stretch interval, and so far the vaccine effectiveness has been very high, even at that 12-week mark. We're monitoring that very carefully.

Mr. Earl Dreeshen: Thank you. That's great to know, because I'm sure the rest of the world will be waiting for us, for the studies we've done.

What about the concept of mixing vaccines? There are a lot of people who are thinking there's going to be a four-month delay before their next one. They might have taken a Pfizer vaccine, but perhaps a Moderna one might show up earlier, or quite frankly, the way we've been seeing it, probably if you got a Moderna one then Pfizer would be the one that would be more available.

If we could magically get all of these vaccines, would we then be going back to the recommendations from the manufacturers, down to the 21 and 28 days?

● (1525)

Dr. Theresa Tam: The National Advisory Committee on Immunization advised up to four months, but of course that can be adapted based on the evolving data but also supply.

Mr. Earl Dreeshen: Certainly, but the question I asked was about the mixing of vaccines. Of course the mRNA ones perhaps could be mixed—I'm not sure—when it comes to the second one or the booster shot that we're expecting later in the fall.

Dr. Theresa Tam: The current recommendation is that your second dose in a two-dose series should be with the same vaccine or from the same group or class of vaccines, so if you got an mRNA, you get the other mRNA, but there are studies right now in the United Kingdom. We're looking toward getting that data soon, we hope, and that would inform the Canadian strategy going forward.

Also, there is dose mixing, if you like, a mix of different classes of vaccines in Canada that's also being studied, planned and supported.

Mr. Earl Dreeshen: It's good to know, as you said, that we were able to lead the world in expanding to the four months. It would be great to know that we're able to take that information on the mixing of vaccines, because people are going to be very concerned about it.

I saw yesterday that Albert Bourla, the CEO of Pfizer, said that a third COVID vaccine dose is likely needed within 12 months. I was just curious about what the procurement plans are as far as that is concerned. Is that 12 months from the time we get the second dose, or is that 12 months from when the first dose was administered?

Mr. Bill Matthews: Maybe, Mr. Chair, I can start on the procurement aspects, and I'll turn to health colleagues to talk about the duration or interval of the third dose to the extent that—

Mr. Earl Dreeshen: I am very interested in the health aspect of it, but yes, quickly go ahead on that.

Mr. Bill Matthews: Canada has bought more doses than we need for each Canadian, so there are those doses under contract as well as options for more. Obviously, as the science evolves, the vaccine manufacturers are working on, potentially, boosters, improved vaccines or adjusted vaccines because of variants, and we have ongoing discussions with those companies about what the next round of buying might be.

Mr. Earl Dreeshen: Thank you.

Again, I think the NIH has started testing a new COVID vaccine from Moderna, designed to protect against a problematic variant first found in South Africa. Do you have any knowledge about how quickly that particular vaccine might be available?

Mr. Bill Matthews: We are in discussions with the companies around the next round of buying. I can't speak to the timelines required to get through regulatory approvals, etc., but I suspect that my Health colleagues might be able to help there.

The Chair: We'll ask the Health colleagues, if they wish to respond, to do so.

Dr. Stephen Lucas: I'll just respond that from the perspective of any regulatory submissions we would receive for reformulated vaccine, be it for a booster or a second-generation vaccine, it would be subject to our rigorous review through the rolling review process. We would attend to that rapidly.

Mr. Earl Dreeshen: From that perspective, there would be no concern for—

The Chair: Thank you, Mr. Dreeshen.

We'll go now to Dr. Powlowski.

Dr. Powlowski, please go ahead for five minutes.

Mr. Marcus Powlowski: I actually want to ask about the same thing—the interval between the first and second doses. Certainly, a lot of people are concerned about the interval. I have had health care people saying, “Look, we're high risk. Why are we getting only one dose?” I've also had concerned elderly people saying, “We're supposed to have the same dose after three or four weeks. Why is it longer?”

The evidence, certainly for AstraZeneca, seems to suggest that it's better if you have a longer interval between doses. With both Pfizer and Moderna, to my understanding, although I haven't looked in the last few days, the evidence was that starting at about three weeks, at least in young people, you had about 90% efficacy. The evidence from British Columbia, Quebec, Israel and the United Kingdom seems to be that for at least two months you have pretty good immunity. We have other vaccines where there are two doses and where it's six months in between. We have reason to believe that immunity is going to last for the full four months.

For someone like me, that's no problem. As somebody who still works a bit in health care, I've had my first dose. I'm not going to have my next dose for four months. The concern is more with the elderly, because studies seem to at least suggest that their immune response is poorer. The initial data from Israel suggested that one shot wasn't protective, although that seems to have been reanalyzed in that, well, a lot of those people were getting infected in the first two weeks, when no vaccine was going to work.

I want to ask the person from NACI what the current evidence is regarding the safety of that increased interval in elderly people and people who might otherwise be immunosuppressed, such as people on chemotherapy.

Thank you.

● (1530)

Dr. Matthew Tunis: NACI has certainly been reviewing in detail all of the emerging evidence on effectiveness in the elderly and also, as you mentioned, some immunosuppressed populations.

There are a few things that are important to establish. First, there is no correlative protection established for protection against COVID-19, as you're probably aware of. Many of these studies, the preprint studies, on certain immunosuppressed or solid organ transplant populations are based on antibody measures, and in some cases cellular responses, but not true effectiveness in the real world. It's hard to bridge those data over to real-world effectiveness. That's one thing the committee advised us in their report.

The second thing is with respect to the elderly. Much of the data that was reviewed by the committee early on in making their recommendations in fact came from long-term care settings and from the elderly. If we look at their analysis of what's been reported from the United Kingdom, where they were using an extended 12-week interval, for example, they found very good protection and very good effectiveness against severe outcomes—hospitalization and death—certainly above 80%. The effectiveness against symptomatic disease is lower, and we're seeing that reported, but the most critical outcomes are being very well protected.

Looking to Canada, the committee was reviewing presentations, as Dr. Tam mentioned, from Quebec and British Columbia. Both provinces, by the way, are doing weekly vaccine effectiveness monitoring. They're keeping a very close touch on how this is evolving. That's being fed back to NACI and the provinces and territories. We've seen in the range of 80% to 90% effectiveness in the long-term care setting in those jurisdictions, not only against severe outcomes but actually against PCR-confirmed COVID-19 infection.

It's a very strong evidence base, at this point, understanding that it's not out to 16 weeks. As Dr. Tam mentioned, we're getting up to the 10- to 12-week mark in Canada with no signs of deterioration, even in those elderly populations. The committee is watching carefully, but at this time was very comfortable to say that up to four months could be considered by jurisdictions, understanding that they may choose to shorten it for specific populations, based on their epidemiological context.

Thank you.

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

Health Canada's approval of monoclonal antibody combinations, specifically the Eli Lilly bamlanivimab-etesevimab combination and Regeneron's.... Those applications for approval have been there since February, and growing evidence suggests that the combinations are quite effective in preventing the progression to severe disease. Obviously our ICUs are overflowing. The NIH is recommending, because of the American variants, that we use these in Canada—at least in Ontario. Bamlanivimab alone, it seems, would cover 90% to 92% of the variants in Ontario.

When can we expect to hear something from Health Canada on these other monoclonal antibodies? Can this be expedited given the situation, particularly in Ontario?

Dr. Stephen Lucas: As the member noted, the combination therapies involving bamlanivimab of Eli Lilly and of Regeneron and Roche are before Health Canada, the regulator. The submissions were received in February and are undergoing the expedited review process that I spoke of earlier, under interim order. I can't say when they will be approved, but scientists are working day and night to review the submissions.

The Chair: Thank you, Dr. Powlowski.

● (1535)

[*Translation*]

It is now over to Mr. Thériault, for two and a half minutes.

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

Dr. Tam, in response to questions I asked you previously when you were before the committee, you said—much to your credit—that, looking back, you think you waited much too long to recommend closing the border with the United States.

I realize there are jurisdictional issues at play, but given your understanding of the situation in Quebec and Ontario, where do you stand on a potential closure of Ontario's borders and, by extension, the Ontario–Quebec border?

[*English*]

Dr. Theresa Tam: At a technical level, I have discussions with the chief medical officers of health, and that's to facilitate discussions among the provinces. Interprovincial travel and indeed intraprovincial travel are in their jurisdiction. I have been happy to support some of the deliberations, but it is actually up to Ontario and Quebec.

[*Translation*]

Mr. Luc Thériault: You don't have a scientific opinion on that specific issue, or you prefer to let them make their own decisions. I was just curious to know your take.

Can you tell me what you think, nonetheless?

[*English*]

Dr. Theresa Tam: The virus is transmitted human to human, so any measure that reduces mobility in order to control a third wave is something that provinces can consider.

[*Translation*]

Mr. Luc Thériault: Dr. Tam, in working with its Quebec and provincial counterparts, the Public Health Agency of Canada provides decentralized coordination. That means information has to flow seamlessly. The Auditor General identified deficiencies in the agency's ability to share data.

What have you done since to improve data sharing, specifically?

[*English*]

Dr. Theresa Tam: As I said earlier, the public health system is under stress, so even though there was a will to provide information, we were not getting everything we had agreed to, really, with the provinces and territories. However, I was very happy that support of over $4 billion was provided to the provinces.

We have another refresh of the expectations regarding what's to be collected at the national level, including race information and occupation, such as whether a case is a health care worker or not, and that data collection has improved over time. We have a bit of a way to go, but that is improving. We have already started on a pan-Canadian health data strategy and have also established a cloud-based data-sharing platform to assist in collecting information in a more timely and efficient way.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

Mr. Luc Thériault: Thank you.

[*English*]

The Chair: We will go now to Mr. Davies.

Mr. Davies, please go ahead for two and half minutes.

Mr. Don Davies: Thank you.

Mr. Matthews, did Canada pay more or less for our vaccines than the U.S. did per dose?

Mr. Bill Matthews: I can't answer that question, Mr. Chair, because the nature of the agreements is confidential. Remember, with the U.S. arrangement, in many of its situations, the government actually invested in the companies themselves, so you can't do a dose-per-dose comparison.

Mr. Don Davies: Dr. Tam, given that Brazil is currently running such an extremely high case rate, are you concerned that it could be a crucible for an ultrainfectious or vaccine-resistant variant? If so, can you explain why the federal government quietly dropped specific screening requirements for travellers arriving from Brazil this week?

Dr. Theresa Tam: The situation in Brazil is of international significance. Countries, including Canada, I think, need to participate in multilateral discussions as to how to assist in terms of Brazil's really tragic situation. Some of it might be sharing expertise, but there are other measures as well.

We have instituted many layers of border health protection over time. That includes, as you are probably aware, a series of tests including pre-departure and two post-arrival tests, as well as the 14-day quarantine period stays, including awaiting test results from a GAA.

Very stringent measures are being applied by the quarantine team in terms of a quarantine plan. Those are the really key layers—

● (1540)

Mr. Don Davies: Dr. Tam, could I please ask you whether it wouldn't be prudent to keep those extra screening requirements? What's the benefit of dropping them?

Dr. Theresa Tam: Well, in fact, stringent measures are being applied to every country. I think that was reassessed because the number of arrivals from Brazil is, in fact, pretty low, and the same stringent measures.... By the way, the P.1 variant is found in over 40, maybe 50, countries right now, so you can't just focus on Brazil.

Mr. Don Davies: Major-General Fortin, I have a quick question.

I want to be clear. We know thousands of vaccine appointments are being cancelled across the country. Everybody's saying it's a lack of supply.

From your perspective, is the problem right now in Canada a supply bottleneck, a lack of supply, or a capacity issue by the provinces to vaccinate?

MGen Dany Fortin: Thank you, Mr. Chair.

Provinces indicate that they require more supply to scale up. Clearly, there are jurisdictions that don't book appointments until they have certainty on shipments, so that avoids their having to cancel appointments when they see a delay in shipments. Others choose another option.

All options work. It's a matter of risk management. It really is the responsibility of those jurisdictions.

The Chair: Thank you, Mr. Davies.

That brings question round four to a close. I believe we will have time for a shortened fifth round if it's the will of the committee to do so.

I would suggest we have three-minute slots for the Conservatives and the Liberals, and one-and-a-half for the Bloc and NDP.

Is that acceptable to everybody? Seeing no heads shaking, we will go ahead on that basis.

Ms. Rempel Garner, I believe it's over to you for three minutes.

Hon. Michelle Rempel Garner: Thank you, Chair.

This question is for Mr. Matthews. It builds on my colleague Don Davies's questions.

An email was just released to the House of Commons committee in a document dump for one of the motions we had in the House of Commons. It's from a Rick Theis, on September 24, 2020. It states, “On [AstraZeneca], folks are reviewing a final MOU right now. Basics are 20 million doses, delivery to start in late Q2/early Q3, and all doses by end of 2021. Price per dose is $8.18.”

Mr. Matthews, why did Canada pay almost double the price of any other country for the AstraZeneca vaccine?

Mr. Bill Matthews: I'm not sure what you're using as a comparative figure, Mr. Chair, in this case, so I would have to get back to you.

Hon. Michelle Rempel Garner: The European Union paid $2.15 a dose, the United Kingdom three dollars and the U.S. four dollars. Why did we pay double the amount that the U.S. paid?

Mr. Bill Matthews: There are a couple of things here, Mr. Chair.

Number one, location and manufacturing are important in terms of considering price. As I mentioned before, the U.S., in particular, had some investments in the companies.

The rest I can't speak to, except for the EU. Just remember there are two prices in the EU. There's the price paid—

Hon. Michelle Rempel Garner: You're confirming $8.18 for—

Mr. Bill Matthews: I'd have to go back and check. I haven't seen that email; I apologize, but I just.... For members, Mr. Chair, on the EU front, I think it's worth noting there are two cost components, the price paid by the member state as well as that paid by the EU itself.

Hon. Michelle Rempel Garner: In terms of facts, for reporting tonight, did we pay $8.18 a dose for AstraZeneca?

Mr. Bill Matthews: I'd have to go back and confirm that.

Hon. Michelle Rempel Garner: Parliamentarians can't look at the price per dose of vaccines, but now you're commenting on it. When are you going to release the price per dose to this committee?

Mr. Bill Matthews: There are couple of things here, Mr. Chair. Number one, the contracts are confidential—

Hon. Michelle Rempel Garner: When do I get the price per dose for everything else?

Mr. Bill Matthews: Mr. Chair, if I could finish on this, I'm very reluctant to effectively be in breach of a contract while we're in a world of competition for doses and negotiating the next round of buys. I can't speak to this email; I haven't seen it.

Hon. Michelle Rempel Garner: Why did we pay double for this?

Mr. Bill Matthews: I can't confirm the doubling, but I can tell you that—

Hon. Michelle Rempel Garner: We were late to the table for negotiating, so we had to pay a higher price premium per dose. Is that why we paid higher?

● (1545)

Mr. Bill Matthews: The only thing I can offer here, Mr. Chair, is that location of manufacturing is an important consideration in the price discussions across the board, so I'm not commenting specifically on AstraZeneca and I can't comment on the suggestion that it's double.

The Chair: Your time is up. Thank you, Ms. Rempel Garner.

We will go now to Ms. Sidhu for three minutes, please.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

Dr. Tam, earlier this week, your deputy chief public health officer, Dr. Njoo, provided a clear answer to a Conservative colleague's questions. Can you clarify what other tools, such as masks and physical distancing, are necessary while we vaccinate Canadians? Can you clarify why wearing masks continues to be necessary?

Dr. Theresa Tam: Yes. The basic immunity in the population is still very low, based on our serologic surveys, for example, and vaccines are only just getting going while there is a significant resurgence of cases.

Every person in Canadian needs to layer up the layers of protection. The masks are important because the virus can spread through these droplets and aerosols that can be generated, and when someone's infected.

Of course, there's the distance thing when you're not with people from your household. People want to have many celebrations, but they should do that virtually, because it is that closeness between infected individuals and the uninfected that helps the virus transmit.

Also, avoid the three Cs—the closed, crowded environments where there is close interaction between people—as well as, of course, maintaining hand washing and hand hygiene measures. Those are the very important basic individual measures, and of course respect your local public health unit's advice about what to do in your community.

Ms. Sonia Sidhu: Can you also speak to what you are doing to increase uptake among multicultural communities for those who may experience issues with the registration because of a language barrier?

Dr. Theresa Tam: Yes, of course. The provinces and territories are responsible for the delivery of the vaccine programs. I think the federal government can help in many ways. Of course, providing credible information in multiple languages is really key; that's one investment.

We're quite excited about investment in community-based projects whereby people can apply for funding to communicate credible information to their communities, whether they're faith leaders or business leaders who can speak the language and can do the outreach to others.

I've been very fortunate to be able to participate in some of those events with business leaders, but also with Black physicians, for example in BlackNorth, a public-private sector collaboration to reach those hard-to-reach populations. They're also giving health care workers who are trusted by their communities—family physicians and others—the tools to be able to answer the questions that their communities might have.

In the end it's about access as well, so we're helping where we can, supporting the provinces, if needed, to mobilize to areas where some of the increased access is required. For example, Major-General Dany Fortin and the Canadian Armed Forces are helping to get the vaccine into certain indigenous communities.

In the end, it's the people and the leadership in those communities, like the elders getting vaccinated and communicating about this, that have really helped. The vaccine uptake has been great in those communities.

Thank you.

The Chair: Thank you, Ms. Sidhu.

We now go back to the Conservatives. I'm not sure who's up for the Conservatives on this round.

Hon. Michelle Rempel Garner: I'll go again.

The Chair: Go ahead, for three minutes.

Hon. Michelle Rempel Garner: Mr. Matthews, why did Canada pay so much of a premium?

For other countries, production capacity on all the factors you mentioned would be a common denominator, so why did Canada pay a premium for the AstraZeneca vaccine compared to other countries?

● (1550)

Mr. Bill Matthews: Thank you, Chair.

On price per dose, you can't compare country to country, because other countries actually invested directly with the manufacturers. I don't have the specifics, but it's not as simple as that. You have U.K. and U.S. manufacturing occurring. The location of manufacturing is a factor. I would imagine volume might be a factor as well.

Hon. Michelle Rempel Garner: Did we know what the other countries were paying when we negotiated our contract with AstraZeneca?

Mr. Bill Matthews: At that time, no, we didn't. All the contracts were confidential, and many of them continue to be confidential.

Hon. Michelle Rempel Garner: How do you know if those factors played a role in Canada's paying a premium?

Mr. Bill Matthews: Number one, we had discussions with AstraZeneca. We talked about locations. On the volume issue, I'm speculating a bit, but based on experience in procurements, it matters. I can't say specifically in AZ, but the size of the order certainly matters.

Hon. Michelle Rempel Garner: If you didn't know what other countries were paying, did you just kind of accept $8.18 a dose?

Mr. Bill Matthews: We were in a world.... With vaccines, it's the same story as PPE. These are effectively a short commodity with great competition, so essentially you negotiate as best you can, but it's certainly a seller's market. It continues to be so in the vaccine market.

Hon. Michelle Rempel Garner: With the seller's market, did we pay a premium because we were late to the table or because we signed contracts after other countries did? Do you think that had anything to do with it?

Mr. Bill Matthews: No, I wouldn't accept that at all. In fact, in many cases, Canada was one of the first countries negotiating. That has never been brought up as a factor.

Hon. Michelle Rempel Garner: How come we paid so much more, if we were one of the first countries? How did $8.18 come to be? How did you guys agree to that?

Mr. Bill Matthews: Mr. Chair, again, I can't comment on the comparability, because when you have governments investing directly into manufacturing, like the U.K. and the U.S. did, I'm not sure I can make that comparison.

Hon. Michelle Rempel Garner: Did our lack of domestic manufacturing capacity for a virus-based platform vaccine lead to a higher premium with the AstraZeneca vaccine?

Mr. Bill Matthews: No. That's not what I'm saying. I'm saying that governments that subsidize the manufacturing of vaccines end up with a different deal, where they're actually—

Hon. Michelle Rempel Garner: Did we provide no subsidies for AstraZeneca whatsoever?

Mr. Bill Matthews: AstraZeneca's not manufactured in Canada, so we're dealing with a straight price-per-dose model here, as opposed to a broader manufacturing discussion.

Hon. Michelle Rempel Garner: Mr. Matthews, were there any other factors that contributed to the $8.18 a dose?

Did we pay a premium for every other vaccine as well?

Mr. Bill Matthews: Mr. Chair, I'm not accepting the comparison, simply because I can't speak to whether there is a premium here or not.

I can tell you that we negotiated in good faith with all suppliers and it was definitely a seller's market.

The Chair: Thank you, Ms. Rempel Garner.

We'll go now to Mr. Van Bynen for three minutes.

Mr. Tony Van Bynen: I'll start off by saying hello.

We're in a pandemic. We're in the third wave, and we need to get medicine in people's hands. We have some vaccine hesitancy around AstraZeneca lately. Some of this has been fuelled by opposition members. We've seen some examples of those questions again today.

Dr. Tam, what can you or your officials share about the AstraZeneca vaccine to reduce hesitancy?

Let's focus on the immediate issue, which is to get people well and keep people well. How can we go about doing that?

Dr. Theresa Tam: We're really fortunate to have the vaccines. They've been performing very well, particularly all vaccines in Canada—AstraZeneca included. They are very effective for reducing severe outcomes, hospitalizations and deaths. That's really important, particularly for older populations who are at higher risk. That is why everybody should get vaccinated.

We even have a bit of an early signal that if you have highly effective vaccines and you cut down on the number of infected people, asymptomatic or symptomatic, there is a good chance you will reduce transmission. That is some of the initial data that we're really looking forward to. That's also good news.

Vaccines alone can't reduce transmission right now, when there's such a huge amount of force from this virus in this third wave. Just keep up with those personal protective measures and roll up your sleeves. With all these discussions, all I can say is to rest assured that the Canadian regulators and our expert committees are doing their due diligence in providing the advice according to data.

In the end, please roll up your sleeves. Whatever you get in your clinic and what is being offered to you are safe and effective vaccines.

● (1555)

Mr. Tony Van Bynen: Great. This is a good segue.

I've heard people talking about vaccine monitoring when they are asked about what happens if someone has a reaction to a vaccine.

Can you tell us more about Canada's vaccine monitoring system and how that works once a vaccine is approved for use in Canada?

Dr. Theresa Tam: Yes, and Dr. Lucas has part of this because the regulators in Health Canada, even though they've authorized a vaccine and continue to have a role in monitoring its safety post marketing, are also asking the manufacturers to provide data on this on an ongoing basis. That's one stream.

The health system that is administering the vaccine also provides their data on any adverse events following immunization to the Canadian adverse events surveillance system. This data comes to the Public Health Agency, where we publish it on our website and share it with Health Canada as well.

Any serious or unusual events reviewed by medical experts are being taken very seriously. This is why, for example, very recently, given the signal of the thrombosis with low platelet event, the whole system was activated and one report was picked up from Quebec. That's one. It's reassuring that the system is actually working and monitoring that safety signal. That is really important.

Then we have active surveillance systems. There are hospital networks that are actively engaged in searching out cases that may be adverse events following immunization, so they can be investigated. There are specialty clinics set up as networks, where patients who may have experienced an adverse event following immunization can receive the specialist advice needed to sort out whether the event was indeed related to the vaccine.

It is actually a multi-layered, interconnected system. That's why I think Canadians should rest assured that anything unusual, any signals, will be investigated.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

Mr. Thériault, you may go ahead. You have a minute and a half.

Mr. Luc Thériault: Mr. Matthews, you said it was a seller's market.

Have you spoken to Pfizer at all about the third dose that's needed six to 12 months after the second dose?

Mr. Bill Matthews: Thank you for your question.

In the beginning, we didn't know exactly how long vaccine protection would last, so we negotiated a contract based on two doses per person. We always had a number of options with Pfizer. As I previously said, we have started talking to suppliers about purchasing updated versions of their vaccines, booster doses and things of that nature.

Mr. Luc Thériault: Do you feel like you were had in the negotiating process?

The company advertised a two-dose vaccine, and suddenly we find out that a third dose may be necessary. Needing a booster shot is understandable, but the situation has changed.

Mr. Bill Matthews: Bear in mind that, when we were negotiating the contracts, we had no idea which vaccine would work, so we negotiated on the basis of the scientific data available at the time. The data have continued to evolve, and Pfizer is now telling us that another dose may be needed.

Mr. Luc Thériault: Did you request a scientific opinion on whether a third dose was needed? For instance, did you ask Mr. Stewart to reach out to NACI for a scientific analysis of whether a third dose was needed before beginning new negotiations with Pfizer?

Mr. Bill Matthews: We can purchase many doses of the current vaccine or conclude an agreement for the next version of the vaccine. The talks are ongoing. As Mr. Lucas said, if the product changes, it has to go to Health Canada for approval.

● (1600)

Mr. Luc Thériault: Before going ahead, you will—I assume—request a scientific opinion on whether a third dose is needed, will you not?

[*English*]

The Chair: Thank you, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Mr. Chair—

[*English*]

The Chair: Thank you, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: I would just like a yes or no answer.

[*English*]

The Chair: Thank you.

[*Translation*]

Mr. Luc Thériault: Are you going to request a scientific opinion or not?

Mr. Bill Matthews: I did not request a scientific opinion.

Mr. Luc Thériault: Are you going to?

Mr. Bill Matthews: Mr. Chair—

Mr. Luc Thériault: Are you going to request a scientific opinion?

Mr. Bill Matthews: That's not a question—

Mr. Luc Thériault: Mr. Chair, we are having trouble understanding one another, in addition to the delays caused by the interpretation. I just need a bit more time.

Mr. Matthews, are you going to request a scientific opinion, yes or no?

Mr. Bill Matthews: All I can add is that the documentation related to the next version of the vaccine has to be submitted to Health Canada.

Mr. Luc Thériault: Very well.

Thank you.

[*English*]

The Chair: Thank you, Mr. Thériault.

Mr. Davies, go ahead. You have a minute and a half, and we'll give you a little extra time.

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

Dr. Tam, one week ago you issued a statement that said the following:

> The Government of Canada's longer-range forecast presentation on March 26th predicted a strong resurgence in the absence of enhanced public health and individual measures. Two weeks later, this strong resurgence is showing in national surveillance data we are seeing now. National case counts are plotting along the strong resurgence trajectory of the March 26th forecast. This clearly shows that we need stronger control to combat variants of concern that are driving rapid epidemic growth in many areas of the country, even as vaccine supply and programs continue to accelerate.

Dr. Tam, what specifically are those stronger control measures that we need to put into practice in this country?

Dr. Theresa Tam: When the modelling was done, people were a bit concerned about that trajectory and were plotting against that.

The measures are to reduce social mixing through whichever means is appropriate for that community, and whether it's Toronto or whether it's Montreal it might be a bit different.

Some of those measures you've seen the provinces put together now in reducing workplace transmissions. Ontario has decided that people should follow essentially staying at home and mixing only with their household and going out only for essential activities. All those things are really important.

At the same time, I believe that outdoor spaces are safer and that you can go out more safely and keep healthy and physically active. It's also good for your mental health, particularly if you stick to your household, like in Ontario.

Those are the tried and true measures. They have worked. If you look at the United Kingdom and that massive spike, all those measures have helped them for sure.

Mr. Don Davies: Doctor, we've been hearing those same measures from the beginning. We're in a third wave, and the numbers are higher than they've ever been. What is it that we have to do differently?

Dr. Theresa Tam: The criticality of that modelling was that you can't relax. The provinces know how to clamp down on those cases. They've done it before.

However, you have to be really careful now, on the way down, not to relax them too quickly. Any relaxation must be done very thoughtfully and carefully, in stages. I think they are trying. It's the same measures but with less room for any stringency—.

Mr. Don Davies: Do you think it is time to maybe look at interprovincial travel restrictions? I know Atlantic Canada had great success early on. Is it time for us to start looking at that?

Dr. Theresa Tam: The Atlantic area and the territories have actually done this. As I've said, it is a provincial matter. I am happy to support those discussions with the other chief medical officers of health, but anything that reduces mobility, whether it's between regions of the province or between different provinces, can be considered by them.

I also know that it's easier said than done, because of the necessity of accessing essential services, for example, on either side of those borders. It's not for me to get into that space.

One actual message I put out there is that you should avoid non-essential or recreational or vacationing in another province right now. Of course, there are reactions to that, but that's what the chief medical officers have come down to, asking if I can please message this across the country. Now is not the time to go skiing in British Columbia. That is really important to follow as well.

● (1605)

Mr. Don Davies: Thank you for the extra time, Mr. Chair. I really appreciate that.

The Chair: Thank you, Mr. Davies, and thank you, Dr. Tam.

Thank you to all the witnesses. It is really appreciated that you could spend your time with us today and give us the advantage of your expertise and knowledge. Thank you for what you do on a day-by-day basis, 24-7.

If there is no further business, we are now adjourned.

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