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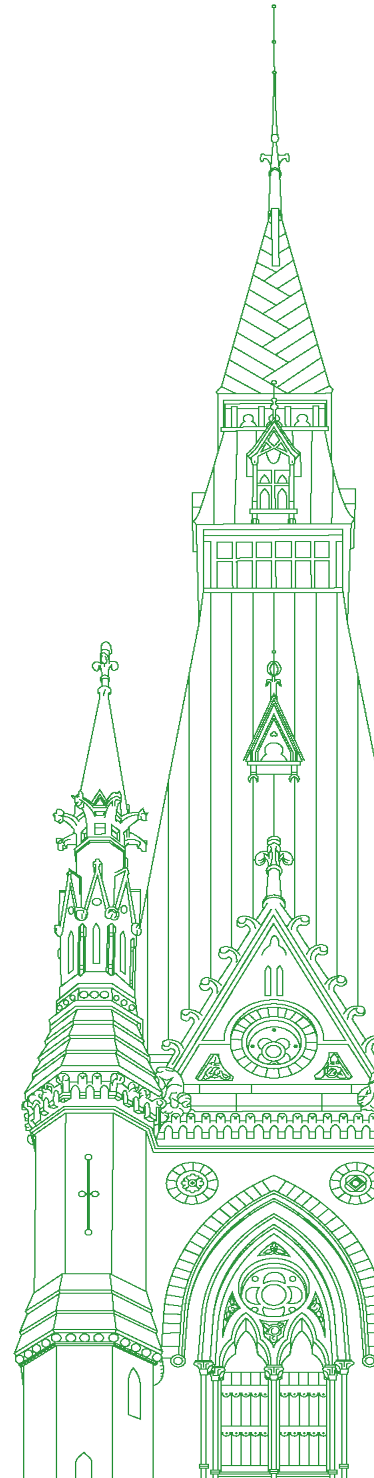

Chair: Mr. Ron McKinnon

# Standing Committee on Health

**Friday, May 7, 2021**

● (1300)

[*English*]

**The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)):** I call this meeting to order. Welcome, everyone, to meeting number 35 of the House of Commons Standing Committee on Health.

The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic, and specifically, examining Canada's national emergency response landscape.

I'd like to welcome the witnesses. As individuals, we have Dr. Lorian Hardcastle, associate professor, Faculty of Law and Cumming School of Medicine at the University of Calgary; and Dr. Wesley Wark. From the Ontario COVID-19 Science Advisory Table, we have Dr. Brian Schwartz, co-chair.

With that, I will invite the witnesses to make their statements.

By the way, I will display these cards. The yellow one is to indicate your time is almost up, typically a minute before, although sometimes I lose track. The red one is when your time is fully up. If you see the red card, you don't have to stop instantly, but please try to wrap up.

Thank you very much.

We'll start with Dr. Hardcastle, for six minutes.

**Dr. Lorian Hardcastle (Associate Professor, Faculty of Law and Cumming School of Medicine, University of Calgary, As an Individual):** Before I start, I want to thank you all for the opportunity to speak with the committee today.

I'll begin by first discussing the specific legal avenues open to the federal government before turning to some more general comments on the role of the federal government in the pandemic.

There's often a perception that health, including public health, is a matter of provincial jurisdiction, subject to narrow exceptions such as the Quarantine Act. This misguided perception and the hands-off approach that the federal government often takes with health is likely the result of the provinces being the ones who deliver most health care services, along with some political issues stemming from the funding of health care services and some politics around the Canada Health Act.

In fact, the federal government plays an important role in public health. The Supreme Court of Canada has repeatedly acknowledged that health is an area of overlapping jurisdictions. Furthermore, at this point, COVID-19 is not solely a health issue. What perhaps started as a health issue has also now become the largest social and economic issue of most of our lives. It has affected all facets of the lives of Canadians.

With regard to the specific legal avenues open to the federal government, the first and the one that's received the most attention is the Emergencies Act, which empowers the federal government to act in response to a public welfare emergency. This is defined to include a disease that results, or may result, in a danger to life or property, social disruption or a breakdown in the flow of goods or services. All of these things we've seen, to some extent, with COVID.

When a public welfare emergency is declared, the Governor in Council can issue orders and regulations on a number of matters, including restricting travel, directing persons to render aid, regulating essential goods and establishing hospitals. These powers may have been used, for example, to deal with the spread of COVID over provincial borders when the variants emerged, or to set up hospitals to serve as testing sites when many provinces were struggling in that regard. Although there is a consultation requirement under this legislation, the federal government does not need provincial approval to act.

The second option would be to draft COVID-specific legislation. Unlike the COVID-specific legislation that's already been drafted, which is primarily financial in nature, it would be open for the federal government to draft COVID-specific legislation that focuses more on the public health aspects of this issue.

This could be done by relying on their powers to legislate with respect to peace, order and good government, pursuant to section 91 of the Constitution. This power enables the federal government to act in response to emergencies or national concerns. We've heard from the Supreme Court of Canada that a pestilence would no doubt qualify under POGG. Although it is outdated terminology, of course, COVID certainly constitutes a pestilence.

Third, and finally, the federal government might have considered using its powers under section 11.1 of the Department of Health Act to issue interim orders on public health matters. Although this avenue hasn't received nearly the amount of scholarly commentary as the Emergencies Act or POGG, I understand that the committee heard about the Department of Health Act at its last meeting.

Turning now to some more general comments on the role of the federal government in a pandemic, I would first note that it's surprising to me that, in arguably the largest emergency this country has seen since World War II, we haven't seen the federal government turn to the exceptional powers granted under the Emergencies Act or pass COVID-specific legislation grounded in the POGG power. If the Emergencies Act was not used here, I am not sure when it would ever be used.

Not only have these powers not been used by the federal government, but they seem to have received very little vigorous consideration. Typically, what I've heard from the Prime Minister and others on this issue are rather vague comments as to the Emergencies Act remaining on the table or to the effect that they're considering all options, with very little transparency for the public in terms of why these powers aren't being used. I would want more transparency around that.

● (1305)

Does the federal government view the problem as a legal one, such that the Emergencies Act is inadequate to address these issues? If so, then I would wonder why the Emergencies Act wasn't fixed in the last year so that it was ready for the arrival of the variants and the third wave.

I'm concerned that the real reason we haven't seen greater federal action is political. We have heard from the premiers that they didn't want the federal government to invoke the Emergencies Act, saying that they could handle it on their own. Premier Moe said they could "effectively manage" it. This has clearly not been the case. Saskatchewan has not effectively managed this, but nor have provinces like Quebec, with the long-term care issues, or Alberta, which is experiencing the worst numbers in North America.

The provinces have relied on the federal government for financial support and preparing supplies, but the federal government's role in actually limiting the spread of COVID beyond that has been quite limited, with their focus being on financial fallout. I know there's a political cost to enacting public health restrictions, but I think trying to walk a political middle ground to try to keep the provinces happy and keep everyone else happy has the effect of undermining those rules. I would want to see the federal government transparently consider the use of the emergencies power and make decisions based on what's in the interest of Canadians rather than the politics of federal-provincial relations.

Thank you.

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

We'll go now to Dr. Wesley Wark.

Go ahead, please. You have six minutes.

**Dr. Wesley K. Wark (As an Individual):** Mr. Chair and members of the committee, thank you for this invitation to appear before the committee in its study of the current health emergency.

Many things have gone badly with our preparedness and response to the COVID-19 pandemic. The crucial first thing that went wrong was our early warning and risk assessment system. This, I think, must be understood and fixed. Early warning and accurate risk assessments are vital to preparedness and response. They buy precious time for informed decision-making and public communications. They save lives and treasure.

Canada had ample opportunity for proper, early appreciation of the threat posed by COVID-19. Because of what I call an epic failure of systems and imagination, we missed many significant signals as COVID began its relentless march across China, and then globally.

Canada's early warning system was not able to function effectively. The first GPHIN special report regarding a viral pneumonia outbreak in Wuhan, China, was issued on January 1, 2020, but no GPHIN alerts meant for a wider global clientele were authorized. Thereafter, GPHIN issued a series of daily and increasingly voluminous global media scan reports that were not geared for value for Canadian decision-makers.

In the period between January 7 and March 16, 2020, PHAC produced six risk assessments on COVID-19. I analyzed these reports in detail while serving as an expert consultant to the Auditor General. Until the final PHAC risk assessment on March 16, the agency delivered a consistently reassuring message that COVID-19 posed a low risk to Canada and Canadians. As the Auditor General found in her damning report, the methodology employed by PHAC in preparing these risk assessments was deeply flawed and untested. The risk assessments failed to consider forward-looking pandemic risk, and risk assessments were not discussed or integrated into decision-making.

Now, PHAC has accepted the Auditor General's report, as you know, and has promised a lessons-learned review, but it has also punted this review to December 2022 at the earliest.

To understand how we set ourselves up for such an abysmal failure, we have, I think, to look back to the period after the SARS crisis. In April 2004, with the SARS crisis still fresh on its mind, the government published Canada's first-ever national security policy called "Securing an Open Society". That policy stated:

> Going forward, the Government intends to take all necessary measures to fully integrate its approach to public health emergencies with the national security agenda. ...the public health dimension will figure prominently in the Government's integrated threat assessments....

Now, regretfully, none of this happened in the years after 2004.

What Canada must now build is a system for health intelligence that understands and utilizes the model of the classic intelligence cycle to achieve the following: timely, all-source collection; rigorous, high-quality assessment; reporting for impact on decision-making. When COVID-19 struck, not a single element of this system was in place within the federal government. We must also reinforce an international dimension, including full and timely sharing of health intelligence with the WHO as per the International Health Regulations.

A future system of the kind I'm advocating cannot operate within a PHAC silo. To escape from a siloed approach, we need to do a number of things. We need to produce a guiding national security strategy. We need, I think, to create a national security council structure at the centre of government to consider security threats, including health security, holistically. We need to build a health intelligence fusion or watch centre, and we need to ensure contestability by reaching out to experts and stakeholders. These are all concepts being explored in a path-breaking research project on reimagining a Canadian national security strategy for the 21st century, which is being led by the Centre for International Governance Innovation, CIGI, in Waterloo.

● (1310)

Our closest allies understand the need to do things differently. Britain has established, as of May 2020, a Joint Biosecurity Centre to better manage and use information and assessments to inform decision-making. President Biden issued a national security memorandum in January 2021, which calls for the establishment of an inter-agency national centre for epidemic forecasting and outbreak analytics to modernize global early warning.

Canada, alongside its allies, could be a world leader in global epidemic intelligence, but this will take innovative thinking, commitment to meaningful change—including organizational change—and urgency. I hope the committee will share my concern about these matters and lend its weight to this vital reform agenda.

Thank you.

**The Chair:** Thank you.

We will go now to Dr. Schwartz, please.

Go ahead for six minutes.

**Dr. Brian Schwartz (Co-Chair, Ontario Science Advisory Table):** Thank you, Mr. Chair.

Thank you for your invitation to speak with the committee today. I'm appearing here as a co-chair of the Ontario COVID-19 Science Advisory Table, a mostly volunteer group of 54 scientists drawn from across medical, scientific and mathematics disciplines.

We are not part of the provincial government. We operate entirely independently. While some of our members, including me, are public health professionals who may also work for government agencies, we do not operate as part of the public health apparatus of Ontario. We don't issue public health orders or recommendations. We don't advise communities on public health practices.

Our sole job is to seek out and analyze the scientific evidence that will help the government, public health and health professionals, and Ontarians fight the battle against COVID-19. We regularly brief different parts of the Government of Ontario. We make all of our work available to the public.

Today I am happy to share our thinking about what the scientific evidence tells us about the situation in Ontario, but I would ask the committee to bear a few things in mind as we have this discussion.

The first is that as an independent science table, it is not appropriate for us to comment on government policy. We can tell you what the numbers are and what they mean. We can say what the evidence tells us about measures that give us the best chance against COVID. We can tell you whether we see those things happening. However, it's not appropriate for us to review, criticize or assess any government's performance.

Second, our focus is firmly forward. I am a physician, and while many of the scientists on the table are not physicians, we think of our service to the population in the way a doctor might think of service to a patient. Arguments about the past don't belong at the bedside. Only the forward view helps the patient.

Finally, science is a process. Evidence evolves as the facts on the ground change. We're learning something new every day. There's a great deal more we don't know. In science, uncertainty isn't a failure. Uncertainty is part of the process.

With that, I will summarize a document we prepared last month, entitled “Fighting COVID-19 in Ontario: The Way Forward”. It represents our clearest thinking on what the current evidence says Ontario needs to do right now.

Since its formation in July, the Ontario science advisory table has operated according to three principles. One, we are guided by the most current scientific evidence. Two, we are transparent. All of our science briefs and presentations are publicly posted. Three, we are independent. While we generally advise the provincial government of what we say publicly, no government body or office vets or controls our scientific content or communications in any way.

More than one year into the COVID-19 pandemic, we know that the following six things will reduce transmission, protect our health care system and allow us to reopen safely as soon as possible.

The first thing is essential workplaces only. Some indoor workplaces have to remain open, but the list of what stays open must be truly essential while strictly enforcing COVID-19 safety measures. For example, essential workers must wear masks at all times while working indoors or when close to others outdoors, and must be supported.

The second is paying essential workers to stay home when they are sick or exposed or need time to get vaccinated. SARS-CoV-2 spreads when people go to work sick or after they've been exposed to the virus. Workers often do this because they have no choice. They must feed their families and pay their rent. An emergency benefit will help limit the spread if it offers appropriate income, is easily accessible and immediately paid, and for the duration of the pandemic is available to these essential workers when they are sick, exposed or need time off to get tested or vaccinated.

The third thing is accelerating the vaccination of essential workers and those who live in hot spots. Vaccines are essential in slowing the pandemic. We need to allocate as many doses as possible to hot-spot neighbourhoods, vulnerable populations, and essential workers; accelerate the distribution; and make it easier for at-risk groups to get vaccinated.

The fourth is limiting mobility. This means restricting movement between and within provinces. COVID-19 is not a single pandemic, because different regions of Ontario and Canada face distinct problems. Moving around the country may create new hot spots, because the variants of concern are so transmissible. People need to stay as much as possible in their local communities.

● (1315)

The fifth thing is focusing on public health guidance that really works. This means not gathering indoors with people from outside one’s household. It means people can spend time with each other outdoors, distancing two metres, wearing masks and keeping hands clean.

The final one is keeping people safely connected. Maintaining social connection and outdoor activity is important to our overall physical and mental health. This means allowing small groups of people from different households to meet outside with masking and two-metre distancing. It means keeping playgrounds open and encouraging safe outdoor activities.

What won't work are policies that harm or neglect racialized, marginalized and other vulnerable populations. They will not be effective against a disease that already affects these groups disproportionately. For these reasons, pandemic policies should be examined through an equity lens.

In conclusion, there's no trade-off between economic, social and health priorities in the midst of a pandemic when it’s at its peak, as it has been recently in Ontario and some of the other provinces. The fastest way to get this disease under control, as quickly as we can, is to do it together.

Thank you.

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

We will begin our questions with Ms. Rempel Garner, please, for six minutes.

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

My questions will be for you, Dr. Wark. I share your concern. You know, there's going to be a lot of time for inquiry, but we have to be getting things right now. Looking to change only in December 2022 is too late. I note that one of the significant variants of concern from India was identified in October of last year, yet Canada.... We're just so reactionary on emerging threats, even in the middle of a pandemic.

However, I digress. I wanted to get to recommendations on what we could do to fix some of these gaps right now and then going forward, so that we can include them in our report. The Auditor General's report talking about the risk to Canada being low and not looking at the forward-looking risk was very damning, as you said. What could we do differently right now?

I'm wondering if there's some sort of.... First of all, there's no centralized way of collecting intelligence. You talked about that. I think we need to remedy that, number one. Second, we need to somehow put that information into a very clear risk assessment system that can be used to assess a wide variety of pathogenic risks—almost like a Defcon-level system—so that it can be clearly communicated to the public. Third, associated with each of those risk levels would be measures that the government would undertake, be it flight bans or travel advisories or quarantine measures or whatnot.

That's roughly what's been in my head, reading the Auditor General's report, and I'm wondering if there's anything we could do right now, if it is reorganizing that way or not, to make sure we're not vulnerable, particularly to variants.

● (1320)

**Dr. Wesley K. Wark:** Ms. Rempel Garner, thank you for your question.

I suppose I should address the chair, but that's always seemed to me a strange formality. My apologies.

I think you make an excellent point, but I would say two things in response to the question of what we can do now. One is that there are a lot of, if you like, ad hoc possibilities for immediate application of the kinds of capabilities and talent that exist in the federal government.

The security intelligence community is extremely well versed in collecting all-source information and doing professional risk assessments. The problem was that, as I said, PHAC was siloed from that activity and that expertise. In an ad hoc fashion, the thing we need to see being done—perhaps it is being done behind the walls of the security intelligence community—is simply ensuring that the expertise and set of capabilities from the variety of agencies in the Canadian security intelligence system are available to PHAC for an ongoing risk assessment process.

I'm not even aware of the extent to which risk assessments may continue to be done. They were essentially stopped in March 2020 after it was realized that the pandemic had arrived. Now, perhaps they've been restarted. I don't know; I've not seen anything in the public domain on that.

There should certainly be an ongoing risk assessment capability. If we'd had one, it might have helped us prepare for second and third waves and variants and all the things we know of.

The last thing I would say is we just have to be careful to make sure that whatever ad hoc measures we take in our scramble to deal with an emergency don't get baked in as permanent measures. We have to keep our minds on what we ultimately want to achieve.

That's why I think there are some very important structural and strategic things that we need to undertake. A national security strategy.... We need a national security council structure, finally, at the heart of government. We need to have a whole-of-government intelligence collection and assessment capability to deal with not just health emergencies, but a range of non-traditional threats that we're now confronting in Canada.

**Hon. Michelle Rempel Garner:** Just to re-emphasize, as a legislator I see that one of the gaps is taking even that limited information we have right now and porting it into some sort of framework for action. I don't think the ad hoc nature is just limited to intelligence-gathering. I think it's also limited to porting it into consistent and cohesive action and then also monitoring the efficacy of that.

Would you characterize that as the right assessment of the situation right now?

**Dr. Wesley K. Wark:** I'm afraid I would have to say that seems to be the case, certainly up to the period in which we have some public documentation on how PHAC handled the emergency. Senior executives in the Public Health Agency of Canada and across the government have to—and I'm sure are now—taking the ongoing threat presented by COVID very seriously, in ways they weren't at the beginning, but—

● (1325)

**Hon. Michelle Rempel Garner:** Are you aware of any of those measures that are happening right now? Has there been any change since the Auditor General's report came out?

**Dr. Wesley K. Wark:** I'm not aware in detail, Ms. Rempel. I know there have been enormous changes in the senior leadership at PHAC. Clearly, some of those changes in the executive ranks at PHAC were designed very specifically to bring expertise from the security intelligence community into the agency. I think that's a good thing.

Organizationally—

**Hon. Michelle Rempel Garner:** I just have 30 seconds left.

If there was a country that you think did this well that the committee could be looking at for best practices, what country would that be?

**Dr. Wesley K. Wark:** Some obvious candidates—and they'll probably be familiar to many members of the committee—are among our Five Eyes partners. Australia and New Zealand come immediately to mind. That's not necessarily because they had better intelligence capabilities or better structures, but for some reason they were just more alert to the past history of pandemics and things like SARS, which we should have been alert to. Those are a couple of countries.

Some of the other countries in the region, such as Taiwan and Korea for example, certainly did better and were much better prepared to deal with COVID when it reached out beyond the Chinese border. We have a lot of lessons to learn from our global partners.

Very briefly, one of the things that troubles me about our response is that we weren't attempting to learn those lessons in the early stages of COVID at all.

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

We'll go now to Ms. O'Connell.

Ms. O'Connell, please go ahead for six minutes.

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

My questions are for Dr. Schwartz.

First, let me say thank you to you and your colleagues. I'm sure that at times this feels like a thankless job, but we certainly appreciate your expertise in coming together during this difficult time.

I appreciate your outlining very clearly the six priority areas you're talking about in terms of moving forward. I took note of them.

In that vein, my question is around the biggest risks you're seeing in Ontario right now. We have data that suggests more than 60% of outbreaks are from workplaces and education—43% are from workplaces and 21% from educational settings. In that vein, and with the six priority areas you mentioned, where do you see the biggest threat of spread in cases that are putting the strain on our health care right now in Ontario?

**Dr. Brian Schwartz:** First of all, thank you for your kind words, Ms. O'Connell.

I think the biggest threat moving forward is, in fact, related to crowded workplaces and crowded workplaces in hot spots. In particular, certainly less in education and more in workplaces involved with distribution and transportation, we have workers in those workplaces who live in hot spots, in crowded conditions and with other workers in multi-generational households, particularly in northwest Toronto and Peel.

Because of that, we have recommended, and the province is rolling out, very targeted vaccines to those areas. We're very gratified that those recommendations, which are based on some of the modelling we did, will—we hope—start being effective in reducing the transmission in those settings.

**Ms. Jennifer O'Connell:** Thank you for that.

In my previous life, I was also in politics, but at the municipal and regional levels in Ontario. We had some areas of responsibility over health through our local health agencies. Part of that responsibility is communication and educating residents on how they can help prevent the spread in this instance and, really, education on risks.

If we're looking at workplaces right now as the number one concern, I noticed your six priority areas don't cover borders. The kind of political.... I fully recognize your comments off the top. I'm not asking you to criticize a political decision, but if these are the areas of concern, and workplaces are the biggest threat, when it comes to the resources and the efforts to communicate with Ontarians in this case, would it not serve the broader public health measures to invest in resources that focus on the hot-spot areas or focus on the areas of concern to also arm and educate the public in those areas that are most affected right now? In putting communication priority on things like the borders, which account in Ontario for less than 2% of transmission, aren't we missing an opportunity to educate and help Canadians in stopping the spread? Is that a missed opportunity to educate our communities?

● (1330)

**Dr. Brian Schwartz:** If I understand, your question—and correct me if I'm wrong—is really about communicating the risks and the interventions that might mitigate those risks in those specific areas that are hot spots. The answer is that, while it's not part of that six-point structure, it's certainly a connector to those points, because we have.... Certainly, it is challenging to get into many of the communities. Again, the greater Toronto area is a very diverse population with many different needs. It really also speaks to things like vaccine acceptance. It's important to communicate risk in language that people understand—literally in languages people understand—as well as with the cultural sensitivity that's needed to communicate those risks and interventions in ways that are appropriate for the communities they have access to, and that they will accept.

**Ms. Jennifer O'Connell:** Thank you.

I'm switching gears just a bit, because I don't have much time left, but long-term care in Ontario is something very concerning. My riding in particular was hit very hard, and it was devastating. Early on we were told that everything that could be done would be done to protect long-term care through a second and now third wave.

In your professional view, do you think everything has been done that could be done to protect our residents in long-term care?

**Dr. Brian Schwartz:** Well, I think one thing that has been done is the targeted rollout of vaccine to elderly individuals, particularly in long-term care, and we've seen a tremendous effect of that program that's been very positive. I hope other interventions like reducing crowding within long-term care, increasing personal protection for health care workers and, again, looking at that as a very important workplace to reduce transmission, will be treated as very important.

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

[*Translation*]

I now give the floor to Ms. Gaudreau for six minutes.

**Ms. Marie-Hélène Gaudreau:** Thank you very much, Mr. Chair.

I'm very pleased to be with you today replacing my hon. colleague Mr. Thériault.

The two messages we heard gave me pause. Now that we have experienced this pandemic, others will follow. That is what I understand.

I also wondered about the role of the provinces and Quebec. While you were speaking, I looked up the word “confederation”, and it means an alliance of independent states. During a pandemic, the independent states forming a confederation must be consulted. Section 25 of the Emergencies Act actually stipulates that the lieutenant governors must be consulted before a state of emergency is declared.

I would like the witnesses to explain what consultations were held and what the outcome was. Logically, a health transfer should have resulted from the consultations, to address the critical needs during the pandemic.

A situation like this must not occur again. Obviously, we need to respect each other's powers, but each state must have the necessary tools and means, depending on factors like culture, language or territory. As I have heard so clearly, things vary greatly.

First, I invite Professor Hardcastle to comment on what can be imposed on all provinces.

● (1335)

[*English*]

**Dr. Lorian Hardcastle:** It depends what you're talking about imposing. Certainly some things might be more palatable than others for the provinces to accept federal involvement in.

One of the things, though, that comes to my mind as being the most obvious role for a federal government in this space would be—

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** Give me one or two examples, please.

[*English*]

**Dr. Lorian Hardcastle:** Sure. The travel issue is one very obvious example. We had B.C. saying they didn't know if they could prohibit travel across the Alberta border. They needed legal advice. They weren't sure. Meanwhile, on one side of the border, we have Banff, which is one of Canada's hot spots, and on the B.C. side, there are much lower rates.

To me, an obvious role for the federal government, which they could still do now as opposed to looking backwards and saying here's what you should have done a year ago, is to use the Emergencies Act to deal with that travel issue, as provinces have vastly different rates of COVID and that's how variants spread.

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** This pandemic was a first. If we were to go through another one, we would have to do it in a completely different way, especially in terms of consultations. What we went through, in my opinion, was far too focused on parliamentary sparring.

Before I finish, I'd like to ask Mr. Wark a question.

You mentioned New Zealand, Australia, Korea, Taiwan. Why do you think so highly of those countries? Do you have examples of what they have done to justify your esteem?

[*English*]

**Dr. Wesley K. Wark:** Very quickly, I think the key to the responses of the countries that have proved best able to deal with COVID-19 quickly out of the gate—countries such as Australia, New Zealand, Taiwan, and Korea—was first of all that they had the capacity to take the threat seriously and understand the seriousness of the risk. That was a capacity that linked public health experts with government decision-making. I think culturally, to be honest, in all those countries, it was rooted in their experience of SARS, a memory that stuck.

There were a whole host of issues, but one of the key things they did, and probably a key measure at the outset, was early and very strict border closures.

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** Excellent.

How much time do I have left, Mr. Chair?

**The Chair:** You have 30 seconds left.

**Ms. Marie-Hélène Gaudreau:** Excellent.

My question is for Mr. Schwartz.

Mr. Schwartz, you made it clear that the issues during a health crisis vary greatly. My understanding is that action is needed, but does it have to be consistent across the country? We will see how our analysis of the current crisis turns out. To get through another crisis, if ever one were to occur, we will need solutions.

It's absolutely necessary to respect the variables in the different provinces. Do you agree with me on that?

[*English*]

**Dr. Brian Schwartz:** The short answer is that there are different communities and different provinces that have different levels of the pandemic, and I think the key is twofold, Mr. Chair, if I could have about 20 more seconds. One is to reduce mobility in general and reduce numbers of contacts in general. The second is to reduce mobility from hot spots into low-transmission areas, because, particularly with the variants of concern, they can see them very quickly result in quick community transmission.

[*Translation*]

**The Chair:** Thank you, Ms. Gaudreau.

**Ms. Marie-Hélène Gaudreau:** Thank you for indulging me, Mr. Chair.

[*English*]

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

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

● (1340)

**Mr. Don Davies (Vancouver Kingsway, NDP):** Thank you.

Dr. Hardcastle, picking up on Dr. Schwartz's last comment, I think it's fairly common knowledge now that jurisdictions around the world, as Dr. Wark has pointed out, that were able to contain travel with hard stops had the greatest success in reducing transmission. We saw that in Canada with the early closures in Atlantic Canada.

I'm looking at the Emergencies Act, section 8. The very first power given to the federal government, were it to invoke the Emergencies Act, is “the regulation or prohibition of travel to, from or within any specified area, where necessary for the protection of the health or safety of individuals”.

My question is, is it only the federal government that has the constitutional power to regulate travel interprovincially and between provinces and territories? If they didn't do it, would any province have the ability to do it?

**Dr. Lorian Hardcastle:** The provinces can regulate travel within their provinces. Many have that in their public health act as an emergency power that can be done in a public health emergency. Many have it in their emergencies act provincially, but there does seem to be this reticence among some to use it.

For example, B.C. really was concerned about using it to keep Albertans out, so there seems to be.... Once that Albertan is in B.C., then they have the power, potentially, to exclude them, but there seems to be some concern about the legality of that, whereas with the federal government, I think there wouldn't be that same concern, because there's no question that they could do it federally.

I think there are problems with the variants moving from one province to the other. We had a situation in Alberta where one traveller came from B.C. to Alberta. There were 35 cases, at least one death and two ICU admissions, so these provincial borders pose real threats.

**Mr. Don Davies:** I guess, to put a finer point on it, I'm just wondering about the constitutional jurisdiction to regulate travel intraprovincially, within the province, and interprovincially. Paragraph 8(1)(a) gives the federal government the power to put in travel restrictions interprovincially. Is that a fair reading of the act? Am I reading it correctly?

**Dr. Lorian Hardcastle:** It is. I think where the provinces have struggled is that they know they can do it intraprovincially, but it's not clear what that means when it's right at the border, when you have somebody crossing over right at the border.

We know that the Atlantic travel ban has been the subject of litigation, but only on the charter front. It was never tested on the basis of division of power.

**Mr. Don Davies:** Of the several concerns that have been raised by the media—sometimes by the public, sometimes by the government—about the invocation of the Emergencies Act, one of them is, I think, the spectre of the former War Measures Act and its impact on civil liberties. Are there any protections or provisions in the Emergencies Act that speak to protecting civil liberties and might give Canadians comfort?

**Dr. Lorian Hardcastle:** Many of the public health measures we see right now raise those kinds of civil liberties issues. It's not clear how the federal government doing those sorts of things versus the provinces doing those sorts of things jeopardizes civil liberties more. All of this, of course, is subject to the charter. Government actions are subject to the charter. That is going to be the protection for your civil liberties.

The other thing, though, the Emergencies Act has is that things that occur under the Emergencies Act are actually the subject of parliamentary debate. There is that level of accountability. There are more mechanisms of accountability within the Emergencies Act than there are within the provincial public health acts, where you see extensive delegation to chief medical officers of health. There's very little accountability there.

**Mr. Don Davies:** My reading of the Emergencies Act is that it was designed, of course, in the mid-eighties, after the Charter of Rights and Freedoms. When I read the debates that surrounded the creation of the Emergencies Act, two things seem to have been present in the minds of parliamentarians at that time. One was the fact that the War Measures Act, when it was invoked in 1970, was explicitly not subject to the Canadian Bill of Rights or any charter. Second of all, it didn't require any parliamentary oversight. It gave unlimited powers to the cabinet to do whatever they wanted, and for any time period as well.

Are there provisions in the Emergencies Act that deal with giving parliamentary oversight, time-limiting the powers, and subjecting the Emergencies Act to the overriding superiority of the charter?

● (1345)

**Dr. Lorian Hardcastle:** Yes. Absolutely there are provisions around that. The declaration of the emergency is time-limited and has to be renewed. That helps with that. There is also parliamentary oversight in the Emergencies Act that doesn't exist with, as I say, some of the provincial public health rules that have been enacted and that wasn't present in the previous War Measures Act. Then, of course, there is the charter, so there are those measures of accountability that I think don't exist as much within some of the provinces and that didn't exist within the War Measures Act.

**The Chair:** Thank you. That ends round one. We'll now start round two.

We're short on time, but we'll try to have a shortened round two, with three-minute slots for the Conservatives and Liberals and a minute and a half for the Bloc and NDP.

Mr. Barlow, please go ahead for three minutes.

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

Mr. Wark, our focus today is talking about the responsibilities between the provinces and territories and the federal government. Part of the Auditor General's report stated that PHAC was supposed to do a national pandemic simulation in 2019. That actually would have happened before the COVID pandemic.

What difference would it have made had PHAC held that simulation to identify the capacity of provinces and territories to handle a pandemic and maybe address some of the obstacles that we've certainly seen over the last 18 months?

**Dr. Wesley K. Wark:** Mr. Barlow, that's an excellent question. I suppose it's a rhetorical question, in a way. I would just add one point. PHAC had been in the process of planning a national simulation for a public health emergency for nine years, between 2010 and 2019, and hadn't pulled one off. I think that speaks to the key question of how seriously they might have taken such a simulation even if they had conducted it.

I can't really speak to a simulation that they didn't conduct. Looking forward, it will be very important, and I think this is well understood, that we plan for a future pandemic risk. One way you can do that, in terms of ensuring preparedness and understanding gaps, is to do very regular systemic simulations of a variety of kinds.

**Mr. John Barlow:** Thank you.

Next, you mentioned the global public health intelligence network and how that wasn't working up to capacity. Again, this is a role that the federal government should have played when it comes to identifying a pandemic and putting out those warnings to the provinces and territories. Can you maybe go into a bit of detail? I know you have only a minute or so, but what happened with GPHIN that it wasn't working up to its capacity? What difference could that have made?

**Dr. Wesley K. Wark:** That's a great question. I don't really have an answer for you. I'm very much hoping that the independent panel the health minister has struck to look into this question will get to the bottom of it. Their interim report suggested that they hadn't been able—at that stage, when that interim report was prepared—to fully understand why the GPHIN alert system had been put on hold, which it had. They confirmed that reality, which we learned about through Globe and Mail investigative reporting.

I think it speaks to a larger, frankly, cultural problem in the Public Health Agency of Canada, which is that it took its sights off global health early warning and didn't feel this was a priority. For that reason, GPHIN was kind of put on the blocks. The risk assessment process wasn't properly instituted and staffed and resourced and fully understood.

This speaks to the significance of a real cultural change that needs to take place at the Public Health Agency of Canada, alongside much greater integration between health security practices and the national security community, which was exactly what was called for in 2004 and not implemented.

**Mr. John Barlow:** Thank you very much. I appreciate it.

Thanks, Mr. Chair.

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

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

**Ms. Sonia Sidhu (Brampton South, Lib.):** Thank you, Mr. Chair, and thank you to all the witnesses for joining us today.

My question is for Dr. Schwartz.

I come from Brampton, a community that has been the hardest hit in the entire province. We have seen the terrible impacts of the virus on our communities, workers, families, neighbours and residents. Have you provided any advice to the Ontario government that could have prevented the third wave?

● (1350)

**Dr. Brian Schwartz:** Thank you, Ms. Sidhu.

I very much feel for the Brampton community. It has been very severely impacted.

The science table watched with concern what was going on in Great Britain over the course of December and January. We were looking at the B.1.1.7 variant and how it affected Britain and western Europe.

Looking forward and in trying to prevent a fourth wave, the idea of keeping restrictions as restrictive as possible for as long as possible is a very important principle. As we said, reducing the number of essential workplaces and reducing mobility.... It's very hard to look back. I certainly feel for decision-makers who have a number of factors to take into account beyond the science of public health, like the economy and so on. I wouldn't want to second-guess the decisions that were made.

Looking forward, it's very important for us at this point to continue the lockdown as long as possible, to allow the vaccine to take effect.

**Ms. Sonia Sidhu:** Dr. Schwartz, did you give advice to them? Have they taken your advice?

**Dr. Brian Schwartz:** We'll find out. The advice that I spoke to—the six points—are in the public domain. Again, there are a number of factors in making very important decisions. They have to make decisions one way or another on a lot of evolving evidence and a lot of grey evidence that will impact what happens going forward.

What I can say is that the targeted vaccine will, I hope, reduce the transmission quicker than it would have if it had been rolled out on a per capita basis. Keeping the public health measures in place for a longer period of time will allow that vaccine effectiveness to take effect on a population basis.

**The Chair:** Thank you, Ms. Sidhu.

We'll go to Mr. Maguire now. You have three minutes, please.

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

My colleague, Mr. Généreux, has a question to ask. I'll let him go ahead.

**The Chair:** Go ahead.

[*Translation*]

Mr. Généreux, you have the floor.

**Mr. Bernard Généreux (Montmagny—L'Islet—Kamouraska—Rivière-du-Loup, CPC):** Thank you, Mr. Chair.

I thank my colleague for giving me the opportunity to ask a question. Actually, the question goes to all the witnesses.

As you know, Quebec was hit harder at the beginning of the pandemic last year. This was due to the fact that we had spring break earlier than other provinces, but also because we were close to the North American epicentre of the pandemic, New York State.

In light of that, do you think it would have been a good idea for the government to immediately stop all air and land border crossings, including those by the passenger buses that frequently travel between the two countries? Should the government have acted quickly to do that?

I'm referring to one of the witnesses who said earlier that the government was not prepared for the pandemic, unlike other countries such as Australia or New Zealand. After all, we should have learned from the SARS outbreak we had previously experienced.

So should we have acted sooner?

[*English*]

**Dr. Wesley K. Wark:** I'm happy to go first.

Very quickly, in response to the question, the answer is yes, absolutely. I think a variety of measures, including earlier border closure measures, would have been of assistance.

Quebec's timing with regard to its March break and the return of snowbirds and so on, was very unfortunate. Ontario had a similar experience.

If we had taken more seriously all the evidence in front of our eyes about the spread of COVID-19 globally and had been willing to act on that, Canada could have been in a much better position to protect itself nationally and provincially by, at the very latest, the end of February, if not earlier than that, and certainly not having to wait to go into mid-March before we took real action.

● (1355)

[*Translation*]

**Mr. Bernard Généreux:** Why did the government not take those steps? Can you answer that question? Why did the government not act more quickly?

[*English*]

**Dr. Wesley K. Wark:** This is a great mystery that we have to get to the heart of, and I hope, as Ms. Rempel suggested, that there will really be a serious, across-the-board, lessons-learned exercise. I haven't seen any sign that it's going to take place yet. We've had ad hoc efforts to learn some lessons.

At the heart of it, I think there was a systemic failure. We didn't have the structures in place to deal with the information that was coming to us.

Secondly, there was a failure of imagination. Those of you who are familiar with the 9-11 commission report out of the United States will recognize that term. It is that we knew, and should have known, that pandemics could hit us and could hit us hard. We knew that, but we didn't believe it.

Now, why is that? That gap, that failure of imagination, is a profound issue that somehow needs to be addressed going forward.

[*Translation*]

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

[*English*]

We'll go now to Dr. Powlowski.

Dr. Powlowski, please go ahead for three minutes.

**Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.):** I'm a little confused by the order here.

There's an embarrassment of riches on this panel. There are so many people I'd like to ask questions of.

Lorian, sorry. I can't get to you.

Dr. Wark, too, that was great testimony.

Dr. Schwartz, I'm going to put you on the spot a little because I have a bit of a bone to pick with the science council, and that's over the issue of the use of monoclonal antibodies by infectious disease people in Ontario who certainly want to use them.

There have been a couple of randomized controlled trials with the use of bamlanivimab—which our government bought 40 million dollars' worth of—published in pretty good journals, such as JAMA and the New England Journal of Medicine, showing a benefit when used early in high-risk people.

Another recent case-control study in Clinical Infectious Diseases showed that you needed to treat eight people to prevent one person being admitted to the hospital.

With bamlanivimab, I know the FDA changed its approval, but for the variants we have in Ontario, it still works on 90% to 92% of people.

With the whole bunch of new monoclonal antibody combinations, they're still waiting for approval by Health Canada, but there have been a number of studies, not yet published, in which manufacturers have shown pretty good evidence for a 70% to 80% reduction in hospitalization, again when used early in high-risk individuals.

In fact, a recent GlaxoSmithKline study of their monoclonal antibody had to be stopped early because it was considered unethical to continue the study because of the decrease in hospitalization.

Despite this, infectious disease people in Ontario, 12 of whom I recently wrote an op-ed with, who want to use monoclonal antibodies, can't get hold of it. Why is that?

It would seem that there are a few influential people who aren't elected, some of whom sit on the science table, who feel that there's not enough evidence for the use. What I would question is that these are non-elected people—these are a few infectious disease people—yet why should they have the power to control what other infectious disease people use as therapeutics? Therefore, I'm kind of questioning whether the science table is really serving the public in giving some advice.

Thank you.

**Dr. Brian Schwartz:** Thank you, Dr. Powlowski.

Mr. Chair, I'd like to take that question back, if that's okay, given the time and given my relative lack of expertise in infectious diseases and therapeutics.

We have a drugs and biologics working group that is looking at that. I appreciate the question and can get back to you through the clerk, if that's acceptable.

**Mr. Marcus Powlowski:** I'm happy with that.

● (1400)

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

To all the witnesses, if you have any further information you wish to share with the committee, please send it to the clerk. The clerk will ensure that it is translated and distributed appropriately to the committee.

[*Translation*]

Ms. Gaudreau, you now have the floor for one and a half minutes.

**Ms. Marie-Hélène Gaudreau:** Thank you, Mr. Chair.

We are trying to find out what happened between January 7 and March 7. I will tell you: we were distracted by parliamentary sparring. Since my party is the only one that doesn't want to take power, I can say these things. When parliamentary sparring predominates, it takes time to act when crises like the one we experienced arise.

Earlier, I heard my colleague say that, with respect to COVID-19 transmission, the border was involved in only 2% of cases.

Mr. Wark, I don't understand how you can say, all at once, that the government didn't act swiftly enough, that a variant came in from another country, and that managing the border is not that important.

I'd like to hear your opinion on that.

[*English*]

**Dr. Wesley K. Wark:** Sorry, I think I was on mute.

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** There is a lag because of the interpretation. I hope those few seconds won't count in my speaking time.

[*English*]

**Dr. Wesley K. Wark:** I'll be very brief.

It's a complex issue. I don't think it's properly understood. I'm not sure that CBSA and the government are doing a great service in treating the issue as they are.

The question is not just how many people come across the border with a variant that might be an issue. It's not a statistical question. It's a question of understanding how people crossing a border through various transportation nodes might be spreaders. We don't have the answer to that and I think we have to proceed very cautiously. We don't have the answer because we're not doing enough contact tracing and we're not doing enough testing.

I think the prudential thing is to say this is a bigger problem than the statistics suggest. We have to act prudentially in that regard.

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** That's all for me, Mr. Chair.

**The Chair:** Thank you, Ms. Gaudreau.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, go ahead for a minute and a half.

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

Dr. Hardcastle, I have some quick questions and hope you'll be able to give me quick answers.

In your view, does the current COVID pandemic in Canada meet the definition of being a national emergency under the Emergencies Act?

**Dr. Lorian Hardcastle:** Yes, absolutely. It's a disease. It's threatening human health. It's threatening supply chains. There is no question.

**Mr. Don Davies:** I have a related question. Does it meet the definition of a public welfare emergency under the Emergencies Act?

**Dr. Lorian Hardcastle:** Absolutely. I think it satisfies the definition of a public welfare emergency.

**Mr. Don Davies:** I know that you're from Alberta, so maybe you can think of Alberta, but also other provinces. In your view, has the third wave of COVID-19 exceeded any provincial government's capacity to respond effectively?

**Dr. Lorian Hardcastle:** I think that's exactly what we're seeing right now with the vast disparity between different provincial rates, the spread of the variant and the seeming inability they have to keep people out of their province—apart from the Maritimes. All those things point to an inability to manage this at the provincial level.

**Mr. Don Davies:** Finally, I'm going to switch gears a bit.

You have written about the issue of medical officers of health. Basically, you've said that in Canada, the law gives public health and safety officials the power—indeed the duty—to act. You point out that this is not subject to politicians approving it, but rather it's the other way around. In fact, you've said, "Canada's medical officers of health must find the morality and courage to stare down the politicians making dangerous errors. That is why our society entrusts them with sweeping legal powers."

Can you give us a little testimony about what their powers are and whether you think they're being exercised properly?

**Dr. Lorian Hardcastle:** In the provinces, the chief medical officers of health, for the most part—I'll speak broadly, but there's interprovincial variation—have the sweeping power to do almost anything necessary to contain a communicable disease. In the law, they're very powerful.

Where it gets complicated is the politics. For example, even though many chief medical advisors of health have broad legal authorities and the public health orders are in their names, at the same time, politically, they have been put in more of an advisory role. I think the provinces need to go one way or the other. Either they're independent people with legal authority who can speak out or act independently, or they are made subordinate to the government and their orders are subject to ministerial approval.

We can't have it both ways. We can't have these people be in charge when it's convenient for the provinces to have them be in charge or subordinate when it's convenient for the provinces. That's a—

● (1405)

**Mr. Don Davies:** Is that the case with Canada's chief medical officer as well?

[*Translation*]

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

[*English*]

**Mr. Don Davies:** Could I get a quick answer to that?

**The Chair:** Answer very quickly, please.

**Dr. Lorian Hardcastle:** No. That's a different role from in the provinces. The provinces have more power because they're doing this as day-to-day operations of public health.

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

Thank you, Mr. Chair.

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

That wraps up our questioning for this panel. I would like to thank the witnesses for sharing their time with us today and for their enormous expertise and great advice. Thank you for helping us with our studies.

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

● (1405)

_____________________(Pause)_____________________

● (1405)

**The Chair:** Welcome, everyone.

We are resuming meeting 35 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. Specifically, today we are examining Canada's national emergency response landscape.

I would like to welcome the witnesses. We have appearing today, as an individual, Dr. Lisa Barrett, assistant professor. Also as an individual, we have Reverend Michael Garner, Anglican priest.

I will invite the witnesses to go forth with their statements. I will start with Dr. Barrett.

I also advise the witnesses that I will be using these cards to indicate when your time is almost up. I will display this when there's roughly a minute remaining—but that's approximate—and this when your time is officially up. If you see the red card, you don't have to stop instantly, but try to wrap up.

Thank you.

With that, we'll go to Dr. Barrett.

Go ahead for six minutes, please.

**Dr. Lisa Barrett (Assistant Professor, Dalhousie University, As an Individual):** Thank you so much.

The invitation to bear witness here this afternoon is very much appreciated. Thank you to the committee for inviting me.

I'm an infectious disease physician and clinician, scientist and researcher at Dalhousie University, and I speak from that perspective today. Although I work with and collaboratively around both the Nova Scotia Health Authority and the public health department at the government of Nova Scotia, I speak as an individual here today.

I want to provide a bit of context perhaps of somewhat of a microcosm of the pandemic response from Atlantic Canada, specifically in terms of Nova Scotia and our response. As an infectious disease person, I think the things that have made our response arguably very successful.... We have, even with our current wave, 346 per 100,000 people who have had COVID-19 infections. To put that into context, other provinces include Ontario at 3,200 per 100,000 and Saskatchewan at 3,800 per 100,000. Again, as I said, there were 346 per 100,000 here in Nova Scotia.

We have arguably had a successful response and, as an infectious disease person, I would say there are several components to the response that are rather important.

Number one, we understood speed of response fairly quickly, as in infectious disease, speed is always important. Number two, that speed has added distance between human beings which, with a respiratory infection, is an incredibly important thing to do. Number three, in addition, there has been awareness of the infection and where it is through the use, primarily, of an exceptional amount of testing, both in people who are symptomatic and those who are asymptomatic, throughout the pandemic. The fourth, less quantitative and I think exceptionally important thing that we have managed to do as part of our pandemic response is to engage the community, not just as passive members of the pandemic response but as active members in being tested, getting tested, being the testers and being actively engaged throughout. I'll speak briefly to each of those components.

On the first part, speed, I'll use our most recent wave as an example. We went from zero to six cases per day from about last June until November, when we had a small number of increased cases up into the low double digits. Until then, we had gone back down to zero to six cases, again per day, with almost zero unlinked epidemiologic cases. For those who don't spend their lives looking at microbes and infectious diseases, that would imply that community spread was limited, which is very important. We knew where the cases were coming from and how. That changed in April. Between April 15 and April 21, we started to go into double digits of new cases per day, and there was the beginning of a signal by April 27 that we had community spread when we hit 97 cases per day. At that point, our restrictions went from being fairly open to being very closed.

In the intercurrent period between our waves, the Atlantic bubble still existed, and I'll speak to that in the distance part of things, when people coming into the region were required to quarantine. Anyone coming in from outside the Atlantic bubble.... In fact, our bubble burst a couple of months ago when our cases started to go up a little, and even people coming from within the Atlantic provinces were required to quarantine for 14 days.

The reason that's important is that we were able to keep track of where the cases were and how they were. At 97 cases, our government closed down public places where you would be unmasked and indoors, both retail and restaurants, etc., which had been open in between waves. Gyms were closed down very quickly, and people were asked to be at home. Then the cases went up even higher, into the hundred range, and the whole province was shut down. That's the speed part of things.

Seeing cases go up and community spread go up met the criteria that we have in place here that are quantitative: high numbers of unlinked cases, high reproductive numbers of the virus and case numbers going up in the community per hundred thousand. That was done very quickly, and distance was added. Inside, and in places where people can't mask, they were asked to do so quite a bit.

● (1410)

Then there was awareness. We always maintained asymptomatic testing between waves, so we knew when there was asymptomatic virus in the community. We also ramped that testing up to between 1.5% of the population per day when we went into this wave of the last week and a half ago and 5% of the population per day in our hot spots. In addition to that, awareness through our symptomatic testing was maintained.

On the engagement part, which I will be happy to give testimony on later, is the fact that we ran much of this testing outside our labs. Community-based volunteers were doing this work. There were taught to test, swab and provide an exceptional resource to people at the time, so we had a warning detection system for virus in the community.

I think, together, this has been an example of how we may be able to do things better in Canada and in different parts of the world as we go forward in this pandemic. The effects of speed of response, distance of people, awareness through diagnosis, and engagement of the community cannot be underestimated. I'd love to take questions on that afterwards.

Thank you for allowing me to speak.

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

We'll go now to Reverend Garner.

Please go ahead, sir. You have six minutes.

**Reverend Michael Garner (Anglican Priest, As an Individual):** Good afternoon, Mr. Chair and honourable members of the committee. Thank you for inviting me here today to speak with you.

My name is Michael Garner. I am an Anglican priest and an infectious disease epidemiologist. I worked at the Public Health Agency of Canada from 2006 to 2019. I was invited here today to expand on my comments in the July 25 edition of The Globe and Mail.

When the Public Health Agency of Canada was created in the aftermath of SARS in 2004, the government of the time decided that the chief public health officer should be the deputy head of the agency because then the authority and responsibility for public health in Canada would reside in one person who would be an expert responsible for the public health resources of the federal government. This leadership structure echoed most other national public health institutes around the world.

I trust you have all read the recent Auditor General's report on the performance of PHAC in the pandemic. The Auditor General's conclusion confirmed the reality of what all Canadians have been living. It said, “The agency was not adequately prepared to respond to the pandemic, and it underestimated the potential impact of the virus at the onset of the pandemic.”

Despite identifying a myriad of issues at PHAC, the Auditor General failed to identify the root of the problem. At no point did she ask why the systems were allowed to go untested. Why didn't the risk assessments from January to March of 2020 look adequately at the potential for COVID-19 to become a global pandemic?

Plainly, we have a national public health institute that is run by non-experts.

Six and a half years ago, the Harper government moved the leadership of PHAC from the CPHO, who is a public health doctor, to a president who is a career bureaucrat. This decision set PHAC on a course that has gravely influenced its ability to put into place the foundational elements required to proactively prepare for and effectively respond to the coronavirus pandemic. It also created a cascade where public health experts are no longer present at the senior levels of the agency. They have been largely forced out and replaced over time by generic bureaucrats with no experience in or understanding of the very basic principles of public health science.

Perhaps even more troubling was that in the midst of the pandemic, when faced with the need to install a new deputy head of PHAC in September of 2020 and with the failures of responding to the crisis evident to all Canadians, the Prime Minister, rather than installing a doctor with expertise and experience in public health and pandemic response, picked another career bureaucrat with no credentials in public health, who would have to learn on the job in the midst of the biggest health crisis of the last century.

Interestingly, the United States' CDC faced a similar situation of needing a new director. It replaced the outgoing director—a physician and virologist—with a physician and public health expert.

In the midst of the catastrophe of the federal response to the pandemic, the government has continued its long practice of devaluing expertise and subject matter competency in favour of bureaucrats. However, I would suggest to you that the failures in the PHAC response to the pandemic should not be pinned solely on the bureaucratic leadership of PHAC. If I was put into a cockpit of an airplane and the lights began to flash, I wouldn't understand what to do because I wasn't trained to be a pilot. It is unfair to expect Mr. Stewart or any of the other non-experts running PHAC to adequately manage the Canadian response to the pandemic. They don't have the training or experience required.

As we emerge from the pandemic—as we surely will—I hope this committee and others will initiate a re-examination of where public health experts are needed in the federal government. I hope the Public Health Agency of Canada Act will be restored to its original form, with the position of president of the Public Health Agency removed and that power restored to the CPHO role.

Ideally, this will initiate a new cascade, where public health training and expertise is valued over the ability to work the bureaucracy for personal gain. It is the decisions of the Harper and Trudeau governments over almost a decade that have led us to the depths of this crisis. The decisions of Mr. Harper and Mr. Trudeau have had a cost—a cost that has been paid for with the lives of Canadians who have needlessly died from COVID-19.

Thank you. I look forward to our discussion.

● (1415)

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

We'll start our questioning right now.

We will go once again to Ms. Rempel Garner, for six minutes, please.

**Hon. Michelle Rempel Garner:** It will be the Garner and Garner show here, I think.

I really appreciate your comments, Reverend Garner. The question is how we move forward.

I almost wonder if PHAC is the right organizational model, writ large, to deal with a public health challenge or a pandemic. In the previous panel, there were comments about four silos of work. There's the need to be able to gather intelligence on emerging pathogenic threats, to be able to meld that into some sort of a consistent warning system that is associated with clear action, and then to have some sort of monitoring for efficacy framework.

Do you think this is even possible with the current model of PHAC?

● (1420)

**Mr. Michael Garner:** The Public Health Agency, as originally constituted, was set up to manage the pandemic. You need to remember that the Public Health Agency of Canada was set up because of a coronavirus outbreak. It's the changes that have come, with the diminishment of science and the diminishment of public health expertise in the agency at the most senior of levels, that mean we're unable to act and understand the evidence and the signals that are coming.

I was listening to Dr. Wark's commentary, which was very interesting. He's right that we need a process of risk assessment, but ultimately if the risk assessment is going to someone who has no training to interpret and act on that risk assessment, we could have the best risk assessment in the world and we'd not be able to go forward.

**Hon. Michelle Rempel Garner:** In a minute or so, could you give us an illustrative example of where that lack of expertise impacted this particular pandemic?

**Mr. Michael Garner:** As someone who's not on the inside, it's hard to give a specific example of that, but I can suggest that GPHIN provides a nice example. You have a group of people who are in charge of GPHIN but don't understand that you have to keep looking for the pandemic, and the fact that you haven't found one yet doesn't mean you can stop looking.

If we look at the mandate letters of recent ministers of health, you'll notice that at some point “pandemic” falls off the mandate letter. I would suggest that “pandemic” should always be part of the Minister of Health's mandate letter.

Continuing to invest, despite the absence of this event that we're seeing, is part of the issue at hand.

**Hon. Michelle Rempel Garner:** Something else has struck me.

Absolutely, we need medical advice and that needs to be driving this. I can't even imagine the frustration you must feel.

This week we've seen, for example, a lack of clarity of communication on vaccines. How can we fix that? To me, that's something that needs to happen in the very short term. I think there's this fallacy that somehow the public doesn't perceive all the different moving parts that the government does in relation to, let's say, vaccine advice.

How can we fix that in the short term?

**Mr. Michael Garner:** You need bureaucrats. You need communications experts to help the public health professionals. Regarding that group at NACI, what they're saying needed to be run through with some communications people and tested and thought through. I know where they're coming from, but they're not thinking through all the various impacts. I think that's the thing.

In my comments, I'm not saying we don't need a bureaucracy. We do, but we need the public health expertise actually making the decisions, with the support of comms and bureaucrats and all the rest.

**Hon. Michelle Rempel Garner:** That is where I was hoping you were going to go with regard to a recommendation.

Tell me if I'm getting this wrong, but public health expertise has to be driving the advice, and then you need the suite of support experts—comms, even finance, looking at the corollary impacts or opportunity cost to public health—coming together in some sort of system to communicate to the public and then monitor the efficacy of that advice.

Is that what you're getting at? If so, is there any low-hanging fruit that the government could be implementing now to get to that point?

**Mr. Michael Garner:** In the movement in the 2014 revision to the Public Health Agency of Canada Act, where you had a bureaucrat put in charge of this organization, that's the key. The bureaucrat needs to support the CPHO, but ultimately a trained medical professional—a public health doctor or a public health nurse—needs to be responsible for the resources.

**Hon. Michelle Rempel Garner:** This is the last question.

I notice there's a lack of frontline clinicians involved in any area. There are just not a lot of people who actually practise. Do you think that's something that needs to be rectified as well?

**Mr. Michael Garner:** Do you mean in the federal government or on the ground?

**Hon. Michelle Rempel Garner:** I just mean, where are the frontline doctors advising the government right now?

**Mr. Michael Garner:** Yes, we need more public health expertise: doctors, nurses, epidemiologists who are not subordinate but are actually the ones with the decision-making power, who are supported by the bureaucracy. That's where we've gone wrong.

● (1425)

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

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

We'll go now to Mr. Kelloway.

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

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

My questions will be for Dr. Barrett.

Dr. Barrett, I want to thank you so much for taking the time to be here today. You are an expert, and you've been such a leader in Nova Scotia and in our response to COVID-19. I can speak on behalf of my constituents when I say I'm so proud—so proud—to have people like you representing our province.

We've demonstrated, I think clearly, that provinces can control the spread of this virus if they take a committed stance and follow provincial public health advice, so I have a couple of questions for you.

From day one of this pandemic, Dr. Strang and his public health team, and of course former premier McNeil and now Premier Rankin, have taken COVID-19 seriously by implementing very strict public health measures.

This is a chance, Dr. Barrett, to unpack the measures you spoke to in your opening statement. I'd like to hear a bit more and maybe do a deeper dive on that in respect to the first wave, but given the severity of our third wave, do you think we could be doing more?

I have one more question I'm going to put in there, because I want to take this time we have for you to answer these questions. With the record-high cases—I think it's 227 today, and I think that's a total of a little over 1,400 cases—can you tell us what you think the next couple of weeks look like for Nova Scotians? What advice would you give to those watching at home?

Thank you, and over to you.

**Dr. Lisa Barrett:** Maybe I'll start with the end first.

I think we have a bit of a rough go yet. We still have a large number of cases that are unconnected, and we're about day 10 or 11 into a lockdown. That's the real lockdown, not the kind of lockdown you see in some places. I think we're going to need a few more restrictions that are going to hopefully come into play right now. It's tough, because a lot of this is engagement, and I truly believe that Nova Scotians and Atlantic Canadians, and people, Canadians.... You can have the best bureaucrat in the world or the best doctor in the world leading something and suggesting to people they do something, and unless people are engaged at a real level and a granular level—at an individual level in places and provinces—you're not going to get a response, because people just won't do whatever is suggested. I think we have a rough few weeks ahead, but I think we'll get there, because there is an incredible amount of engagement.

Do we need to do more? Probably a little more. People need to get their heads back into last April's mode of a state of emergency, not current mode. I think that's probably something that heralds into the bigger picture here and what other places have done.

Nobody in Nova Scotia, because our numbers.... I mentioned to you that there are quantitative numbers that have been followed. To come back to the federal approach, I'm shocked and appalled that we haven't, as a federal agency, prescribed some quantitative measures of what would be useful guidelines for people in terms of regions and when they might loosen restrictions at different points. We've stayed pretty close to our quantitative measures of community spread, reproductive number of virus and number of cases on a daily, rolling seven-day average. This is not rocket science; this is called epidemic/pandemic management 101.

I'm surprised that we haven't federally required people in eight regions to do that at the provincial level before restrictions are reduced. I see headlines today about places that are thinking about reducing restrictions when the number of cases and unlinked cases is still exceptionally high. I know we won't do that, and I think that's a key, core part of what has kept us safe. That comes back to the four things, which are distance, speed, awareness through testing, and engagement. Testing has been a huge part of the way we're going to make it through this, but that's also because we have an engaged population. You can suggest anything. If people aren't doing it, then you're not going to get anywhere.

I think, one, yes, there's a bit more we need to do; two, it requires a little more engagement; and, three, I'm saddened and disappointed that we haven't done that with a prescriptive set of guidelines for provinces. I think it's a bit unconscionable that, just because you live in a different part of Canada, your public health advice may be a little different around things that can be helpfully quantitative and are able to be implemented.

**Mr. Mike Kelloway:** Thank you so much, Doctor.

I particularly like.... I think there are four pillars: awareness, speed, distance and.... What was the fourth one?

**Dr. Lisa Barrett:** It's the most important one: engagement.

**Mr. Mike Kelloway:** Engagement. Of course. That wasn't an artificial pause on my part; I just drew a blank.

It's an ongoing thing, obviously. The pandemic evolves, and our response to it evolves. Do you see those four pillars changing, or any additional pillars being added to those four measures or four pillars? For example, we're in a third wave now. Do you see us deviating from that or adding to that in terms of a repertoire to better engage people and better react to COVID?

● (1430)

**Dr. Lisa Barrett:** I think the pillars are core to the management of any infection that spreads with a respiratory mechanism. By that, I mean the way we implement those and the tools that are used, at times after vaccination, etc., are going to be different.

Surveillance, understanding where the virus is and how it's moving, and understanding the geolocation of different variants and what they look like all require the ability to test people frequently over time and to monitor borders, but not necessarily keep them closed. The tools we use in the toolbox are going to change, but I think the pillars remain the same and the goals remain the same.

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

How much time do I have, Chair?

**The Chair:** You're out of time already. You're right on the money.

Thank you, Mr. Kelloway.

[*Translation*]

Ms. Gaudreau, you have the floor for six minutes.

**Ms. Marie-Hélène Gaudreau:** Thank you, Mr. Chair. Your French is excellent. It's very nice to hear you.

My thanks to the witnesses. I must admit that it's great to hear about good practices. I commend the work that's been done at all stages, particularly in your case, Ms. Barrett. As you explained so well, we in Quebec saw a lot of enthusiasm for volunteering. People came together to support the community. They even created a website called jebenevole.ca. People were so supportive that it was hard to manage all the volunteers willing to help the community.

With respect to how quickly action was taken, I confess that I was also outraged at the two-month delay that we had to deal with. I'm thinking of the lives that could have been saved.

We are now in the third wave. I hear a lot of people saying that government actions are grossly inadequate. Mr. Garner's comments are very specific, and I thank him for that.

Ms. Barrett, I would also like to hear your comments about how quickly governments took action. I would also like to hear what you have to say about rules and communications, that is, the whole issue of government public relations in all the provinces and in Quebec.

[*English*]

**Dr. Lisa Barrett:** I'm certainly not a communications expert, that's for sure. I will comment from the perspective of the science and the infectious disease point of view.

The engagement part is important. I think it was interesting.... We didn't try to manage the volunteers. Once there was that wave of engagement that was partially generated, there was an opportunity. We generated opportunities for people to be engaged, particularly through testing. Not just around testing, but also as part of the testing events, as it was the actual people doing swabs and doing the point of care tests. However, we didn't try to manage that.

It's important that there is sometimes a great deal of oversight—paternalism, maternalism or they-ism—that comes into our public health responses, in that we try to control it. It's a notifiable disease. We let go of that a bit. We let go of medical professionalism and protectionism of fields to include people in a very real way that was very much generated by them as well.

I think if we're going to be successful as we go forward in any province, we have to give people a bit of autonomy at the same time as we're telling them to restrict. I'm not a human behaviour specialist, but I think that was an important part of the combination of responses here in Nova Scotia. I hope that's going to continue.

To your point about speed, we can't do this if governments aren't definitive and quick. The speed at which you take away the restrictions should be as slow and guided by quantitative measures as the implementation should be swift. Taking things away too fast, before the numbers go down, is a catastrophe.

In terms of speed and communication to people, we just provided a whole lot of information to folks in a real way and said that this is the way it is.

● (1435)

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** Congratulations, Ms. Barrett. You are a great role model. It made me realize that in Quebec, we're also very fortunate with respect to public health.

Mr. Garner, you talked about inertia in decision-making and the relationship between public health authorities and government. In my view, in Quebec, but certainly elsewhere as well, public health authorities made all the recommendations and codified everything that had to happen, such as restrictions or physical distancing, and the government made decisions. It all had to be done extremely quickly.

I'd like to get more clarity on the process: listen to the science, take responsibility, and put partisanship aside, because we're talking about human lives. We have a few seconds left, so I would like to hear from you on that, Mr. Garner.

[*English*]

**Mr. Michael Garner:** The challenge of public health is that our political benefit is to respond to something rather than to prevent, and I think that's the question of inertia. If we had prevented all the cases of COVID, people would ask why we were making such a big deal about it. Before things get bad, you need people in places of decision-making who can understand the potential for really significant outcomes and significant events. It think that's part of what I'm proposing—this reordering of the public health experts actually being in the places to make those decisions.

[*Translation*]

**The Chair:** Thank you, Ms. Gaudreau.

**Ms. Marie-Hélène Gaudreau:** Thank you, Mr. Chair.

[*English*]

**The Chair:** We'll go now to Mr. Davies, once again, for six minutes, please.

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

Reverend Garner, the Vatican recently threw its support behind the request of India, South Africa and I think almost a hundred countries that have proposed that the WTO waive the intellectual property restrictions that are preventing countries from getting access to technology to produce their own vaccines. Does the Anglican Church of Canada have an official position on this proposal?

**Mr. Michael Garner:** I'm here speaking as an individual and not as a representative of the Anglican Church of Canada.

As an individual, I think anything we can do to ensure that vaccines are distributed with equity and with rapidity is in line with the moral teachings of the church, so I think we want to see..., but that also goes for Canada. We want to ensure that, for people who have the least access, those barriers are removed. I think that is something we need to continue, both at the level of the federal government and all the way down to the local level, to ensure that the most needy of Canadians have equitable access to these vaccines and perhaps even preferential access.

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

Dr. Barrett, you recently co-signed an open letter in Maclean's, along with a group of leading Canadian physicians and researchers, calling for strict nationwide restrictions to control COVID-19. The letter said, among other things, the following:

> It did not have to be this way. A maximum infection suppression strategy implemented early in the epidemic to reduce COVID cases to as low a level as possible, and then stamp out outbreaks as they arise, would have saved tens of thousands of Canadian lives. This approach, with some modifications, remains the best strategy right now.

Dr. Barrett, you mentioned the word “nationwide”. Should the federal government use its powers under various pieces of federal legislation to bring in nationwide restrictions?

**Dr. Lisa Barrett:** It was a co-signed, fairly large group in the letter.

The nationwide part does refer to something I've alluded to a couple of times, which is that when you're talking about an infectious disease like this, there is science around some of the numbers that can lead to suppression and control. Some of those measures I've already mentioned around how fast the virus moves, how many contacts, the number of cases in a certain area and the ability to spread from person to person.

Therefore, if you have a certain number of cases and a certain type of interaction—distance was one of my pillars—nationwide guidance around areas that have parts of a pandemic that are out of control and suggestions for what to do at that point to limit the distance, increase the awareness or surveillance, and increase the speed of response and engagement, that would make exceptional sense to me.

I guess, in short, what I'm saying is that yes, there are quantitative things that people can fight about till the cows come home in terms of the exact number, but there is very good science around how to contain an epidemic like this. You take those numbers; you go to places that need that guidance and you provide them with the support and the guidelines to be able to do that. I think we need official and national guidance on those items. They don't have to be implemented equally across all regions, but in areas that meet the criteria, those guidelines should be followed or else you are going to see spread of the infection.

This is not a hypothetical; it's a definite, and we know how to fix that.

● (1440)

**Mr. Don Davies:** Right. I'll come back in a moment to maybe challenge a bit on guidance and suggestions versus measures.

You also wrote in an article on the Al Jazeera website that you noted that Atlantic Canada’s COVID-19 success has been due in part to the guiding principle that “prudence is best” when it comes to restrictions. The article said this contrasts with the approaches taken in other provinces, where people “opened things up before there were good, quantitative, number-based reasons to do so…and when 'lockdowns' were put into place, they were partial.” You were also quoted as saying that “essential activity included things that were not essential, like buying duvet covers.”

Should Canada adopt a nationwide, circuit-breaker shutdown to control this, so that we have a consistent application of that prudence-based model, or should we continue to leave it to the happenstance of provinces who might or might not follow that guiding principle?

**Dr. Lisa Barrett:** Your due diligence in reading the article is appreciated. I didn't write that; I said that. Just to be clear, it was an interview, and that was an interpretation and excerpt from the interview.

On that note, what I'm saying is that the guidance needs to be implemented in areas and regions. There doesn't need to be equal introduction of all restrictions at all points. That may be different for travel and borders. However, the implementation of guidance needs to be done regionally, in areas where there is connection with people.

What I mean by that is not all provinces have to do everything across their entire province at the same time, but the guidance around the numbers when you have a certain number of cases, a certain amount of transmission and a certain amount of unknown transmission should be done nationally. The implementation can be given at a provincial level in a regional way to still provide the same support and answers outside the border part of things.

**Mr. Don Davies:** Okay. That's fair enough.

More directly, in your view, should the Atlantic model of a 14-day quarantine for interprovincial travellers be replicated across Canada?

**Dr. Lisa Barrett:** The 14-day quarantine has been a large part of our success. I can't imagine that people and respiratory tracts are different in different provinces.

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

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

That brings round one to a close. I think we'll have time for an abbreviated round two as well. We'll do as we did for the last panel. We'll have time slots of three minutes and one and a half minutes.

I believe for the Conservatives we have Mr. Maguire next.

Mr. Maguire, please go ahead, for three minutes.

**Mr. Larry Maguire:** Thanks, Mr. Chair. I just want to go back to Dr. Barrett.

Dr. Barrett, I really like your four points. The speed, the distance, the awareness and getting people engaged are key.

I want to know how rapid testing fit into the model of the maritime bubble. Was it used extensively?

We are behind in vaccines compared to many of our G7 country colleagues, and vaccines weren't used as readily as they could have been.

I wonder if rapid tests were used more in the Maritimes. These other issues of distance and awareness are great, but I think the speed of response is one of the key issues. Could you expand on how rapid tests fit into that?

I know the government has made an announcement just today, but my colleague has been calling for this for over 10 months. We still have increasing numbers, so I wonder if rapid tests could be used in the variant areas as well.

● (1445)

**Dr. Lisa Barrett:** We have used all forms of the rapid point-of-care tests that have been disseminated from the federal government as part of the pandemic response. That includes two tests that have a machine and are not quite as easy to scale up or as portable, as well as a large number, over 100,000, of point-of-care tests that are almost like pregnancy tests. We've used them extensively and across the province, both in waves and between waves, for asymptomatic diagnosis.

The point of that testing in between waves is to provide us with a feeling. It's an early detection system in the community for an asymptomatic virus, because this is an asymptomatic virus that spreads easily. That was useful in helping us get an early fix on where the virus was and wasn't.

During the waves, it has off-loaded pressure from our medical systems because it is not being run in labs, of course, and it's also being done by volunteers. During this wave, we've managed to maintain asymptomatic testing of up to 5,000 tests a day to promote early detection and diagnosis.

**Mr. Larry Maguire:** Thank you.

I have just one quick question as well on the directness and decisiveness of the decisions that you made in the Maritimes to keep the numbers down as you did. As I mentioned in my previous question, I can see that early responses really help make that happen.

Did you use clear emergency information that you already had in the Atlantic bubble to be able to make those decisions as quickly and as decisively as you did, or did they just happen to be the right decisions that you used from common practice you've had in the past?

**Dr. Lisa Barrett:** I didn't make the decisions; our government did. I will say that the government took great advice; there was almost sole input from public health and they took advice from the science and the numbers. There was very little wiggle on other reasons to not shut things down or put restrictions in place very quickly. I would say there was rapid, decisive science used with a minimum number of distracting other factors. That seems to be, at least as an outsider, part of the decisiveness that was maintained through the first, second and third waves.

**Mr. Larry Maguire:** Thank you.

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

We go to Ms. O'Connell now, please.

You have three minutes; please go ahead.

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

Dr. Barrett, first, thank you for being here. I'm sure you're incredibly busy, and your testimony is quite helpful .

Quickly, as I only have three minutes, your point about strong restrictions—and I think you said real, not half measures—is one that I want to speak about.

Obviously, any sort of lockdown or restrictive measures are difficult for everybody. I don't think anyone would not acknowledge that's the case; however, I would assume death and severe illness would be far worse.

This past week, we had an emergency debate on the situation in Alberta, and some of the testimony by our Conservative health critic, our colleague here, referred to lockdowns. She said, “Lockdowns are a very bourgeois concept for a lot of legislators.” She said, “It is a luxury.” She referred to it as being “classist”.

The suggestion that was made was to just use vaccines, and then we don't have to get into this luxury lockdown situation. My community doesn't find that lockdowns are easy, but we do it to make sure we keep our communities safe and our loved ones safe. In terms of that context, is there any jurisdiction that was able to get through the pandemic with vaccines alone, given the fact that we know it takes time for the effectiveness to take hold, even when the person gets a vaccine. What is the importance of strong lockdowns in conjunction with vaccines, and why is this a public health measure and not a bourgeois concept, as has been suggested?

**Dr. Lisa Barrett:** Okay, I'm not quite sure how to respond to the concept. A lockdown is about distance, right? Distance is a key part of preventing and maintaining control of a respiratory illness transmitted by air. Distance is an important part of that; lockdown generates distance, so that's a fact, not an opinion.

It is a luxury if we don't support people who are homeless, under-housed and can't stay at home, and that is a key, core part of this. A lockdown requires a heck of a lot of support, and that should be provided and shouldn't be a luxury. Otherwise, vaccines are an adjunctive measure. You don't vaccinate your way entirely out of a lockdown situation or a high-spread situation. Everyone touts the U.K.; they used the lockdown with a massive vaccine rollout.

Then, to be clear, that's a combination measure. Vaccines are your long-term plan, not an acute plan. I'm happy to do an infectious disease management lesson on that, but that's the actual part of it. There's no such thing as one or the other.

● (1450)

**Ms. Jennifer O'Connell:** Thank you.

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

We go now to Mr. Barlow.

Please go ahead, Mr. Barlow, for three minutes.

**Mr. John Barlow:** Thank you very much, Mr. Chair.

My question is for Mr. Garner.

Thank you very much for your very frank and open testimony. That's certainly much appreciated in the situation we find ourselves in.

We were talking earlier with previous witnesses about some of the missteps along the way, and I know you can't give that inside information, but I found it interesting that PHAC was going to do a national pandemic simulation in 2019 but put it off. This would have been in partnership with the provinces and territories and in conjunction with the federal government, which is the focus of our study here.

What kind of a difference would that have made, from your expertise, in terms of identifying the capacity of provinces and territories to handle a pandemic and maybe identifying as well some of the obstacles or shortfalls that we may have had in that provincial-territorial-federal relationship?

**Mr. Michael Garner:** I think best practice for emergency preparedness, universally, is that you exercise. You practice and practice, and then, when the earthquake happens, you are basically running on muscle memory. In general, we can say that exercising those pandemic plans, and practising, would have identified issues in our response at that time, during the practice.

The challenge becomes how to respond to that. Do you have the willpower and the budget to make the changes to the plans that you then implement in response to the deficiencies that you have found, and then have to practice again? It is an iterative process, which, in the absence of a pandemic, can seem like a waste of money because you're spending all this money and not preventing anything, just preparing.

Again, it's that challenge of people who aren't emergency experts or public health experts being the decision-makers. They don't keep their eye on the prize; and the prize, at this point, was being prepared to respond to a coronavirus pandemic.

**Mr. John Barlow:** Thank you very much.

I have only a couple of seconds left. You bring up a really good point, which I don't know if any of us really asked about. It came out a bit during the debate the other night. We've seen the dismantling of the early warning system and that PHAC didn't go ahead with the simulation. During your time with the Public Health Agency of Canada, I'm assuming you felt confident, after H1N1 and SARS, that a global pandemic wasn't about “if” but “when”.

Wouldn't you agree that we knew this was coming and that we should have been prepared?

**Mr. Michael Garner:** Yes. We knew it was coming.

The challenge with public health is that it has a massive scope, from opioids to pandemics. It's really tough to focus on things that don't have an immediate payoff, and we're seeing the consequence now.

**Mr. John Barlow:** Thank you very much. I appreciate your time.

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

We'll go to Dr. Powlowski again. Please go ahead, sir, for three minutes.

**Mr. Marcus Powlowski:** That's an interesting comment and, I would suggest, Reverend Garner, that yes, public health has changed its focus in recent years away from infectious disease and towards non-communicable diseases. That was perhaps part of the problem.

I was also very interested in your allegations about the bureaucratization of PHAC, in terms of the doctors and scientists being replaced by bureaucrats. I want to perhaps engage you in a bit of an academic conversation. Isn't this something that has happened broadly across other departments, and not only here in Canada but globally?

I was speaking to a friend, a scientist who worked high up in the British government, and he was talking about the same trend of replacing content experts with bureaucrats. I know that in the hospital, it's basically the same thing. A lot of administrators are people who don't actually practice medicine. I think this is part of a broader movement. Why is that? Why don't we have people who are more content experts in positions of authority?

● (1455)

**Mr. Michael Garner:** I can't speak to the worldwide situation. I can say that most public health institutes worldwide have public health doctors or public health professionals in charge.

I agree that there is a move to more bureaucratic...or non-experts. I think, in part, it's because the advice of a doctor is hopefully going to be driven by health, whereas the advice of a bureaucrat can be balanced with politics. We have the example in Canada. There was a change made in 2014 that demoted the CPHO and promoted a bureaucrat to the head of that organization, and we've seen the impact throughout the Public Health Agency of Canada, where science is devalued and there is an inability to brief with complexity because the people you are trying to brief don't have any training in public health.

There are lots of examples worldwide. We could have an academic conversation, but we could also have a specific conversation about the impact of the decisions that both the Harper and the Trudeau governments made around the Public Health Agency of Canada Act, and say, “This is why we're in this situation.”

**Mr. Marcus Powlowski:** Is that why you left PHAC?

**Mr. Michael Garner:** It is not why I left PHAC. I loved working at the Public Health Agency of Canada. There are so many amazing public health professionals there, but I had a sense of calling and wanted to exercise some of my public health skills at a very local level, in a parish.

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

[*Translation*]

Ms. Gaudreau, you have the floor for one and a half minutes.

**Ms. Marie-Hélène Gaudreau:** Thank you, Mr. Chair.

This is my first term as a member of Parliament. It always amazes me to hear that public health people become administrators. The message sent to all Quebecers and Canadians was to trust in the science. However, clearly, no scientists are at the table. I am becoming aware of several things today, and I thank you for being here.

My question is for Ms. Barrett.

Ms. Barrett, you mentioned the key contribution of volunteers. I believe there was some mention of rapid testing. You talked about traceability and speed. Could you tell me more about what you did to help your community, because it might serve as a model for us.

[*English*]

**Dr. Lisa Barrett:** It's interesting, because many times I've spoken to many folks in many parts of this country, and the first thing that people always bring up is, “You're small. You can do this. You can engage people because you're small.” I think what I would say to people is that I've been doing this at a national level with HIV and hepatitis C for 15 years, and it's an economy of scale, in fact, smaller but fewer resources.

Anywhere can do this. You need to find the granular unit of engagement, whether that's a neighbourhood, a city or a municipality, in order to engage people. Here, we are smaller, but we sent out a very organic, grassroots call for volunteers, and instead of—

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** I'm sorry to interrupt, but my time will soon be up.

Do you have anything to say about rapid testing?

[*English*]

**Dr. Lisa Barrett:** All our rapid tests are run almost exclusively by volunteers. We said, “Hi, everyone. Would you like to come help?” They actually do the swab. They've been trained. They could be a secretary. They could be a librarian. They could be an airline attendant. They do the swabs. They do the physical tests. They do the reporting. They do the registering of people, and it's a tool of engagement in the community. Over 1,400 people so far have volunteered, and continuously volunteer over the course of seven months.

● (1500)

[*Translation*]

**Ms. Marie-Hélène Gaudreau:** Thank you, Ms. Barrett.

Thank you, Mr. Chair.

**The Chair:** Thank you, Ms. Gaudreau.

[*English*]

Mr. Davies, it's over to you now.

I must confess, I got distracted by the testimony, so I went a little over last time. Why don't you take two minutes this time?

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

Ms. Barrett, in that letter you co-signed to Maclean's, it says,

> As much as we might wish otherwise, COVID-19 is not done with us yet. The consistent failure to learn from the experience of other jurisdictions and even worse, failure to learn from our own miscalculations, is a sad statement on Canada’s political leadership.

I have two questions. In your view, what has Canada's political leadership failed to learn from other jurisdictions? Can you provide us with an overview of best practices from other jurisdictions that you think could be applied to Canada?

**Dr. Lisa Barrett:** That's a big one in a couple of minutes, so I'll try to squish it in.

I think we can learn from what's been going on in Atlantic Canada and Q-14. I don't know why we haven't done it in the rest of Canada. That's not another jurisdiction, but it's here.

Do things early. If you have a reproductive level of the virus that's 1.5, or if you have an average of 400 new cases a day in an area, don't leave your gyms and restaurants open for a week and a half to two weeks. These are just very practical things.

Don't not engage people. If you have people volunteering to do things, don't say that a medical expert needs to do a test that you can train a 16-year-old to do, who's one of my best swabbers. Don't turf protect.

In terms of other jurisdictions, New Zealand has always been a leader in this. Australia's always been a leader in this. They engage and they fund public health a lot. They lead by public health—not by having other people on the stage when they're giving direction and advice—and by scientists. I'm a scientist, so I'm biased, but I think that's helpful, and when someone says to do something like that, you do it quickly.

I am recapitulating some of the things I mentioned earlier but also with a few specific examples. Don't go far. We have a fairly successful example here in Canada within the Atlantic. Q-14 is a big part of it. Definitive policy is another part of it, and rapid testing and continued testing are a huge part of it.

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

That brings our questions to a close. I thank all of the witnesses once again for sharing with us their time and their great expertise.

It is most helpful and most important that we hear from you. I appreciate your time and your spending it here with us today.

Thank you all, members. With that, we are adjourned.

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