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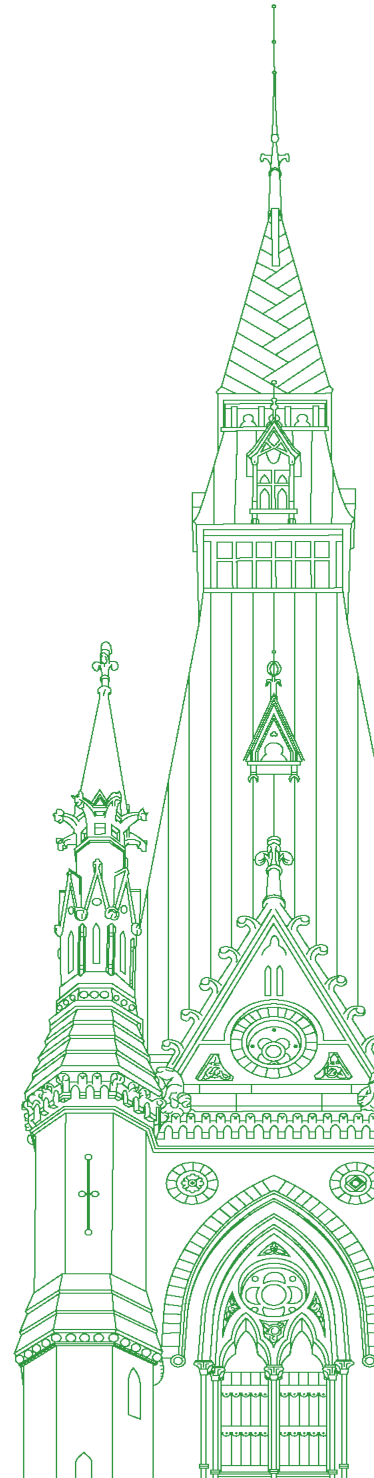

Chair: Mr. Ron McKinnon

Standing Committee on Health

Friday, May 21, 2021

● (1100)

[*English*]

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

Welcome, everyone, to meeting number 38 of the House of Commons Standing Committee on Health. The committee is meeting today to study a number of matters relating to the emergency situation facing Canadians in light of the COVID-19 pandemic.

I would like to welcome the witnesses. From Canada Border Services Agency, we have John Ossowski, president, and Denis Vinette, vice-president, travellers branch; from the Department of Health, Dr. Stephen Lucas, deputy minister; from the Department of Public Works and Government Services, Mr. Bill Matthews, deputy minister; from the National Advisory Committee on Immunization, Dr. Matthew Tunis, executive secretary; and from the Public Health Agency of Canada, Mr. Iain Stewart, president, and Dr. Theresa Tam, chief public health officer.

We'll start with statements from our witnesses.

Let's begin with Mr. Ossowski, please, for five minutes.

[*Translation*]

Mr. John Ossowski (President, Canada Border Services Agency): Good morning, Mr. Chair and members of the Standing Committee on Health.

Thank you for inviting me to participate in this discussion today.

[*English*]

I am pleased to be here to respond to your questions about how the Canada Border Services Agency is implementing and enforcing border measures during the pandemic. I am here with Denis Vinette, vice-president of the travellers branch at the CBSA.

Since the start of the pandemic, the CBSA made its pandemic response a priority. To help keep Canadians safe and protected, the Government of Canada has put in place emergency border measures to limit the introduction and spread of COVID-19 and its variants in Canada.

CBSA border service officers apply over 90 acts and regulations to safeguard Canadians. Over the last year, we have also implemented the provisions of 50 orders in council that apply to foreign nationals and residents of Canada. The OICs are designed to restrict travel and establish public health requirements so that we can reduce the spread of the virus into Canada. The measures have resulted in 96% less air traffic and a 90% drop in non-commercial traffic entering Canada by land, compared with pre-pandemic volumes.

It's important to point out that Canadian citizens, permanent residents and people registered as an Indian under the Indian Act have a right to enter Canada. However, all travellers seeking to enter Canada go through enhanced screening measures by CBSA border service officers, and must meet testing and quarantine requirements to keep Canadians safe, unless they qualify as exempt.

Of course, some cross-border travel is necessary to maintain the flow of goods and services critical to our economy and our people. The majority of individuals crossing in vehicles at the land ports of entry are essential service providers, such as truck drivers and nurses. We must continue to strike a balance between keeping Canadians safe and keeping the economy running.

Data shows that Canada's pre-arrival, on-arrival and post-arrival testing requirements, and quarantine requirements, are working. For example, over 99% of travellers entering Canada have either complied with the pre-arrival testing requirement or were exempt from it.

The CBSA continues to work with other Government of Canada organizations on the pandemic response. Our agency works in close co-operation with the Public Health Agency of Canada to implement and uphold the public health measures that are recommended at the border. The last year has shown that the CBSA is able to rapidly adapt its operations to put new processes, rules and orders in place. We are certain that we will be able to continue to respond to new and evolving measures, including the potential use of proof of vaccination credentials, to facilitate travel and manage the border.

Since the beginning of the pandemic, we have supported the government's efforts to establish strong measures to secure Canada's borders and to help prevent further introduction and transmission of COVID-19 and its variants into Canada. We have demonstrated our resolve and willingness to adjust restrictions based on scientific evidence. I am very proud of the work CBSA officers have done, and will continue to do, to protect Canadians and the Canadian economy in the face of this pandemic.

[*Translation*]

I would be happy to respond to questions from committee members.

Thank you.

● (1105)

[*English*]

The Chair: Thank you, Mr. Ossowski.

We'll go now to Dr. Lucas, deputy minister.

Please go ahead for five minutes, please.

Dr. Stephen Lucas (Deputy Minister, Department of Health): Thank you, Mr. Chair.

It's a pleasure to be here along with colleagues from the CBSA, PSPC, Public Health Agency of Canada and NACI.

[*Translation*]

My remarks today will focus on the actions that Health Canada has taken to keep Canadians safe during this pandemic.

Health Canada is the regulator for health products, including therapeutic products, vaccines and medical devices. Our scientists review health products for their safety before they can be sold in Canada.

[*English*]

Early on, we recognized the need to facilitate the authorization of COVID-19 treatments and vaccines, given that in the early stages of the pandemic none were available. Health Canada expedited the review of COVID-19 clinical trial applications, treatments and medical devices through the use of interim orders so that Canadians could have access to the products they needed to keep safe. We have authorized 265 disinfectants, more than 4,500 hand sanitizers, 645 medical devices and two treatments.

In the context of treatments and vaccines, rolling reviews permitted manufacturers to submit their requests for authorization before they completed all of the clinical trials, allowing Health Canada to evaluate the data of promising candidates as it became available.

As you know, Health Canada has authorized five different COVID-19 vaccines. Ongoing monitoring of the safety and effectiveness of these vaccines is a priority for Health Canada. We also require evidence of product quality before each lot of vaccine is distributed in Canada. This is true for the Janssen vaccines received on April 28 that contained drug substances that were manufactured at the Emergent site in the United States. Health Canada continues to work closely with Janssen and our international partners, including the United States Food and Drug Administration, to confirm the quality of the supply, given the issues reported by the USFDA after its inspection of the Emergent facility in April.

Let me take a moment now to say a few words about testing and screening, which, along with public health measures and vaccines, help to slow the spread of COVID-19.

As of May 15, the department had approved 68 test kits, including 17 rapid tests. More than 27 million rapid tests have been shipped to the provinces and territories. In addition, as of May 18, the Government of Canada has provided almost 1.5 million rapid tests directly to private and not-for-profit organizations in critical sectors across the country. These rapid tests used in screening programs can help to identify pre-symptomatic and asymptomatic cases so they can be isolated early to help stop the spread of COVID-19 in workplaces and other settings.

As vaccine rollout continues, testing and screening remain important in protecting public health and supporting reopening.

[*Translation*]

Now more than ever, Canadians need access to virtual health care services.

[*English*]

The government is supporting the expansion of virtual care in Canada, which will help reduce the pressure on health systems and provide Canadians with needed health services and authoritative information in a safe and secure manner through telephone, text or video conferencing, in addition to face-to-face visits.

In May 2020, the government announced an investment of $240.5 million to increase access to virtual services and digital tools to support Canadians' health and well-being, and $150 million of that funding is being provided to provinces and territories through targeted bilateral agreements. In addition, Canada Health Infoway will receive an additional $50 million to support provinces and territories in their efforts to implement these new virtual health initiatives and work with the Canadian Institute for Health Information on content standards for virtual care.

In conclusion, we continue to work closely with provinces, territories and other partners to adapt to the challenges of delivering health care during the pandemic.

I look forward to answering your questions.

[*Translation*]

Thank you.

[*English*]

The Chair: Thank you.

We'll go now to Dr. Tam.

Dr. Tam, please go ahead for five minutes, please.

Dr. Theresa Tam (Chief Public Health Officer, Public Health Agency of Canada): Thank you, Chair and members of the Standing Committee on Health, for inviting me to speak to you today.

The Government of Canada has taken a whole-of-government approach in its response to the COVID-19 pandemic.

Every day we are achieving important milestones in Canada's vaccine rollout. In just five weeks, we have doubled the number of COVID-19 vaccine doses given across Canada, from 10 million doses administered by mid-April to almost 20 million doses administered to date. As of May 15, 55% of eligible adults have received at least one dose of COVID-19 vaccine.

As outlined in Canada's COVID-19 immunization plan, the goal throughout our campaign has been to enable as many Canadians as possible to be immunized as quickly as possible against COVID-19 while ensuring that high-risk populations are prioritized. In doing so, we will reduce serious illness and death while minimizing societal disruption.

To meet these goals, we have conscientiously relied on the accumulating scientific data, the emerging evidence and the guidance of public health experts to inform our decisions, strategies and recommendations. The Public Health Agency of Canada's vaccine rollout task force has been guided by committees of immunization experts such as the National Advisory Committee on Immunization and through close collaboration with provincial and territorial partners.

Grounding our approach in public health science and equity resulted in the identification of priority populations and the extended dose strategy currently in place. These strategies have been instrumental in meeting our public health goals and maximizing protection both for at-risk groups and the population overall.

Although the national daily number of COVID-19 cases remains high as we continue to feel the effects of a variant-driven third wave, there is reason to be optimistic, as public health measures are demonstrating an impact and vaccination coverage broadens. Over the past seven days, there has been a more than 25% decrease in daily cases, and compared to last week, the number of patients in hospitals has dropped by 10%. Nationally, deaths have decreased by 15% compared to last week.

The success of vaccinating priority populations first, specifically people 70 years of age and older and those living in congregate settings, is borne out by the observation that this age group has the lowest case rate nationally, and its hospitalization rate is also decreasing.

While nationally all age groups are seeing a decline in case rates, people aged 20 to 39 years old now represent the highest rate of infection. As additional age groups become eligible to book vaccines in different jurisdictions across the country, this highlights the importance of everyone stepping up to get their shot as soon as it becomes available to them.

We are committed to removing barriers to vaccination and building vaccine confidence. The success of the vaccination campaign relies on as many people as possible taking part. We are broadcasting this message loud and clear through the nationwide “Ripple Effect” communications campaign launched this week, which uses multiple multiple mass media formats to encourage vaccine uptake. I, myself, am reaching out to key priority groups such as personal support workers and key influencers such as faith leaders and YouTube personalities popular amongst younger adults.

The good news is that a strong majority of adults in Canada have indicated an intention to become vaccinated. However, despite this encouraging finding, we know that we must sustain our pace of vaccination even as coverage rates climb. As case rates come down and there is pressure to relax health measures, there remains a risk that those who face barriers to accessing vaccines will be left behind.

In this regard, community-based efforts to encourage vaccination will be crucial in the coming months. We know from experience that those approaches are effective. For instance, we have seen positive results in vaccine uptake using approaches that engage indigenous leaders and supporting, for instance, urban vaccine clinics operated by indigenous organizations, and we have seen success in reaching racialized and marginalized communities with information about vaccines by engaging individuals in their own languages and on platforms they already use.

Through dedicated funding, we are doing more to support the efforts of those with the expertise and capacity to promote vaccine confidence in their communities, especially in those communities experiencing health and social inequities or that have been disproportionately impacted by the COVID-19 pandemic.

● (1110)

The immunization partnership fund has provided $3 million per year since 2016, supporting 22 projects to increase vaccine uptake. In 2020 an additional $30.25 million was confirmed to fund more than 100 projects focused on capacity for health care providers and community-based programs, specifically social media campaigns, targeted resources and frontline interventions.

The vaccine community innovation challenge, funded with $1.5 million, supports projects in diverse communities to help spread the word about vaccines, increasing vaccine confidence through creative, community-driven and culturally appropriate means.

There is reason to be hopeful as we begin to feel the impacts of widening vaccine coverage across Canada, but we're not yet in the clear. Long-range modelling suggests that new cases will continue to decrease if current measures are sustained. We have an important window of opportunity to bring COVID-19 under control in Canada very soon, but it requires two key actions. The first is getting vaccinated as soon as it is possible to do so. The second is continuing to follow public health measures until it is truly safe for them to be relaxed. These two elements will provide the vaccination campaign the environment it needs to yield the highest possible results to protect Canadians and support the reopening that we all so eagerly await.

Thank you.

● (1115)

The Chair: Thank you, Dr. Tam.

We'll start our questions now.

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

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

I will start by directing my questions to Mr. Stewart.

On what day did you become aware of the allegations against Major-General Dany Fortin?

Mr. Iain Stewart (President, Public Health Agency of Canada): Mr. Chair, honourable member, there are two elements to that question. I first became aware that there was some issue in the third week of March—round about—and then of the specific allegation, moving into a process, I became aware on May 13.

Hon. Michelle Rempel Garner: Thank you.

On what day did you first discuss or correspond with the Minister of Health or any staff within her minister's office regarding the allegation against Major-General Fortin?

Mr. Iain Stewart: I discussed the allegation with Minister Hajdu on the afternoon of May 13.

Hon. Michelle Rempel Garner: So you were aware that something was going on in March, and you had no correspondence with the minister or any of her staff—

Mr. Iain Stewart: I did not—

Hon. Michelle Rempel Garner: —until May 13.

Mr. Iain Stewart: Mr. Chair, honourable member, that's right. I did not raise the March...understanding that it was unclear what exactly was involved, so I did not raise it with the minister.

Hon. Michelle Rempel Garner: Who made you aware of this issue in March?

Mr. Iain Stewart: In March it was the deputy minister of national defence.

Hon. Michelle Rempel Garner: What was described to you as the issue at that time?

Mr. Iain Stewart: It was that there was an issue affecting Major-General Fortin, but its nature was not apparent. That was just kind of a heads-up that there was a potential issue.

Hon. Michelle Rempel Garner: Was the potential need to replace Major-General Fortin discussed at that time?

Mr. Iain Stewart: No. We did not discuss that at that time.

Hon. Michelle Rempel Garner: At what point was the need to replace Major-General Fortin discussed?

Mr. Iain Stewart: May 13 is when we decided that there needed to be a change.

Hon. Michelle Rempel Garner: Mr. Stewart, did you ask any other questions of your colleague at National Defence after first being made aware of this allegation in March?

Mr. Iain Stewart: This is an area that involved some kind of situation that would pertain to personal information concerning that person. Also, it was regarding a serving member of the Canadian Armed Forces. It's not a space that the Public Health Agency would get involved in.

Hon. Michelle Rempel Garner: Did anybody suggest to you, between the time you were first made aware and May 13, that Major-General Fortin might need to be replaced?

Mr. Iain Stewart: Well, I certainly began thinking: If there is some incident, what would it entail? I guess that's kind of what my response was.

Hon. Michelle Rempel Garner: Did you share those concerns with the Minister of Health?

Mr. Iain Stewart: No. I did not.

Hon. Michelle Rempel Garner: Why?

Mr. Iain Stewart: It's an operational matter. The personnel at the Public Health Agency of Canada and the teams involved are under my responsibility.

Hon. Michelle Rempel Garner: Did you have any concerns that an undisclosed problem with the person in charge of Canada's vaccine rollout might be problematic?

Mr. Iain Stewart: As I said, I began to think about it, but at that time, it actually wasn't clear what we were dealing with.

Hon. Michelle Rempel Garner: Did you press for any more information between March, when you were made aware of this, and the end of May?

Mr. Iain Stewart: Who pressed for information from...?

Hon. Michelle Rempel Garner: I meant you. Did you do anything to get more information to understand how this might compromise Canada's vaccine rollout?

Mr. Iain Stewart: We have a highly effective and well-performing team that involves over 200 people doing the vaccine rollout. We have a variety of executives leading that team, including 2ICs, etc. The vital mandate of the vaccine rollout is taken extremely seriously by this organization. At that stage it was not clear what the potential issue was, nor was it clear what the repercussions were going to be.

● (1120)

Hon. Michelle Rempel Garner: Did you discuss this issue with anyone in the Privy Council Office, any other minister's office or the Prime Minister's Office when you became aware of it in March?

Mr. Iain Stewart: As I mentioned, when I became aware of it I did not discuss it with the minister or with the minister's office; nor, of course, would I discuss it with the Prime Minister's Office.

Hon. Michelle Rempel Garner: Was there no one else you discussed it with beyond the person who made you aware of it in March?

Mr. Iain Stewart: Do you mean within my organization? What do you mean?

Hon. Michelle Rempel Garner: Sure. I just want to know who knew, essentially, once you became aware of this.

Mr. Iain Stewart: I have a chief of staff, for instance. I would have discussed it with my chief of staff just as an issue that we were thinking about.

Hon. Michelle Rempel Garner: Thank you.

Mr. Stewart or Dr. Lucas, by what date do you currently expect 20% of Canadians to have received both doses of vaccine?

Mr. Iain Stewart: Steve, are you going to answer that or do you want me to?

Dr. Stephen Lucas: You go ahead, Iain.

Mr. Iain Stewart: We're trending well toward late June to make an achievement of that nature.

Hon. Michelle Rempel Garner: Thank you.

What date do you expect to have about 50% of Canadians having received both doses of vaccine?

Mr. Iain Stewart: Two doses of vaccine I think would be something we would be achieving in July—the back end of July or August. It would be in around then.

Hon. Michelle Rempel Garner: Thank you.

This is my last question.

Mr. Stewart, do you think that not acting on a potential allegation of sexual harassment might send out the wrong message to women in your department as well? I'm just kind of flabbergasted that you would know about this in the middle of March and not do anything about it.

Mr. Iain Stewart: I can't possibly be more clear than to say that I did not know there was an allegation of a sexual nature. There was a potential issue. There was no allegation. You're using words that I knew about an allegation. There was an issue. I was aware that there was an issue, but its exact nature was not specified. We did not have an allegation.

Hon. Michelle Rempel Garner: You didn't think that, like—

The Chair: Thank you, Ms. Rempel Garner.

We go now to Ms. Sidhu for six minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Thank you to all of the witnesses for being here today and for all of the hard work you are doing on the front line.

My first question is for Dr. Lucas.

Dr. Lucas, while PCR tests are the gold standard, rapid tests are important tools in our arsenal and so far the federal government has provided millions of rapid tests to provinces and territories. How many rapid tests have been procured for the provinces and territories? How many have been procured for Ontario?

Dr. Stephen Lucas: Mr. Chair, as I noted in my opening remarks, the federal government has procured and shipped approximately 27 million rapid tests to the provinces and territories. There are approximately 11 million for Ontario.

Ms. Sonia Sidhu: What role can rapid tests play in certain high-mobility settings? How can provinces and territories use them effectively?

Dr. Stephen Lucas: Rapid tests have been demonstrated to be useful in regular serial screening of people, as well as helping in settings where there are outbreaks for rapid screening followed by confirmatory PCR testing.

The government in Nova Scotia has used them effectively in settings in downtown Halifax, for example, for patrons of restaurants and bars in terms of rapid screening. It has used them through the wave that the province has been experiencing over the past several weeks.

Ms. Sonia Sidhu: Thank you.

The next question is for Dr. Tam.

Dr. Tam, you talked about community-based approaches. I'm from Brampton in the Peel region, and about 60% of the adult population have received a first dose. It's now being made available to anyone over the age of 12. The vaccine has been made available through alternative clinics, such as those targeting specific culture groups for people working high-risk workplaces.

Can you speak to the importance of these alternative clinics in the efforts to reach all the population?

● (1125)

Dr. Theresa Tam: Yes, it is really important to use every method available. At this point in time, when vaccines are essentially now being provided to all eligible groups in many areas of Canada, I think having more targeted approaches means really listening to the community and what their needs are. That is very important.

Some of it will necessarily come from providing more information to individuals, but a lot of it is about trust. Having community leaders, having language support and having the clinics open during all hours are really important for access purposes. I do think that all of these efforts combined are really important.

As I mentioned in my opening remarks, some of the key target groups will be younger adults, as well as workplaces and engaging the private sector to see what more can be done to encourage vaccine uptake. With some of the examples we have, I think that best practices can be transferred across Canada.

Our vaccine community innovation challenge has been really very, very popular in these projects supporting diverse communities like the ones you just talked about. I'm really optimistic, and I think, with everybody's support, including community groups, we will get there.

Ms. Sonia Sidhu: Thank you.

The next question is for Mr. Matthews. The government said back in December that every Canadian who wanted a vaccine would be fully vaccinated by September. How many doses have been administered so far, and how many people have been vaccinated? Do you believe that we are on track to meet this goal?

Mr. Bill Matthews (Deputy Minister, Department of Public Works and Government Services): I can speak to procurement of vaccines, but questions about rollouts and being on track, I think, are probably a better directed to my colleague Iain Stewart.

Mr. Iain Stewart: Regarding the vaccine rollout, we definitely are on track. In fact, we just clocked 20 million doses administered, I think, in real time during this proceeding today. There's always a bit of a difference between what we've distributed to the country, which is about 23 million doses, and what the provinces and territories have been able to organize, line up and deliver. They just hit 20 million doses for Canadians.

That takes us to about 48% of Canadians who have now received their first dose, so the vaccine rollout is a huge effort. The provinces and territories are, of course, doing much of the delivery work, but it takes a large collaborative team, and we're very pleased with the progress being made.

Ms. Sonia Sidhu: Thank you.

To Dr. Lucas, how does Canada compare with the United States and comparable countries in the G7 and G20 in terms of vaccination rates?

Dr. Stephen Lucas: Canada's rate of administration on a per capita basis is certainly significant at this point. In terms of first doses administered, we're at about the same level of the population having received it as the United States.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

We will now go to Mr. Thériault.

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

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

My first question is for Dr. Lucas.

This week, we learned that, like Europe, Health Canada is allowing Pfizer-BioNTech vaccine to be stored in the refrigerator at normal temperature for 31 days, whereas so far the recommendations have been to keep it at minus 60 to minus 80 degrees Celsius. That's very good news in itself.

First, I'd like to know what's changed. How is it possible to do that now?

Then, can you tell us how that will accelerate vaccine rollout?

● (1130)

[*English*]

Dr. Stephen Lucas: Thank you, Mr. Chair.

As the honourable member noted, indeed this week Health Canada authorized the submission by Pfizer to extend the period in which the vaccine could be stored, subsequent to thawing it in a refrigerator between about 2°C and 8°C, to 31 days. It had been previously authorized five days in refrigerators. Pfizer has gained experience through its initial work with ultra-cold storage and then for a period of time at -20°C and now is able to store it for up to 31 days in refrigerators.

This will enable a broader utilization of the Pfizer vaccine. I'll make a few comments and then turn to Iain Stewart for any further comments, given the Public Health Agency's responsibility for vaccine rollout, but it will enable broader use of the Pfizer vaccine in settings such as pharmacies or in the territories, as well as in settings such as family physicians' practice clinics.

Mr. Chair, I would turn to Iain Stewart for any further comments.

Mr. Iain Stewart: Thanks for that, Steve.

I'm sorry?

[*Translation*]

Mr. Luc Thériault: Please respond quickly, as I have a related question to ask.

[*English*]

Mr. Iain Stewart: Okay. I would just say that it's actually very empowering and enabling for the distribution of the Pfizer vaccine in a much more distributed way, so we're very excited about it, Mr. Chair.

[*Translation*]

Mr. Luc Thériault: Much has been made of the diversity of Canada's vaccine portfolio.

First, since we now have access to environments that we didn't have access to before with mRNA vaccines, don't the other vaccines become secondary and can they just be left behind? Second, who does that affect?

In terms of the vaccines that we have reserved, can we effectively tell the providers that we don't need them, without it necessarily costing us a fortune?

[*English*]

Dr. Stephen Lucas: Mr. Chair, I may turn this question to Iain Stewart and Dr. Tam for a response. Health Canada has approved five vaccines, as I noted in my opening statement.

I'll turn to Iain and Theresa on the rollout and advice.

Mr. Iain Stewart: Thank you for that, Steve.

Mr. Chair and honourable member, the portfolio approach that we've taken has proven robust. A number of the vaccines that we were hoping would be part of our immunization campaign have had challenges—sometimes in production and sometimes in their approval—and so the net result is that we've ended up with a couple of vaccines that are playing a very foundational role.

As you would know, both Pfizer and Moderna have been a major part of what we've done, as well as AstraZeneca to a lower level. Having that diversity of options, in fact, has been very beneficial for the country and therefore I think the portfolio's been quite advantageous.

With respect to the difference among them or the quality—

[*Translation*]

Mr. Luc Thériault: Excuse me. It was advantageous when we had a shortage. Now that we can get vaccines with no adverse effects like AstraZeneca's and perhaps Johnson & Johnson's, because they have issues associated with them, why continue down that road? Unless we assume we will have a shortage of the Pfizer-BioNTech vaccine.

Since we know we can now roll out the vaccines, I imagine we have no interest in exposing people to thrombosis. We've already had four cases in Quebec.

[*English*]

Mr. Iain Stewart: Thank you.

Mr. Chair, and honourable member, your question itself reflects the progress that we've made as a country in our national immunization campaign. Getting sufficient doses in order to address the public has been the key priority and we are now reaching a point...and the National Advisory Committee on Immunization's advice reflects the point that you're making.

I'll turn to Theresa.

Dr. Tam, maybe you'd like to talk to the topic.

● (1135)

Dr. Theresa Tam: Thank you.

Mr. Chair, I think we are at a turning point, for sure, given the supply. The vast majority of vaccines will be the Pfizer vaccine. Having a diverse portfolio as a backup option is always a good idea.

With the AstraZeneca vaccine, the provinces and territories have chosen to pause giving any more new first doses. We do, however, need additional supplies, which we have, for the second dose for people who wish to take the AstraZeneca because they started on that schedule.

As you probably appreciate, there are data that we are still looking at on the mixed schedule. The National Advisory Committee on Immunization, once they have that data, will be able to provide a recommendation to determine whether the mRNA vaccines, such as Pfizer, are suitable for that second dose.

After that, there still need to be some backup options for people who might be allergic to mRNA vaccines or who for some other reason can't take them. It's still important to have some diversification in our approach.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

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

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

Dr. Tam, can a partially vaccinated individual transmit COVID-19?

Dr. Theresa Tam: The data is still accumulating. Some studies have shown that even with one dose there is a reduction in transmission to others. It won't be 100%, nor would it be that even with two doses. I think the data is trending in a very positive direction.

I would just clarify. Of course, if you prevent infection, whether symptomatic or asymptomatic, you will reduce transmission. That's one thing. Those vaccines, even after one dose, have had a very high vaccine effectiveness, particularly against serious outcomes. That's very positive.

One study, for example, from the United Kingdom, demonstrated a 50% to 60% or so reduction in transmission. Overall, even with one dose we expect to see that effect.

Mr. Don Davies: That's a long reach to an answer that I think is that a partially vaccinated individual can transmit COVID-19.

Would that be a correct statement?

Dr. Theresa Tam: We believe that would be a correct statement.

Mr. Don Davies: Okay.

Thank you.

Dr. Theresa Tam: Of course, even a fully vaccinated person will have a much reduced risk, but there is the potential.

Mr. Don Davies: Thank you.

I'm not sure whom to ask this question of, Mr. Stewart or Mr. Ossowski.

How many doses of the AstraZeneca vaccine are currently sitting in Canadian freezers?

Mr. Iain Stewart: Mr. Chair and honourable member, this question would be for me, I think.

Remember, honourable member, we just received a shipment of 655,000 doses of AstraZeneca. Those are only being distributed over the past week. A lot of them will be in handling and storage for further onward distribution.

The answer, then, I guess is, more than 655,000, to the extent that the provinces have had a few left over from the previous shipment.

Mr. Don Davies: Do you expect that all of those doses will be administered, or will some be allowed to expire?

Mr. Iain Stewart: Oh, I think nobody wants to have any doses expire. I think the provinces are very conscious of the fact that there's a need to get them into use. I would go on to add that I think the provinces, as Dr. Tam mentioned, are beginning to move away from first doses of AstraZeneca and towards second doses.

There's going to be a bit of watching this space. As you probably know, the National Advisory Committee on Immunization is also looking at the idea of mix and match, whereby, instead of second dose....

I'm sorry, sir.

Mr. Don Davies: You anticipated my next question, which is whether NACI is planning to issue guidance on dose mixing for Canadians who received the AstraZeneca vaccine as their first dose.

If so, when can Canadians expect that guidance will be issued?

● (1140)

Mr. Iain Stewart: Maybe, Theresa, I can turn this topic over to you.

Mr. Don Davies: Mr. Chair, can I have my time halted, please?

The Chair: Yes.

Mr. Don Davies: I'm not sure who's waiting to answer.

Dr. Tam, are you going to answer that question?

I can't hear Dr. Tam.

The Chair: Dr. Tam, you're now muted.

Dr. Theresa Tam: Sorry.

The evidence that NACI is waiting for is likely to be available by the end of May. We expect a recommendation on a mixed schedule around the first week of June.

Mr. Don Davies: Okay. Thank you.

Mr. Ossowski, why are hotel quarantine requirements on international travellers applied to people arriving by air but not international travellers crossing the border by ground?

Mr. John Ossowski: First of all, it's important to understand that, however you come across the border, the perimeter and the quarantine and all the pre-arrival requirements apply. You still have to have a PCR test; you still have a day-one test on arrival; you still get a day eight test; you still have quarantine requirements.

In terms of the pure GAA phenomenon, the reality is that we have 117 land ports of entry and there just simply isn't the hotel infrastructure available to potentially service all those who would cross the land border to put them in a GAA-type situation. From that perspective, we've been relying on our perimeter controls to great effect.

Mr. Don Davies: Okay.

You do realize that there have been tens of thousands of travellers who have diverted their plans in order to escape the hotel quarantining by simply changing their flights to land in U.S. border towns and crossing by vehicle. Are you aware of that phenomenon?

Mr. John Ossowski: Yes, I am.

Mr. Don Davies: Do you have any comment on that? Has that reduced the effectiveness of the hotel quarantine policy?

Mr. John Ossowski: As I say, in the quarantine requirements and the referrals that we would make to PHAC if we find that people are offside with respect to the quality of their quarantine plans or some other issue, the perimeter control regime is well established. I think the infection rates demonstrate that.

Mr. Don Davies: Okay. Let me explore that a bit.

Media reports have revealed that mandatory hotel quarantine rules are not being enforced at two of the four Canadian airports currently permitted to receive international flights. That's in Montreal and in Calgary.

Can you confirm if hotel quarantine rules are being enforced at these airports in those provinces?

Mr. John Ossowski: I think I would pass that question on to my colleague, Iain Stewart at PHAC, because they're responsible for the enforcement of the hotel requirement.

Mr. Iain Stewart: Thank you, John.

Mr. Chair and honourable member, I'd like to just add a couple of things if I could.

The public policy rationale of the government-approved accommodations, the hotels, is that somebody comes off an international flight, we don't know if they're infected and infectious or not, so they do the test. They're tested immediately if they come off the plane, and then they go to the hotel to wait for the result.

A lot of people coming in internationally, of course, are boarding a domestic flight and what we didn't want was infected people, perhaps carrying the Indian variant or something like that, getting on a plane from Toronto to Winnipeg and infecting a bunch of people on the plane. That was the public policy rationale for that.

At the land border, you don't get the same type of profile. People are usually arriving in a conveyance and continuing on. That's one thing I wanted to mention.

The other thing to mention is that the infection rate of people arriving by air is about 1.7%, so about 6,185 people out of about 369,000.

Mr. Don Davies: Mr. Stewart, the question was on enforcement at those two airports.

Mr. Iain Stewart: I do understand, sir. I'm sorry. I just wanted to provide the background—

Mr. Don Davies: That's what I would like an answer to.

Mr. Iain Stewart: I would just like to provide the background that, at the land border, it's 0.3%. The threat at the land border is substantially smaller.

We do, in fact, enforce at all four international airport points of entry. In two provinces where we don't have the Contraventions Act, we rely on litigation as opposed to tickets. I think that has created a perception you're referring to.

Mr. Don Davies: Has there been any litigation initiated?

The Chair: Thank you, Mr. Davies.

Go ahead. The witness may answer, please.

Mr. Iain Stewart: Yes, of course there is.

Mr. Don Davies: Can you quantify that for us?

Mr. Iain Stewart: In the case of Saskatchewan, for instance, I believe we have 15 court cases in process at this juncture.

The Chair: Thank you, Mr. Davies.

We'll start our second round of questions now with Mr. d'Entremont. Please go ahead. You have five minutes.

• (1145)

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

Earlier I think Mr. Stewart talked about some 600,000 doses of AstraZeneca coming in. Could you tell us which program that's from, whether that's from the COVAX program or the bilateral contract that we're expecting?

Mr. Iain Stewart: The 655,000 doses that are currently being distributed were Canada accessing our payment under COVAX.

Mr. Chris d'Entremont: There is a bilateral contract with the manufacturer, so we're going to be expecting some doses from them as well. When will those be coming?

Mr. Iain Stewart: You're absolutely right. We have a procurement agreement with AstraZeneca for U.S. production. The first shipment is anticipated by the end of June and then another six and a half million in Q3.

Mr. Chris d'Entremont: Thank you.

Dr. Tunis, we've had a number of issues around AstraZeneca. A lot of provinces have made a decision not to offer it to their populations. Will NACI be coming up with some advice on what to do with those folks who might not want to have AstraZeneca as their second dose?

Dr. Matthew Tunis (Executive Secretary, National Advisory Committee on Immunization): That is on the forward work plan for NACI. The committee is currently reviewing evidence on interchangeability across vaccine platforms. As Dr. Tam mentioned, we expect some of that evidence to become available later in the month or into early June. There has already been some news released from a Spanish study looking at the same.

The committee is reviewing the scientific evidence on this topic in order to provide that advice on interchangeability. The Public Health Agency of Canada does intend to ask NACI for their advice about options for individuals who have received AstraZeneca as a first dose and whether interchangeability might be an option.

Thank you.

Mr. Chris d'Entremont: We know that some people will be having their second doses pretty soon, especially the ones who got it earlier. I think at the beginning of March some people began receiving AstraZeneca. Are we going to be a little crunched on time if we're waiting for another month or two?

Dr. Matthew Tunis: When we've looked at the national numbers, it's around the first week of June that individuals would start being available for their second dose, according to a 12-week or a three-month interval for AstraZeneca vaccine.

I'll also note that NACI has advised us that up to 16 weeks could be considered for an interval. In fact, with the AstraZeneca vaccine in the clinical trials, an interval of 12 weeks or greater than 12 weeks was the most efficacious. There are also options for extended intervals beyond that first week of June as well.

Mr. Chris d'Entremont: Thank you.

I don't know if this is for Health Canada or the Public Health Agency. Are there any legal concerns around giving Canadians a different brand from what they consented to originally?

Mr. Iain Stewart: We do, of course, take into consideration consent. It's an important part of the vaccination process. The NACI study will create guidance regarding the mixing of the two doses. I'm not aware of any legal issues that would arise of that nature.

Based on your experience, Theresa, I don't know if you have any comment or advice in that regard.

Dr. Theresa Tam: Mr. Chair, I have nothing further to add. I think the guidance will be based on the evidence that we have at the time, which is up-and-coming. Provinces will look at that evidence as they roll out the vaccine program. Absolutely, informed consent is part of the program.

Mr. Chris d'Entremont: With vaccine hesitancy, are you concerned when people who were expecting both doses to be the same brand...? How will government messaging ensure that Canadians have confidence in the different-vaccines regimen?

Mr. Iain Stewart: Is that for a particular person?

Go ahead, Theresa.

Dr. Theresa Tam: Mr. Chair, vaccine confidence is extremely important. I think Canadians should know that between the regulator, the National Advisory Committee on Immunization and the provinces structuring the vaccine programs, thorough scientific data review as well as expert advice have been taken into account. Canadians should feel confident that we have effective and safe vaccines being provided. That is very important, for sure. When the advice comes out on the option of receiving the same vaccine for their second dose or a mixed-dose schedule, they should know that it has come from a thorough review.

• (1150)

Mr. Chris d'Entremont: Okay.

Just quickly, Mr. Stewart, when you were updated on the information about Major-General Fortin, did they ask you not to mention it to Major-General Fortin? Or, did you have a discussion with him, from that March date to the day that you actually...the 13th?

Mr. Iain Stewart: I received no instruction about whom to talk to regarding that information, to be honest.

Mr. Chris d'Entremont: Thank you.

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

We'll go now to Mr. Van Bynen for five minutes, please.

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

Thanks to all of the witnesses for joining us today. This is quite a panel, and I appreciate your taking time off of your schedules to answer some questions today.

I'd like to start my questions with Dr. Tam.

We continuously said that, as we learn more about this virus, our approach will evolve, and, as we vaccinate more and more people from different priority groups and locations, I think it's fair to say that our knowledge about these vaccines evolves too.

I've heard of a few cases abroad where the antibodies were found in babies whose mothers received the vaccination while they were pregnant. I think this is certainly something to give us some hope.

I'm wondering if either nationally or internationally you have seen any of these cases. Are there are any studies about these situations, and if so, can you tell us about them?

Dr. Theresa Tam: As you indicated, we're studying the science as we go along. I think, based on other vaccines, it wouldn't be surprising that some antibodies could, for example, be passed on from the mother to the baby either through the womb or, indeed, through breast milk. These are being studied. Yes, I have heard of some of these accounts, and that evidence is being reviewed.

We have research on vaccination for women during pregnancy as well—persons who are pregnant—and we will look forward to some of that data. It is also important to emphasize that persons who are pregnant have an increased risk of COVID-19. The advice at this point in time is to offer persons who are pregnant the vaccine because of this increased risk, and it may provide some benefit to the baby, but that remains, I think, to be studied.

Mr. Tony Van Bynen: Thank you.

Still on the topic of priority groups, our approach across Canada was to identify specific groups and target them for early vaccination. Could you please share with the committee how impactful this decision might have been?

Dr. Theresa Tam: Mr. Chair, that decision has been very impactful, because COVID-19, of course, has a disproportionate impact on certain populations, including our most senior age groups as well as those in congregate-living settings such as long-term care, and then, of course, those at high risk of exposure to the virus such as health care workers.

I'll just point out that, in this third resurgence, the number of deaths—and we should take note of every death—is much smaller, whereas we would have expected that to be much higher. As the protection of the very effective vaccines have taken hold, long-term care facility cases and outbreaks have dramatically decreased. That was the first thing that we noticed about the vaccine program. Then the rates in the 80 years and older age group plummeted, really, at a very fast rate. That was another really good sign.

Vaccine effectiveness studies being carried out in Quebec and British Columbia indicate the effectiveness of even the first dose of vaccine. Health care worker cases have also dropped as a result of their being vaccinated as a priority group, so I do think that those prioritizations have had an impact.

First nation communities and the territories were prioritized and have had a really high vaccine uptake. I do think the vaccine has played a very key role in protecting those populations.

Mr. Tony Van Bynen: Thank you.

Throughout this entire study and even through our previous study, we heard from numerous witnesses about the importance of sharing health data across Canada. While we've mostly heard about this in the context of COVID-19, I think it's applicable to other health-related contexts.

Do you see a benefit in such a system, and if so, would it impact the efforts to prevent and to manage diseases across the country?

● (1155)

Dr. Theresa Tam: Mr. Chair, that is a very important question.

I think public health policy should be driven by data. We have had data presented, and it has to come from the local level up to the national level, so I do think we've seen data improve over time. This is the first pandemic where we're having case-by-case data reported nationally through the pan-Canadian health data strategy. With the safe restart agreements and the resources being provided to the provinces and territories, we have seen improvements in the data being gathered, including on race, indigeneity and occupation. That has improved, and that kind of improvement must be taken forward as we look to keep going and strengthening that data system.

Mr. Tony Van Bynen: Thank you, Dr. Tam.

The Chair: Thank you, Mr. Van Bynen.

We go now to Mr. Barlow, please, for five minutes.

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

Just to go along with what Dr. Tam was saying about decisions on public health having to be based on data, Dr. Tam, what data shows that requiring a fully vaccinated international traveller to stay at a quarantine hotel is more effective in stopping the spread of COVID than quarantining at home? Is there some data that shows that hotel quarantining is more effective than quarantining at home?

Dr. Theresa Tam: We are very actively examining the policies related to fully vaccinated travellers, so that—.

Mr. John Barlow: Right now, then, Dr. Tam, there is no data. Right now you've made a decision on hotel quarantines without data that shows that it is more effective than quarantining at home.

Dr. Theresa Tam: That policy will be evolving, because there haven't actually been that many fully vaccinated travellers. Canada is still in a very difficult situation with the third wave. Our domestic vaccination rate is still catching up and is accelerating, but I think part of the decision-making related to vaccinated travellers has to take into account the global as well as the domestic epidemiological situation. We're still learning about the reduction in transmission.

Mr. John Barlow: I appreciate that, but it was a pretty yes or no question.

We've had the quarantine hotels for many months. Is there any data that shows, for any traveller, that the spread of COVID is controlled any better in a hotel quarantine situation than with quarantining at home?

Dr. Theresa Tam: The GAAs or accommodations are there so that we can wait for the PCR results. That's the primary rationale for doing this, and it has been effective, in that PCR-positive individuals are then referred to quarantine facilities.

From that perspective, it doesn't matter whether you're vaccinated or not; if you're positive and your PCR is positive, you will be quarantined for essential safety for the individual and for the population.

Mr. John Barlow: I'm getting from that, Dr. Tam, that there is no data showing that controlling the spread of the virus is any better when quarantining at a hotel than when quarantining at home.

I want to change to the vaccinations on travel, to try to clarify some misinformation or miscommunication that has happened over the last week. This is either to the CBSA or Dr. Iain Stewart.

Are Canadians exempt from quarantining if they cross the land border to the United States, with appropriate documentation for the purpose of vaccination, and then immediately return?

Mr. Iain Stewart: You're referring to an exemption that was created for people who have something such as a specialized cancer and want to go to the Mayo Clinic. To do that, they get a letter from their physician saying that they need to go and get that medical treatment. On that basis, they can return, because they're ill and under treatment, free of quarantine.

I believe some people have used that provision and secured that exemption to go to get a vaccine. We have 23 million vaccines in the country right now, so I guess I would wonder why a physician would write a letter in that regard. It was intended for specialized medical treatment. We tried to clarify that, Mr. Chair, and honourable member.

● (1200)

Mr. John Barlow: I don't know whether that clarification has worked very well, from the 24-hour differences between two messages.

The question is not even about going for special circumstances, Mr. Stewart. If a Canadian has a doctor's letter to go across the border to the United States to get vaccinated and return, are they exempt from quarantine?

Mr. Iain Stewart: I guess I would add that the United States government does not view that as a reason to enter their country. From our perspective, I would ask the physician involved, does it actually require that they leave the country to get what they can get at a drugstore?

Mr. John Barlow: Mr. Stewart, the question is, yes or no, are they exempt from the quarantine? It's not whether the doctor has given them a note and whether he should have given them the note. The question is, if they have that note, regardless of how it came about, if they go down to the United States to get vaccinated and return, are they exempt from quarantine? Yes or no?

Mr. Iain Stewart: I believe that border services officers will not be accepting that. I will let my colleague John Ossowski speak to the border services officer's exercise of discretion. It would, though, be inconsistent with what our expectations are.

Mr. John Ossowski: Thank you for the question, Chair.

My understanding is that, to Iain's point, first of all, you would likely not be allowed into the United States to receive a vaccine. For people who do have a medical treatment, we will not require them to do the testing and quarantine requirements and we will not be adjudicating that medical note.

If they don't have a note then they're for sure going to be subject to all the testing and quarantine requirements.

Mr. John Barlow: I would say that a doctor's note for a vaccine is a medical reason, regardless of whether it's for cancer or something else. I think getting a vaccine is a good medical reason to get a note.

Mr Stewart, why was the advice provided differently last week and then reversed 24 hours later? What was the reason for providing the advice that, yes, you would be exempt from quarantine, and then that reversed 24 hours later?

Mr. Iain Stewart: The reality is the world around us is changing. There are 23 million vaccines in the country at present and if you need to get a vaccine, there are plenty of pathways to do so, whether through the province or a drug store or whatever.

Mr. John Barlow: You're basically—

The Chair: Thank you, Mr. Barlow.

We'll go now to Mr. Kelloway. Please go ahead for five minutes.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair, and hello to my colleagues. Thanks again to the witnesses for coming here today.

My first two questions will be directed to Dr. Stewart. If I can, I'm going to ask a third question of Dr. Tam.

My questions are going to change a little bit. I was going to ask some questions around vaccines, but from what I'm hearing today and what I'm learning on a daily basis, we're trending in the right direction with respect to doses. We're looking at 19.6 million doses of COVID-19 vaccines being administered so far in the country. If I'm not mistaken, that's a little over 55% of eligible adults who have received at least one dose. That's really encouraging.

I'm going to pivot to rapid tests, actually.

Dr. Stewart, as you and everyone knows, I'm from Nova Scotia and our province has done a really good job at managing the virus, but the third wave, I have to tell you, has been challenging here. This week, the Nova Scotia Health Authority said that its province's asymptomatic rapid testing sites have been key in identifying, I think, at least 10% of all confirmed cases.

My question to you is this: Are there any lessons to be learned from Nova Scotia's experience with rapid tests?

Mr. Iain Stewart: Thank you, Mr. Chair and honourable member. I'm not a doctor. I'm also from Nova Scotia.

I would add that it's actually my colleague, Stephen Lucas, who speaks to the testing topic. I'll ask him to take that question.

Dr. Stephen Lucas: Thank you, Mr. Chair.

As I'd noted before, Nova Scotia has really been a leader in the use of rapid tests as part of their broader program. Prior to the resurgence that they've been experiencing, they have used them to effect in downtown Halifax, as I've noted. Now they have a broader utilization of rapid tests for screening purposes, which allows for quick determination of potential or presumptive positives and then follow-up confirmatory tests.

That can lead to broader screening in a workplace or in other settings if, for example, cases are detected, and effective utilization of the PCR tests. I think that has allowed them to really get a broad handle on the number of cases and effective tracing and isolation of cases and contacts. The steps they've taken, coupled with other public health measures, have allowed them to control the spread and bend down the curve of the resurgence they've experienced.

● (1205)

Mr. Mike Kelloway: Thank you, Dr. Lucas.

I'll stay with you, Dr. Lucas, and not Mr. Stewart.

Do you think that the federal government should take further action to promote increased usage of rapid tests and if so, how?

Dr. Stephen Lucas: Thank you, Mr. Chair.

The government is working on a number of pathways, as I had previously responded. The government has distributed a significant number of rapid tests to provinces and territories—that started in the fall—and worked to provide guidance and support on their use.

We have been providing rapid tests directly to employers working in critical sectors where there's a risk of infection in the workplace. We've been working as well with pharmacies to distribute rapid tests to small and medium-sized enterprises. We've been supporting the Canadian Chamber of Commerce in a program where they partner with provinces to be able to distribute rapid tests to small businesses. We've been supporting the Canadian Red Cross, as well, who are working with not-for-profit organizations and community organizations and settings, such as homeless shelters, to be able to use rapid tests in those environments.

We see this multipronged effort as really helping to be able to identify those cases and follow up with action, as I'd noted in the case of Nova Scotia.

Mr. Mike Kelloway: Thank you, Dr. Lucas.

Dr. Tam, as you know, last summer, those of us in the Atlantic region were able to travel within the famous Atlantic bubble. Now that more and more Canadians are getting vaccinated, is there anything stopping the provinces from implementing their own interprovincial measures similar to the Atlantic provinces and the territories?

Dr. Theresa Tam: That is a provincial matter. I do know that the Atlantic provinces are having ongoing discussions amongst themselves, but also at a special advisory committee where all provinces and territories participate. Those are the types of discussions that are taking place. It is, of course, up to the provinces. They are looking at their policies for interprovincial travel.

Mr. Mike Kelloway: Thank you, Mr. Chair. That's all for me.

The Chair: Thank you, Mr. Kelloway.

[*Translation*]

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

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

My question will be for Mr. Ossowski.

In the spring of the first wave, although no one would have thought that we would be asking so many questions about vaccines today, the government passed a special law that temporarily suspended patents and authorized vaccine production under licence. Now, as vaccines are emerging, that provision is not being renewed despite all the issues we have had because we depend on foreign countries for our vaccine supply.

The question is simple. Why has the provision not been extended?

Has there been any pressure not to extend it in your negotiations with pharmaceutical companies?

[*English*]

Mr. John Ossowski: Thank you, Mr. Chair.

I think probably my colleague, Bill Mathews or Stephen Lucas, is better placed to answer this question.

Dr. Stephen Lucas: Mr. Chair, I can address that.

There was a provision in the emergency response act in March 2020 pertaining to compulsory licensing at that time. It was unclear what the development path would be for therapies and vaccines pertaining to COVID. Since that time, we have seen the rapid development of vaccines and their authorization here in Canada and around the world, as well as the establishment of global facilities, such as COVAX, to enable the distribution of vaccines around the world, particularly in low and middle-income countries.

● (1210)

[*Translation*]

Mr. Luc Thériault: Excuse me, but that's not what I asked you.

We passed a law that gave the opportunity to execute licensed production in Canada. Now, as vaccines emerge, we are taking away that opportunity.

Was there any pressure from the pharmaceutical industries to remove that provision, to not use it, even if it meant that we would be supplied with vaccines?

Did that kind of discussion take place? That's my question.

[*English*]

Dr. Stephen Lucas: Mr. Chair, I'll respond by saying that the assessment was that that provision did not need to be renewed. As I indicated, we were working with vaccine developers for their authorization that government has announced investments in and partnerships with a number of Canadian companies, as well as Novavax working with the NRC for production of vaccine in Canada.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies for two and a half minutes.

Mr. Don Davies: Mr. Stewart, I was asking about lack of enforcement of hotel quarantine rules in Alberta and Quebec. You responded that we've initiated litigation in Saskatchewan.

Has any litigation been initiated in Alberta and Quebec by the federal government?

Mr. Iain Stewart: With respect to Alberta, I'll have to get back to you with the statistics. Off the top of my head, I don't remember the litigation statistics for Alberta. For Montreal, we in fact ticket there, and we have a good relationship with the police of local jurisdiction. We rely on tickets under the Contraventions Act.

Mr. Don Davies: It was my understanding that Quebec is not enforcing the hotel quarantine rules for those coming out of the Montréal-Pierre Elliott Trudeau International Airport. Am I wrong on that, or do media reports have that wrong?

Mr. Iain Stewart: In my table of contravention tickets and report incidents that have been issued, we have 192 tickets that have been issued. For Quebec, 190 of them have been for a breach of quarantine. I think the fact pattern is that there is ticketing going on with respect to the jurisdictions in Quebec.

Mr. Don Davies: I just want to make sure I understand this. Maybe I have it wrong. We have a passenger flying to Canada from Brazil. They going to land in, say, Calgary. They have to hotel quarantine. But if that passenger instead changes their ticket to fly to Montana and then drives across, the hotel quarantine rule does not apply to them.

If I understand you correctly, you think that jives with our policy design. Can you explain that to me again, why the hotel quarantine rule applies to one but not the other?

Mr. Iain Stewart: Yes, I can. The person flying in from Brazil would have to land in Montana. They'd have to stop. They actually have to get a PCR test in the United States before they even come to the border. They have to show up at the border with a negative PCR test. Then they have to do a day one test. They have to go into quarantine for 14 days and they have to do a day eight test.

So the full testing and quarantine regime pertains, but because they're not going to do a connector flight through an international flight into one of our four airports, the GAA hotel there's less of a public health benefit for.

Mr. Don Davies: But isn't the whole point of the hotel quarantining to protect Canadians, to have an extra buffer, so that the passenger stays in a hotel after they land here? Is that not the point of quarantining?

Obviously, you can't protect the people on the airplane, because they've already been on the airplane. The quarantine in the hotel happens after they've entered Canada. Am I missing something there?

Mr. Iain Stewart: It's the connector flight. If somebody flies in from Brazil, they land in Toronto. They get tested. They have to wait to get the result before we let them get on another public conveyance of Canadians. If they show up at the airport, therefore, they're at risk of exposing others, because they're going to use other conveyances. So that's the GAA; that's the benefit for international air flights. If they're going to fly into the U.S., they have to land. They have to get a brand new PCR test right there. It has to be negative before they can even enter the country.

The Chair: Thank you, Mr. Davies.

We're starting our third round of questions.

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

Hon. Michelle Rempel Garner: Thank you, Chair.

Dr. Lucas, 11 days ago David Musyj, the CEO of Windsor Regional Hospital, applied through Health Canada's special access program to have excess vaccines from Detroit, which are currently going to waste, delivered to his hospital for use in Windsor. By what date do you expect your department to approve this request?

● (1215)

Dr. Stephen Lucas: I don't have that information at hand on that request. As has been noted, there are vaccines available in Canada and being distributed across the country.

Hon. Michelle Rempel Garner: The name, Dr. Lucas, of your employee who's working on the file is Mary Morgan. You might want to get her on the phone after this.

Do you have any idea about this request? Like, are you tracking it at all? It's a fairly significant one. It's made the media quite a bit in the last 24 hours.

Dr. Stephen Lucas: I am aware, Mr. Chair, but I don't have the specific details on the follow-up. As I had conveyed, the—

Hon. Michelle Rempel Garner: Would you commit to perhaps phoning Dr. Musyj this afternoon to deal with this request? It's been 11 days.

Dr. Stephen Lucas: I will follow up with the program, Mr. Chair, but what I would say is that the special access program is designed for accessing medications that aren't authorized for use in the country. It's a unique program. The vaccines are—

Hon. Michelle Rempel Garner: Vaccines are going into the garbage today in Detroit. They want to send them to Canada, because they're about to be wasted, but....

This is a great segue to my next line of questions.

Dr. Stewart, you implied there were enough vaccines in Canada right now, that there were 20 million vaccines, and that there were plenty of pathways to get a vaccine for Canadians. What would you tell somebody who has signed up for an appointment in Ontario but is waiting for a month, who perhaps is a frontline worker? Do you think that's an adequate pathway to get a vaccine?

Mr. Iain Stewart: Mr. Chair and honourable member, just while we were talking, we were looking at Vaccines Hunter for Windsor. There are vacancies available right now in the city of Windsor for those seeking vaccination.

Of course, in any program where you're increasing the number of vaccines available in a jurisdiction—

Hon. Michelle Rempel Garner: Thank you.

Mr. Iain Stewart: —there's going to be a period—

Hon. Michelle Rempel Garner: You do realize, however, that—

Mr. Iain Stewart: Sorry.

Hon. Michelle Rempel Garner: I just don't accept the assertion that we have enough vaccines in Canada right now. We're essentially on a nationwide lockdown, waiting, and some people are being told they will have to wait four months between vaccinations.

NACI has approved a four-month dosing, so I find it problematic that the head of PHAC thinks that we have adequate supply in Canada right now and that we shouldn't be pursuing every option for Canadians to get vaccinated. I mean, Vaccine Hunters is not going to enable every Canadian to get a second dose. It's just, frankly, preposterous and arrogant to make that comment.

I will continue.

Do you believe, Mr. Stewart, that a physician telling a Canadian, or writing a note, to go get a vaccine in the U.S. is not medically necessary, based on your comments that you made earlier?

Mr. Iain Stewart: What I said was that there were 23 million vaccines in the country. I don't know that I said that was sufficient.

We, ourselves, like to pursue additional doses, and we work closely with the PSPC and Minister Anand for opportunities to increase the overall supply.

Hon. Michelle Rempel Garner: Thank you.

Mr. Iain Stewart: However, the rate of vaccination—

Hon. Michelle Rempel Garner: If a physician, for the purposes of—

The Chair: Ms. Rempel Garner, would you please let the witness—

Hon. Michelle Rempel Garner: This is my time. This is my time.

For the purposes of the OIC—

The Chair: Ms. Rempel Garner, please let the witness answer. I will allow time—

Hon. Michelle Rempel Garner: I have a point of order, Mr. Chair.

I understand that people don't like it when I am direct, but this is my time, and these are questions Canadians need answered. I won't be talked over or told what I can and can't do, so I will direct my time accordingly.

The Chair: We are expected to give due courtesy to the witnesses.

Hon. Michelle Rempel Garner: No. Being polite, in your opinion, is a tool of the patriarchy, and I will continue.

Thank you.

Dr. Stewart....

The Chair: It is a prerogative of the chair to allocate time.

Hon. Michelle Rempel Garner: Mr. Stewart....

The Chair: I normally delegate that to the members, but I would like to give the witness a chance to respond, please.

Hon. Michelle Rempel Garner: Then I will ask my question again.

Mr. Stewart, do you believe that, per the OIC—the government's direction—travelling across the border with a doctor's note to get a vaccine is medically necessary?

Mr. Iain Stewart: Mr. Chair and honourable member, the U.S. government has indicated that it doesn't view that as a reason to enter the United States.

Hon. Michelle Rempel Garner: I asked what our government was doing. What do you—

Mr. Iain Stewart: I will continue to answer your question, ma'am.

From our perspective, it entails risk. Somebody has to go across the border. They pose a potential risk for exposure in that country and then coming back, so it would be normal that they would do all of the testing and quarantine related to entering the United States.

Hon. Michelle Rempel Garner: Thank you.

To either Dr. Stewart or Dr. Lucas, on what date will fully vaccinated travellers be exempt from quarantine upon entering Canada?

● (1220)

Mr. Iain Stewart: If I may, Mr. Chair and honourable member, that's a question that, in fact, Dr. Tam, would probably be more appropriate to speak to.

Dr. Theresa Tam: There are both a public health set of considerations and operational....

One is that we want to see that Canada's epidemic is under control and that our population has had the chance to get fully vaccinated as well.

On the path—

Hon. Michelle Rempel Garner: On that point, Dr. Tam, earlier in your testimony, you noted the fact that there weren't enough Canadians fully vaccinated, and that this was part of the reason we weren't looking at allowing fully vaccinated travellers to be exempt from a quarantine hotel.

Do you have a date or a benchmark by which that might be lifted?

Dr. Theresa Tam: We have to look at the data as we go, but I think that we are on track to have two doses provided to Canadians by the fall.

Hon. Michelle Rempel Garner: So that's when fully vaccinated travellers would be exempt from quarantining. It's the fall.

Dr. Theresa Tam: There may be other provisions to change what we would do with vaccinated travellers en route to—

Hon. Michelle Rempel Garner: When would those be? When would that be happening?

The Chair: Thank you, Ms. Rempel Garner.

Mr. Don Davies: Mr. Chair, I have a point of order, if I may. I didn't want to interrupt my honourable colleague in her questioning, but I was advised about five minutes ago that this entire meeting has not been online up until, I think, maybe a minute or two ago. Is that the case? Journalists have not been able to follow this right up until about a minute ago.

The Chair: I'm not aware of that.

Mr. Clerk.

The Clerk of the Committee (Mr. Jean-François Pagé): Let me check with the technical people.

Mr. Don Davies: I'm advised that it's working now, but it hasn't been. Journalists have been contacting our media people and saying that the proceedings have not been online right up until a minute or two ago.

The Chair: Thank you for bringing that to our attention.

I'll ask the clerk, once he finds out about what's going on there.

I do understand it's going now.

Ms. Rempel Garner, I think you have.... Well, your time is officially up, but let's give you another 30 seconds, if you wish to finish up.

Hon. Michelle Rempel Garner: Thank you.

The fall is when fully vaccinated travellers would not have to go through a quarantine hotel to enter Canada, Dr. Tam.

Dr. Theresa Tam: I think we are evaluating those policies right now.

Hon. Michelle Rempel Garner: Do you think not having some language on that by this point is harming Canadians because you're not providing them with some hope?

Dr. Theresa Tam: I do think that it's important to provide some hope. I think that the international arena is discussing this right now, and I do think that vaccines will play a role in facilitating travel.

Hon. Michelle Rempel Garner: Do you have any line of sight on when that might come out?

The Chair: Thank you, Ms. Rempel Garner.

We will go now to Ms. O'Connell for five minutes.

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

I think conducting meetings and asking questions and actually allowing the answer isn't a sign of the patriarchy; it's actually doing our job as MPs to get the testimony from the witnesses we've asked to be here.

In that vein, it's interesting that the Conservatives talked about our never going to have vaccines until 2030, and then today they're saying that we have to get more vaccines or allow Canadians to take additional risks to go to the U.S. even though there are vaccines available in Canada right now. I believe it was yesterday that Canada surpassed the U.S. in first doses.

How appropriate would it be, if we're actually administering more first doses to Canadians than the U.S., to take supply away from another country when we have adequate supply here? I find that a bit odd.

I want to speak to the first-dose strategy. I have a number of questions. The first-dose strategy was also criticized by the Conservatives, which again is very confusing because you can't get a second dose until you have a first dose. Therefore, it makes a lot of sense to administer first doses, and again, we have surpassed the U.S. on this.

To Dr. Tam—or if there are others who would like to jump in, please do so—the real world data has looked very promising in terms of protection from first doses, although people are not 100% protected after a first dose. In real world data on first doses, as well as something I know the minister likes to talk a lot about, a community with less COVID is safer for everyone. If you have a lower risk, even with a first dose, that in fact makes your community safer because that spread is down.

Could you maybe speak to that piece of it and why it's important for Canadians to continue to get that first dose, and why it's so important that our momentum with vaccines and these doses is increasing and continuing?

● (1225)

Dr. Theresa Tam: Mr. Chair, maybe I'll start with the answer to that question.

I think the first-dose, fast strategy was taken up as a result of the National Advisory Committee on Immunization reviewing existing information on the COVID-19 vaccines, but also a wealth of knowledge —decades of experience—about vaccinology, immunology and how vaccines work. Together with mathematical modelling and other considerations, it meant that there was a consensus amongst chief medical officers of health in the provinces and territories to do this strategy.

I think it has paid off and has contributed to increasing population protection. More and more data is coming out, including from the United Kingdom, which shows that the first dose offers significant protection, particularly for serious outcomes, and that the duration of that protection does last.

We also have Canadian data, from Quebec and British Columbia, that I think will provide the world's first glimpse into just how good that first dose is even beyond the 12-week mark. It has been very encouraging.

If you can imagine, if you're doing mathematical modelling, covering twice as much of the population with an effective first dose provides significant benefit, but that doesn't mean you can forget the second dose. You have to come back fast with that second dose.

On that, I will just clarify that the National Advisory Committee on Immunization said “up to 16 weeks”. As the supplies improve, I think we will see that interval potentially being compressed more. I believe British Columbia has just come up yesterday with a 13-week interval now, given their supply management. I think you will see that interval being more compressed as we go along as well.

Just rest assured to Canadians that first doses do matter and they have worked and have prevented a lot of serious outcomes in Canada already.

Ms. Jennifer O'Connell: Thank you.

With the U.K. strategy of this first dose, we were confident....

I have a question for Dr. Tunis, but I'll have to come back to it.

The Chair: Just finish it up quickly.

Ms. Jennifer O'Connell: Okay.

Dr. Tunis, you spoke earlier in your testimony about AstraZeneca, and you were talking about the dosing interval.

For the average Canadian and putting it in regular-speak, you were talking about that effectiveness being extended or some studies showing that. Can you maybe explain that without some of the medical terms and actually explain what that means for the average Canadian who got the AstraZeneca dose?

Dr. Matthew Tunis: Yes, I can attempt that.

NACI has advised us that, based on what we know about the immune system, intervals that are longer can provide the immune system more time to generate a robust immune response. We have seen in some of the clinical trials, such as those for AstraZeneca, that a longer interval resulted in more protection and a better immune response. There have also now been some studies published showing similarly for the Pfizer vaccine that a longer interval can provide a stronger immune response.

These are all things that the committee continues to weigh out, as they look at the interval strategy. As Dr. Tam said, jurisdictions are now looking at whether they can revise their strategies as supply shifts. NACI has always said that an interval of up to 16 weeks could be used, based on their deep understanding of the immune system, immune responses and what we've seen historically from other vaccines—that more time can allow the immune system more time to generate a better response.

Thank you.

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

That questioning went way over what I expected, so I will give Mr. Maguire a little extra time here.

I want to update the committee in response to Mr. Davies' point of order. My understanding is that there was a brief interval at the beginning of the meeting, about three to five minutes, when Web-VU and ParlVU were not operating, but they have been operating since.

That's my information.

Mr. Maguire, please go ahead. I'll give you five minutes plus.

● (1230)

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

I want to direct a question to Mr. Stewart.

During the emergency debate and then in your last appearance before the committee, I raised the issue of rural Canadians not being able to send back their CoV-2 PCR test because of Purolator's lack of presence in small communities. Just this morning, our committee was notified that more than 17% of the tests have not arrived on time.

Since I raised this issue, have you identified any other companies that are going to fill this gap, yes or no?

Mr. Iain Stewart: Mr. Chair and honourable member, we've done a number of things as to timeliness to address the backlog you're talking about.

Number one, we tried to reduce the impact of it by moving.... The test is now a “day-8” test, so if there is a delay, it's less likely to impact travellers.

Number two, we have looked for alternate service providers, or enhancement of service providers, such as—

Mr. Larry Maguire: Is this still a Switch Health decision, or are there other companies helping Purolator do this now? That was my question.

Mr. Iain Stewart: Switch Health remains the service provider for many areas. They have been working with Purolator, but they have also worked in two ways: one is that they have tried to increase the level of service that Purolator is providing, such as with drop boxes; and two, they—

Mr. Larry Maguire: I'm sorry, Mr. Stewart. It was months ago that we raised this. I know that PCR tests are not being sent in on time, and it's clear that the system is still not working.

Are you telling the health committee here today that Health Canada has done absolutely nothing with the information provided to them months ago in regard to getting other people to help Purolator get these tests in on time?

Mr. Iain Stewart: Mr. Chair and honourable member, actually what I was trying to say was that they have started working with alternate service providers as well. For instance, I said they were trying to increase the service from Purolator, but they have also recruited other service providers—in fact, three other service providers—in this phase, such as Uber.

We are on it, and we're trying to improve the performance to ensure that Canadians get their tests.

Mr. Larry Maguire: Can you give us any kind of specific date—because they're still lapsing—for when this issue will be fixed, so that rural Canadians particularly don't have to wait days for their tests to be picked up and can stop leaving them outside in the elements while they're waiting to be picked up?

Mr. Iain Stewart: Part of the service delivery package is that we have drop boxes. As population becomes sparser, it's obviously more difficult to do door-to-door delivery, so the drop boxes will continue.

When you refer to their being left outside, perhaps you have a specific example that we could investigate.

Mr. Larry Maguire: Yes. I raised it a couple of months ago.

Can you please table with the committee, by next Wednesday, the contract that the Government of Canada signed with Switch Health?

Mr. Iain Stewart: Mr. Chair and honourable member, we have the deputy minister of Public Services and Procurement Canada with us. He may be better placed than I am to speak to your request, sir.

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

I have a couple of things to point out. Number one, we are pressuring Switch Health to improve service, because it is uneven. It's working well in some areas and less well in others.

Iain Stewart just mentioned a few improvements, but we continue to work with Switch Health to get better service, because we know—

Mr. Larry Maguire: Can you table the contract by next Wednesday?

Mr. Bill Matthews: Number two, I will look at the contract and see what can be tabled. I can't commit to next Wednesday, only because we would have to go through and agree upon redactions with the company. That typically involves review with legal, etc., so it often takes more than a few days.

I can take back the request and—

Mr. Larry Maguire: We already haven't been provided with the contracts from the vaccine contracts, and now it looks like we're not even getting a contract from somebody like a courier, basically, Switch Health, a company that's trying to pick these things up. It's mainly in the rural areas that the problem is.

Why is that so important? Why are we hiding a Switch Health contract? Is it a transportation issue?

Mr. Bill Matthews: I think, Mr. Chair, it's more a matter that we, as the department responsible for procurements, take the contracts very seriously and don't just release contract information without a discussion with the supplier. Industry watches how we handle ourselves in these circumstances, because there are certain types of information that are confidential—

Mr. Larry Maguire: I take it from what you're saying that we can't see the contract.

Dr. Tam, this morning we were informed that close to 5,000 specimens were unable to be tested.

If the PCR test is left outside over six hours, in either the heat or the cold, while waiting to be picked up by Purolator, will that impact the veracity of these test results?

● (1235)

Mr. Iain Stewart: Mr. Chair and honourable member, perhaps I could speak to that.

We have not been having—

Mr. Larry Maguire: I was asking Dr. Tam, but—

Mr. Iain Stewart: I'm sorry, okay.

Mr. Larry Maguire: Sorry, Mr. Stewart.

Dr. Tam?

Dr. Theresa Tam: Hello.

Mr. Chair, I think the specimens are likely to still be reasonable to test.

If this is a PCR test, it would detect the viral genetic material and it shouldn't impact the quality of the test.

Mr. Larry Maguire: How many days can a PCR test wait before being sent to the lab for test results before it would be impacted? If someone, say, took a test today but doesn't get it to the lab for eight days, would that impact the veracity of those test results?

Dr. Theresa Tam: [*Technical difficulty—Editor*] more technical answer, but when it's just genetic material you can detect it.

It's like DNA being left around in an environment, or in different places, in different materials, which we should be able even if it were left....

Mr. Larry Maguire: That's how long some of these have been out, so I'm just raising that issue.

Mr. Stewart, when I originally mentioned the concerns about Switch Health, you didn't seem very surprised, which indicates that the government has known about these issues for some time.

Since the beginning of the contract, what specific changes has the government asked Switch Health to make—which you alluded to earlier—to ensure that the tests are being picked up on time?

Mr. Iain Stewart: We have been working with Switch Health to improve their delivery.

The key thing is for the people who are waiting for their eight-day test in particular—and I believe when you talk about rural delays, it's those eight-day tests when people are in quarantine.

One of the things that we did first of all was to provide more time. We made it an eight-day test, not a 10-day test, so it was less likely to impact the person waiting for the result. We've added, as I mentioned, more service providers gathering up samples in rural areas—as I mentioned, three new service providers, and then for other areas we have added Uber as well. We work with their company on their level of staffing—

Mr. Larry Maguire: There's no Uber in rural Canada, Mr. Stewart, and I just wanted to say that I've got complaints from constituents about that entire process of submitting the two PCR tests, and receiving—

The Chair: Thank you, Mr. Maguire.

We'll go now to Dr. Powlowski for five minutes.

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

My riding extends from Thunder Bay to the Manitoba border and includes all of the Canada-U.S. border in that region. It's a very large region and largely a very isolated region. Many families and businesses have close connections with families and businesses on the other side of the border.

A lot of people have been severely affected by the border closure. Grandparents haven't been able to see their grandkids. People haven't been able to see their children. People haven't been able to see their spouses. Also, particularly in northwestern Ontario, businesses that deal with tourism have been really devastated because they're almost totally dependent on the American market and American tourists. There is increasing evidence that being fully vaccinated significantly decreases the risk of transmission. The CDC in the United States is recommending a relaxation of social measures, and we've seen it. It seems to me that EU has announced that it will allow fully vaccinated Americans into the EU.

Given the severity of the effects of the border closure, I think it is reasonable for people to ask when we can expect some sort of decision as to the border being open. I would suggest that certainly the summer would seem to be a reasonable time, especially given the effects on the tourism industry where, if there are no American tourists this year, a lot of businesses are going to go bankrupt. A lot of people will lose their livelihood.

I know Ms. Rempel Garner asked about that and I think it's a reasonable question. When can we expect to hear when fully vaccinated people, especially Americans, will be allowed into Canada?

Dr. Tam?

● (1240)

Dr. Theresa Tam: Thank you for the question.

I think it's an extremely reasonable one. We are working very hard at looking at the options going forward. I hope all members know that the orders in council do get relooked at on a very frequent basis. I expect that we will be incorporating some of these policies in the upcoming ones.

Mr. Marcus Powlowski: By “upcoming”, what sort of period of time are we looking at?

Dr. Theresa Tam: I do think that Canada is probably on a good trajectory in terms of its epidemiology and our own vaccination coverage. I do think that between now and moving toward the fall we would expect some shift in that policy.

I think one of the other aspects to remember is that we have to actually look at the proof of vaccinations. As I said, there are some operational considerations, standards and that type of thing that need to be worked out as well.

We do also expect to continue, I think, to do some testing, even in vaccinated individuals, given the potential for variants that may have escaped vaccines, for example. We would be taking all those factors into account.

Mr. Marcus Powlowski: Correct me if I'm wrong, but I think you are a pediatric infectious disease specialist. In Ontario, the schools have been closed for, I don't know, six weeks—at least in Thunder Bay. We kind of started before the rest of Ontario.

I think you'll agree there's pretty good evidence that kids missing prolonged amounts of school potentially suffer long-term learning consequences. That's certainly a significant thing. We know that there haven't been a lot of cases of significant spread within the schools. However, there have been some.

What are your recommendations and what are PHAC's recommendations to the provinces regarding the timing and the importance of reopening schools?

Dr. Theresa Tam: I think schools are very important to children. It is a topic that all chief medical officers are seized with. This is of course in the jurisdiction of the provinces and depends on the epidemiology in the individual location. You might expect schools in Newfoundland to be open in different periods than those in Ontario, for example. It is very much a provincial jurisdiction and a lot of it depends on the epidemiology of what's going on outside that school, not necessarily focusing on transmission in schools.

I do think that now that vaccines are available, teachers getting vaccinated would also help those safe returns to schools.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

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

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

Dr. Tam, we are currently hearing conflicting opinions about giving the second dose of the vaccine to people who have contracted the virus.

What is your opinion on this, and why?

[*English*]

Dr. Theresa Tam: Mr. Chair, I hope I understood the question correctly.

If someone has already had COVID-19, currently the National Advisory Committee on Immunization's recommendation is still that they be provided with the full schedule of vaccines. However, I believe that NACI will be reviewing that information on an ongoing basis, because as the public is probably interested in, it is likely that the original infection provides some level of immunity.

We know that in a lot of the studies vaccines provide better immunity in terms of antibody responses than the actual natural infection, so giving a vaccine after someone has been infected is still the recommendation, but I look towards the committee to provide further information on the exact number of doses.

● (1245)

[*Translation*]

Mr. Luc Thériault: Do you know of any evidence or studies that show how long it would take to adapt a vaccine to a variant? I'm thinking of the mRNA vaccine, for example.

[*English*]

Dr. Theresa Tam: It depends on the technology for the vaccine, but for the mRNA vaccine, one of the benefits is that it can be easily adjusted, and to different variants, should that be a need.

Just on that point, we know that a whole suite of vaccine manufacturers are already looking at different vaccines that are more adapted to some of the variants that have been picked up globally. That study is already taking place and we expect that to be quite fast.

[*Translation*]

Mr. Luc Thériault: Would booster vaccines necessarily be suitable for variants?

Based on the current vaccination schedule, can you tell us when the booster vaccine stage should begin?

[*English*]

Dr. Theresa Tam: I think that question is still being analyzed in terms of a response, but right now with the variants that are circulating globally, even if there's a reduced response to the vaccine, we do expect that the current vaccines will stimulate coverage for most of the variants that are circulating. On the question of boosters, people have come up with certain opinions or perspectives, but I actually don't think we know the answer and we must monitor both the virus and the duration of the vaccine immunity, which is being done at the moment on an ongoing basis.

The Chair: Thank you, Mr. Thériault.

We'll go now to Mr. Davies.

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

Mr. Don Davies: Thank you.

Dr. Tunis, is there currently any effectiveness data available demonstrating that protection from a single dose of an approved mRNA vaccine four months from the date of vaccination?

Dr. Matthew Tunis: Effectiveness has been monitored in United Kingdom and also here in Canada. There are not currently published estimates looking at a 16-week or four-month effectiveness interval.

Mr. Don Davies: Thank you.

Mr. Stewart, I guess this question is for you.

In April, the U.S. FDA stopped AstraZeneca from using the Emergent BioSolutions plant in Baltimore, and halted production of the Janssen vaccine as it began an investigation into multiple areas of concern, including contamination and quality-control issues.

On April 25, Health Canada claimed to have verified that the 1.5 million doses of AstraZeneca vaccine imported into Canada from that facility met the quality specifications, but the FDA's inspection report noted that, “There is no assurance that other batches have not been subject to cross-contamination”.

How was Health Canada able to verify the quality of those doses when the FDA is unable to provide assurances that vaccine batches produced at the plant were not subject to cross-contamination?

Mr. Iain Stewart: Mr. Chair, my colleague Dr. Lucas is actually responsible for that function.

Mr. Don Davies: Thank you.

Dr. Lucas.

Dr. Stephen Lucas: Mr. Chair, indeed Health Canada had reviewed the lot and the information associated with the AstraZeneca doses that were imported from the United States. The timing of the production of those doses preceded the contamination. That was as noted in the statement on April 25.

By contrast, the Janssen doses, which arrived on April 28, are being held in quarantine as we work with Emergent, Janssen and the U.S. FDA to assess any potential risk of cross-contamination.

● (1250)

Mr. Don Davies: Thank you.

On that same day, Health Canada issued a statement regarding those contamination issues and they claimed that, “Janssen vaccines anticipated to come into the country next week do not come from this facility."

However, five days later, on April 30, Health Canada was forced to retract that statement after learning that a drug substance produced at the Emergent site was used in the manufacturing of the initial Janssen vaccines received on April 28 and intended for use in Canada.

Why did Health Canada make an unverified statement of fact on the source of Canada's Janssen vaccines on April 25?

Dr. Stephen Lucas: Mr. Chair, at that time, we were working with information provided by the company, Janssen. Subsequent to that statement, we received information on the specific site of manufacture of the drug substance in the Janssen vaccines and issued our statement.

As a consequence of the concerns accruing from the U.S. FDA report, we placed the drugs under quarantine upon their arrival in Canada on April 28.

Mr. Don Davies: Thanks.

Mr. Ossowski, we also know that hundreds of private flights from international destinations are landing at airports across Canada despite federal rules directing commercial and business air travellers to the four cities with quarantine hotel systems in place.

Why are wealthy individuals being allowed to ignore Canada's COVID-19 restrictions and quarantine requirements for international air passengers if they arrive by private jet?

Mr. John Ossowski: I'm happy to respond. We looked into that information, that reporting, and it's just factually incorrect. Half of the private flights that were cited in that were actually cargo flights that are bringing essential goods into Canada, including vaccines on some of those flights.

There are very few instances where some smaller aircraft are not going to the major airports. They are all being met by border service officers. They're all being given their vaccine kits. They're all going through the same protocols as everybody else.

Unfortunately, it just was incomplete reporting.

Mr. Don Davies: That's half the flights that would be private jets. You said half are cargo.

What about the other half? They're still being exempt from hotel quarantine rules. Why is that?

Mr. John Ossowski: To be more complete, there are a number of people who are trying to use taxi services, if you will, flying into the United States and then they come back into Canada empty. Those flights and flight crew are exempt from the quarantine requirements.

Mr. Don Davies: Do you have any idea how many individuals are using their private planes to land at these airports and avoiding the hotel quarantine rules?

Mr. John Ossowski: I'd have to get that information for you, sir.

Mr. Don Davies: Could you please provide that to the committee?

The Chair: Thank you.

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

I wonder if you could ask the witness to provide that information to the committee at his convenience.

The Chair: I will let the witness respond.

Mr. John Ossowski: Yes, I'm happy to do so.

Mr. Don Davies: Thank you.

The Chair: That's great.

Thank you, Mr. Davies. I got distracted, so you went way over on the time there.

Mr. Don Davies: It appears I'm not the only one.

The Chair: I know it's hard with two and a half minutes allotted.

We're going now into our fourth round. We'll start with Mr. Barlow.

Mr. Barlow, please go ahead for five minutes.

Mr. John Barlow: Thanks, Mr. Chair.

I want to pick up on some of the questions that my colleague Mr. Davies had, specifically to the Janssen vaccine.

Dr. Lucas, when do you anticipate that we'll be receiving more doses of the Janssen vaccine?

Dr. Stephen Lucas: Mr. Chair, I'm going to direct that question to Bill Matthews.

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

There are a couple of points, but the shorter answer is that we can't confirm a shipment date just yet because those dates are very much caught up in that ongoing review that Dr. Lucas already mentioned of the Emergent facility. Until that facility is cleared from a regulatory perspective, we're on hold in terms of a schedule.

We can update the committee once we have further information.

Mr. John Barlow: Do you have any idea, then, when the USFDA investigation will be complete and Health Canada will be able to make a decision on whether or not to release the doses of the Janssen vaccine received in late April?

Mr. Bill Matthews: Mr. Chair, I will kick that back to Dr. Lucas.

Dr. Stephen Lucas: I don't have a specific answer. The USFDA is continuing its work. We're working closely with them as well as doing our own assessment. We'll make a decision as soon as we have all the facts and the USFDA has concluded its work.

Mr. John Barlow: With that in mind, Dr. Lucas, we've seen some provinces make some unilateral decisions on whether or not to provide the AstraZeneca vaccine to their constituents.

Have we had any of the provinces signal to Health Canada that they do not intend to use the Janssen vaccine when it too is available?

● (1255)

Dr. Stephen Lucas: Mr. Chair, I'm not aware of any such instances, but I'll turn to my colleague Iain Stewart, who has direct contact with the provinces on vaccine orders.

Mr. Iain Stewart: Thank you for the question. Actually, Mr. Chair, Dr. Tam may have insight on this as well.

I'll just state, to answer your question, that we've had no communications that I've received that they have no intention to use Janssen, were it available.

Dr. Tam may have a more complete answer, so I'll turn to her.

Dr. Theresa Tam: Mr. Chair, at the last discussions amongst chief medical officers of health, I haven't heard any specific discussions about not using the Janssen vaccine. We are waiting for—

Mr. John Barlow: That's good. I just want to know if there have been any concerns raised.

I want to switch gears—and thanks, Dr. Tam. I didn't mean to cut you off; I just have a limited amount of time.

Mr. Stewart, page 20 of the first interim report of the COVID alert apps advisory council states:

> The Council acknowledges that the Government of Canada has consulted Statistics Canada regarding any data of value they may be collecting.

What data is being referred to here?

That question is for either Dr. Lucas or Mr. Stewart.

Mr. Iain Stewart: Thank you.

Off the top of my head, Mr. Chair, I don't know the citation you are referencing, but it may be that either Theresa or Stephen does, so I'll open it up that way, if I may.

Dr. Stephen Lucas: I'm not aware of the specific citation, but, Mr. Chair, we could follow up with a specific answer in regard to the question.

Mr. John Barlow: Well, then, Dr. Lucas, we've been told from the beginning that the COVID alert app wasn't really going to be used to collect any data on Canadians; it was just a matter of keeping track of close contacts and such things. However, the report—the first interim report on the COVID-19 Exposure Notification App Advisory Council—also says:

> The Council wants to continue to be engaged in discussions on collection of data, particularly on the viability of data collection given privacy considerations.

It's clear that this app is going to be used to collect data from Canadians. Do you know anything about this and what is being referred to here, in terms of what data will be collected?

Dr. Stephen Lucas: Mr. Chair, the app has very strong privacy protections. There is no information stored in the cloud; it's strictly on the app.

The app provides information on one-time key issuance; that would be an example of data that can be collected. Any data, however, has no personal identification and no ability to capture it.

I'll need to follow up on the specifics in the report, but there is no data being extracted.

Mr. John Barlow: If you could, please do.

Dr. Lucas, I don't mean to be the contrarian here, but in your first answer you said that you don't know what they're referring to, and now you're telling me that no data could be collected. Clearly, though, this report is saying that discussions are happening on the collection of data.

Could you table with the committee exactly what data may be referenced in this report and also, say, how many Canadians could be affected and what the government is planning to do with any data that's being referenced in that alert app's advisory council report?

Dr. Stephen Lucas: Just to clarify my response, your initial question mentioned Statistics Canada, and that's the point I was not aware of as a specific reference and would want to follow up on in the page you noted.

With regard to app data, it collects information such as the number of one-time keys issued, as an example, and that may have been what was referred to.

We'll follow up with the committee.

Mr. John Barlow: Yes, I appreciate it. If you could just table to the committee the answers to those questions, that would certainly be very welcome.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Barlow.

We go now to Ms. Sidhu.

Ms. Sidhu, please go ahead for five minutes.

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

My question is for Mr. Stewart or Dr. Tam.

There's a concern among Canadians about the effectiveness of vaccines against the variants of concern, based on real world data.

Can you tell us about the effectiveness of vaccines against the variants of concern?

Dr. Theresa Tam: Mr. Chair, I will make a first attempt at answering that question.

The vaccine impacts of variants of concern are being tracked globally from real, live data that has to be collected. So far, we know that the vast majority of the variants of concern are concerning because they have an increased ability to spread quickly.

In terms of impacts of vaccines, the current data suggests that for the B.1.1.7 variant, and indeed for the latest variant of concern, the B.1.617 variant—originally reported from India, some of these subtypes—we expect the vaccines to provide coverage. For others there may be some reduced impacts of the vaccine, but we still expect that the vaccine will work to a certain extent.

The most important thing is to get vaccinated. Of the variants spreading the most in Canada, we expect the vaccines to have an impact on them.

● (1300)

Ms. Sonia Sidhu: Thank you.

Dr. Tam, you talked about communication being the key. You mentioned some of the initiatives you are working on to increase vaccine updates, such as connecting to Canadians through social media. The federal government recently launched an advertising campaign on vaccinations and their benefits called the “Ripple Effect” campaign.

What can you tell us about the message this campaign hopes to share with Canadians across the country?

Dr. Theresa Tam: Mr. Chair, I'll start and maybe others who are more engaged on that front from a communications standpoint can add.

That campaign is just one out of many approaches. This is a much broader media campaign. It demonstrates, I think, to all Canadians that of course the vaccines protect individuals, but they also have a ripple effect, in that they protect others in the community. If we could all get vaccinated as fast as possible and do so, then we could get back to the things we cherish the most, with much less chance of impacting our health care system and other systems.

I think the concept is that every time someone rolls up their sleeve, the impact permeates through their community and as well protects them as individuals.

Ms. Sonia Sidhu: Thank you.

We heard that approximately 58% of adults have received at least one dose, with that number continuing to climb.

My question is to Mr. Matthews.

How does our vaccine procurement portfolio ensure that we are able to provide so many vaccines in such a short amount of time?

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

I'll make a couple of points, I guess, to start.

The vaccine portfolio includes vaccines across three platforms. I think members know that there are four authorized in Canada: the Moderna, Pfizer, Janssen and AstraZeneca vaccines. Pfizer and Moderna make up the vast majority of deliveries to date.

The other point to make is that there are still vaccine contracts that have yet to deliver. They are still in the works, in terms of stepping through their clinical trials and then going on to production. It's the variety of the portfolio across numerous types of vaccines, but also numerous different suppliers, that is the best mitigation against risk in terms of lack of delivery. There will be bumps, and we've seen them. It's this variety that's important to protect or ensure deliveries for Canadians.

If the member's question is more around the benefit of having various different types of vaccines, from an mRNA to a viral vector to a protein type, I'd have to turn to the Public Health Agency or maybe Dr. Tam.

Dr. Theresa Tam: Let me see if I can understand the question properly.

Having broad ranges of vaccine was very important at the beginning of our vaccine program and our strategies, because we actually had very little information about how these vaccines were going to perform. The really fortunate thing for Canada is that all the authorized vaccines.... You've seen how incredible the mRNA vaccines have performed in clinical trials. It is important to have diversity in portfolio, but we also are very fortunate that our foundational vaccine backbone, which is the mRNA vaccine, including the Pfizer vaccine, is performing so well.

• (1305)

The Chair: Thank you, Ms. Sidhu.

We'll go now to Mr. d'Entremont for five minutes.

Mr. Chris d'Entremont: Thank you very much.

I want to go back to where I left off when we were talking about the COVAX doses.

How many doses of vaccine is Canada going to be receiving from COVAX between now and maybe July 1?

Mr. Iain Stewart: Bill, do you want to take that or do you want me to respond?

Mr. Bill Matthews: Maybe I can start, and Iain can chime in.

In regard to the COVAX schedule, I think the most recent delivery was already referred to, which was AstraZeneca in the past week or so.

The COVAX schedules tend to emerge a bit on short notice, so I don't have an update in terms of what the next delivery might be. I can't really forecast what might be coming in to July 1 in terms of detailed schedules, but Iain might have something to add on that front.

Mr. Iain Stewart: I would just add that we are expecting within five weeks that we would get a next shipment, but as Bill says, they don't tend to provide precise, tight dates. However, that's our expectation: within five weeks.

Mr. Chris d'Entremont: Will we at some point be stopping COVAX shipments, or on what date are we going to stop doing those?

Mr. Iain Stewart: The need for AstraZeneca in general, whether under our own advance procurement agreement or COVAX, and so on, is driven by what the provinces decide to do on second doses. I think the NACI report we were discussing earlier would be an influential factor here.

Mr. Chris d'Entremont: That was going to be my next question.

Because of the issue of provinces shutting down their AstraZeneca vaccinations, will that change our need for those?

Mr. Iain Stewart: There is a scenario in which the United Kingdom data supports NACI's giving guidance that the messenger RNA vaccines are a suitable second dose, and in that instance, you might see, yes, less demand for AstraZeneca.

I think there will continue to be a demand for AstraZeneca by people who are looking for a second dose and want the same vaccine, and so on, and as I think Theresa mentioned earlier, the messenger RNA vaccines don't always....

You can have an allergic reaction, and so on, so you want to have a diversity of portfolio. Therefore, there will be some demand, but much less if it happened that way.

Mr. Chris d'Entremont: My next question is probably for Mr. Matthews.

Since provinces will not be using AstraZeneca as a first dose, our requirement for that vaccine will go down.

Are we changing the contract with them? Are we requesting less AstraZeneca? Are we thinking of cancelling that contract?

Mr. Bill Matthews: Mr. Chair, there are a couple of points to make here.

There is a contract with AstraZeneca for 20 million doses, and the first deliveries against that were through an exchange that I think members are aware of. As the future unfolds and we get a better sense of what provinces might want in terms of additional AstraZeneca doses through the Public Health Agency, we'll talk with AstraZeneca about potential changes to that schedule.

I think what has also been discussed in various fora is Canada does have the right to donate doses that it does not need.

Mr. Chris d'Entremont: Could you respond quickly, because I know I'm going to run out of time quickly here too. This question is probably for PHAC.

When it comes to proof of vaccination for Canadians, we're hearing a lot about vaccine passports, or whatever we want to call them. When will people need a proof of vaccination for Canadians wishing to travel?

Mr. Iain Stewart: Mr. Chair and honourable member, earlier some discussion came up on this topic. We're very seized with preparing for having a significant number of people who are fully vaccinated and how we will adjust and respond at the border, and then there's a longer term issue of the international arrangements to allow Canadians who are vaccinated to go to Greece, or wherever—the internationalization of that issue. That work is also under way.

As Dr. Tam was saying, it's difficult to nail it down a specific date, because there are a number of things that we have to watch. That includes better understanding of whether the people arriving still can be carrying infection even though they've been vaccinated previously. We still need to understand that better before we can go too far.

Mr. Chris d'Entremont: Okay. I'm aware of a number of people who are coming home from Florida—some snowbirds—who have had their two vaccinations. Is government finding a way to recognize the vaccinations happening in other countries?

• (1310)

Mr. Iain Stewart: We are working on how we can recognize exactly a scenario such as the one you're talking about: people coming to the border who have, for instance, been vaccinated with the Pfizer or Moderna vaccines, which we ourselves use here. That is an active area of discussion.

Mr. Chris d'Entremont: As a final question on the broader issue of interprovincial travel, is there consideration of checking vaccination status in order to come into Nova Scotia or to go into other provinces?

Mr. Iain Stewart: So far when it has come to measures regarding interprovincial travel, it has been the provinces that have been establishing them. So far, the Government of Canada has not been active in that space.

Mr. Chris d'Entremont: Thank you.

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

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

Mr. Tony Van Bynen: Thank you, Mr. Chair. My question is for Mr. Stewart.

With the recent increase in doses arriving in the country, provinces across Canada have been able to lower the eligibility criteria. In York Region alone, 52.7% of eligible residents have received at least one dose of the vaccine. I'm hoping you can provide us with an update on how many people across Canada have been vaccinated to date, in numbers and percentages, particularly if you have the information with respect to younger age groups.

Mr. Iain Stewart: To the hon. member, Mr. Chair, we have that data. In fact, we have it on our website, giving some of the coverage data of the nature you're talking about.

Actually, we keep an ongoing league table of “by age” stratification like the one you're discussing. The best way to respond to this may be for me to generate the latest numbers and send them to the clerk for the members.

Mr. Tony Van Bynen: Thank you.

Can you tell me why we should vaccinate adolescents before we vaccinate those at risk waiting for their second dose? What does the added age group mean for the rollout, and does it change the timeline?

Mr. Iain Stewart: Mr. Chair and honourable member, Theresa is probably better placed to respond on this. I would just note that so far, in fact, we have not been getting to vaccinating many youth and children, but I think this issue is a very important one.

Theresa, I don't know whether you want to speak to this.

Dr. Theresa Tam: I would just reiterate that it's very important to get two doses to maximize protection. I think provinces are at the moment going back to vaccinate the initial high-risk groups, so you'll see that happening. Many of the long-term care facilities have already had two doses.

From a supply perspective, given that age group and the amount of vaccine needed in the younger age group, what I've been told is that you can actually do both. Because of so many vaccines arriving, you can do both simultaneously.

Mr. Tony Van Bynen: I have to say I'm happy to hear that, knowing that my grandchildren will be getting their vaccines next week.

My next question is to Mr. Vinette.

I'm sure that pre-pandemic, CBSA officers at the border were used to processing much higher levels of passengers and cargo on a daily basis. With the pandemic, I'm sure the nature of the job has changed.

Can you share with us a bit about how there's been different training for CBSA officers, what they've gone through to adapt, and what's being done to ensure their safety as they continue to do their jobs?

Mr. Denis Vinette (Vice-President, Travellers Branch, Canada Border Services Agency): Thank you, Chair and member, for the question.

I must say that right from the onset of our preparation of our response at the border, our officers' personal health in the performance of their duties on a day-to-day basis was front and centre in all of our preparation, in everything from making sure they had sufficient personal protective equipment on. Since that time, we've moved into providing shelter from some travellers by using plexiglass, and we've instituted sanitization chambers so that their tools can all be sanitized at the end of their work day. It's been an ongoing effort to ensure their safety.

As for how the work has changed, I must say that commercially, the truck traffic and the commercial cargo entering the country have actually surpassed pre-pandemic levels, and so we've been successful in ensuring that economic activity and trade have continued throughout the pandemic, notwithstanding that there was an immediate lull through the March to June period of last year.

As it pertains to dealing with travellers, clearly we've trained them on understanding the new legislation as it passed through the OICs for its application. We've continued to support them in many ways. They have 24-7 access now to our border task force, which provides them with policy advice on the application of the legislation. Also, we've ensured that they have all of the latest information on what is transpiring as their work has shifted. They've been briefed by local health authorities, certainly at the onset, about what COVID was and what protective measures they could take, so that they could continue to come through and report to work.

We're extremely proud of the professionalism of the men and women of the CBSA and of all frontline workers, who continued to come to work on a daily basis, making sure that the borders are secure.

● (1315)

Mr. Tony Van Bynen: Thank you.

I'll go back to Dr. Tam. It's encouraging to see that Canadians are being vaccinated in such large numbers, and I hope this trend continues until everyone is vaccinated. What does this uptake tell you about the confidence that Canadians have in vaccinations?

Dr. Theresa Tam: I think it's very encouraging. Of course, with the groups at the highest risk and seniors, the uptake has been really remarkable, and also in long-term care. I think the key is to keep it up.

The latest surveys indicate that the vast majority of Canadians—more than 80% for sure—want to be vaccinated or have already been vaccinated with at least one dose. Once you get one dose on board, the key is to keep up with making sure people remember to get the second dose.

I think we could do more work in making sure that the younger adults, at this point, and the younger youth, also pick up on that momentum. Things are, however, extremely encouraging at this point.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

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

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

A Government of Canada document entitled “Vaccines for COVID-19: Shipments and Deliveries” states that, as of May 11, 2.3 million doses of the AstraZeneca vaccine have been distributed in Canada. The Janssen vaccine has not been distributed.

However, Quebec and some provinces have already indicated that they will limit their use of the AstraZeneca vaccine to the first dose due to unpredictable supply and safety concerns. I am concerned about the agreements between the vaccine manufacturers and the federal government. The agreements are for 20 million doses of AstraZeneca vaccine and up to 38 million doses of Janssen vaccine.

Is the federal government responsible for the full cost of the doses obtained despite issues with vaccine supply and safety?

Do the agreements include provisions that allow future shipments to be cancelled without financial penalty?

Mr. Bill Matthews: Thank you for the question.

First of all, all contracts have clauses that allow Canada to give the doses to other countries. That is always an option. Almost all contracts include clauses that allow Canada to purchase doses—

[*English*]

The Chair: Excuse me, Mr. Matthews. Could you raise your mike a little bit?

[*Translation*]

Mr. Bill Matthews: Is that better? My apologies.

[*English*]

We have in place clauses that allow Canada to donate as well as to exercise options, if more doses are allowed. I would underline for members that when these contracts were negotiated. it was uncertain whether the vaccines would work against COVID, and also whether there would be any production challenges along with those things. There were thus very uncertain timelines.

If the question is whether Canada can arbitrarily decide to opt out of the doses it has committed to, the answer is no.

[*Translation*]

Mr. Luc Thériault: The answer is no. That means—

Mr. Bill Matthews: The answer is no, but we can adjust the schedule to obtain doses next year or the year after that.

But can we cancel a contract?

[*English*]

There are certain clauses that...when you're referring to AstraZeneca, it is a vaccine approved by Health Canada from a regulatory perspective, so it has met that test. That's really all I can offer at this stage.

● (1320)

[*Translation*]

Mr. Luc Thériault: So the contract has no clause clearing you of all financial penalties if a vaccine has risks and you decide not to use it. You're saying we will take the vaccine and send it somewhere else. So all the vaccines that are reserved have to be paid for.

Is that correct?

Mr. Bill Matthews: Yes. As I mentioned earlier, Canada can give doses to other countries. That is an option.

The Chair: Thank you, Mr. Thériault.

[*English*]

We go now to Mr. Davies.

Go ahead, please, for two and a half minutes.

Mr. Don Davies: Thank you.

Dr. Tam, you've said on a number of occasions that on a global basis no one is safe until everyone is safe. The World Health Organization is urging wealthy countries like Canada to delay plans to vaccinate low-risk people, such as children, and instead donate available doses to the COVAX facility to provide vaccine access to high-risk populations in low-income countries.

In your view, should Canada comply with that request? If not, why not?

Dr. Theresa Tam: Mr. Chair, I think that is a very important underlying principle and global policy on vaccine equity, so I absolutely support the need to ensure vaccine equity. I know that our decision-makers have difficult decisions to make, making sure that Canadians get the doses they need while at the same time supporting COVAX with significant investments. I do know that discussions are very much live on what we should do as the next step in terms of COVAX and donor nations.

Mr. Don Davies: Thank you.

Mr. Stewart, who in government is responsible for quarterbacking the delivery of documents to this committee that were ordered by the House of Commons last October?

Mr. Iain Stewart: Thank you, member.

Do you mean the House motion for the production of documents?

Mr. Don Davies: Yes.

Mr. Iain Stewart: Dr. Lucas is probably best placed to speak to the overall portfolio response in that regard.

Mr. Don Davies: Thank you.

Dr. Lucas, the Clerk of the Privy Council, Ian Shugart, put in writing to this committee that there were over a million documents to date—and that's going on seven months. This committee has received about 8,000, meaning there are about 992,000 documents yet to be delivered. Is the government purposely delaying the delivery of documents to this committee, given that it doesn't have to do any redacting, but is supposed to deliver all of those documents unredacted to the law clerk?

Dr. Stephen Lucas: Mr. Chair, in response to the first part of the question, the organization in government responsible for the overall coordination of this is the Privy Council Office. Within the health portfolio we have worked to gather up documents and have provided them. Further review continues on legal or personal information to at least be able to identify those sections. That work continues on the provision of documents on an ongoing basis through the Privy Council Office and the law clerk.

The Chair: Thank you, Mr. Davies.

We'll start round five now with Ms. Rempel Garner.

Go ahead, please, for five minutes.

Hon. Michelle Rempel Garner: Thank you, Chair.

I just wanted to clarify with Mr. Matthews his response to a question from my colleague, Mr. Thériault.

Are you saying that the contracts that we have with AstraZeneca do not allow Canada to cancel the contracts?

Mr. Bill Matthews: Mr. Chair, just to clarify that, when these contracts were negotiated, these suppliers were effectively experimenting and manufacturing at risk, so when you sign on for doses.... While we have the right to donate them, these doses met the regulatory tests, so they are Canada's to do with as we choose.

Hon. Michelle Rempel Garner: Is there no opt-out clause?

Mr. Bill Matthews: There are opt-out clauses in terms of options, but in terms of the actual initial commitment around doses, they are doses that Canada signed on for.

Hon. Michelle Rempel Garner: Is that the same with all of the contracts we've executed?

Mr. Bill Matthews: I'm going from memory here, but generally speaking these were very much “at risk contracts”, so the vaccine producers were effectively not interested in allowing for opt-out clauses because they were taking all of the risk in terms of the research, the clinical trials, and then the eventual production. When you sign on for doses, you are making that commitment.

● (1325)

Hon. Michelle Rempel Garner: Okay.

Dr. Tunis, on what date will the NACI report be released on second doses for persons who have received their first dose with AstraZeneca?

Dr. Matthew Tunis: It's impossible to provide an exact date because the committee's deliberations are contingent on scientific evidence coming out of the mixed-schedule studies in the U.K. Therefore, depending on the progress of that research, the committee will be timing its advice very shortly after that. We do anticipate—

Hon. Michelle Rempel Garner: Can you give a ballpark date?

Mr. Bill Matthews: Yes. We do anticipate doing so in the first two weeks of June, and the committee is very committed to doing this as quickly as possible, understanding the need for provinces and territories to design their programs around this.

Hon. Michelle Rempel Garner: Thank you.

I guess this question would be either for procurement or PHAC—I'm not sure. How many doses of Moderna are we expecting in the months of June and July?

Mr. Bill Matthews: Maybe I can start, and Iain can chime in.

Moderna becomes the workhorse of the portfolio in Q3. There's a big Q3 ramp up. We are waiting for a revised schedule from Moderna, because I think it's been well document that Moderna has hit a bit of a bump in production. We should have clarity on what the schedule looks like for June and July in the next week or so.

I apologize, Mr. Chair, as I can't give you a firm number on expectations for Moderna in total for June and July, but we should have a better sense after next week.

Hon. Michelle Rempel Garner: We know that Moderna has prioritized delivering doses to EU countries.

Mr. Matthews, has the government directed you to look at any options for legal recourse, given the delays in clarity for delivery from Moderna?

Mr. Bill Matthews: Mr. Chair, it's not clear to me that Moderna has prioritized EU countries. They have, as I mentioned, had some challenges, and they are trying to best serve the various contracts in the best way possible.

More than a million doses arrived this week. We're optimistic that we will get the next shipment of Moderna in the first week of June, but as I said, Mr. Chair, we'll have to wait upon further details on what June and July will look like.

Hon. Michelle Rempel Garner: Dr. Tam, in response to a question from one of my colleagues you cited data saying that approximately 80% of Canadians were open to receiving a vaccine.

Are you or is your agency assuming about a 20% hesitancy rate in Canada, then?

Dr. Theresa Tam: With the rest of the 20% there are some who are questioning and want to know more, but I think there are maybe around 12% to 13% who are essentially against taking the vaccine. I think, then, that the 20% is heterogenous. I would have to say, however, that even with good vaccine confidence, we mustn't be complacent, for sure, in our effort.

Hon. Michelle Rempel Garner: We're assuming, then, about an 80% uptake rate in Canada, roughly.

Dr. Theresa Tam: We don't know for sure, but it's looking quite good from that perspective.

Hon. Michelle Rempel Garner: Thank you.

For my last question I'll go back to Mr. Stewart.

Just to be perfectly clear, as of today, if a Canadian crosses the border to be vaccinated in the U.S., even with appropriate documentation, they would still have to quarantine upon re-entering Canada, is that so?

Mr. Iain Stewart: My colleague, John Ossowski, could speak more definitively than I can, but my understanding is that the U.S. would not admit them, if that were the purpose of their trip.

Hon. Michelle Rempel Garner: There are Canadians who can enter the U.S. legally and could do this. If somebody were allowed access into the U.S. to be vaccinated, would they have to quarantine upon return?

Mr. Iain Stewart: They have now made a trip into the U.S. They would come back, and they would be subject to quarantine and testing.

Hon. Michelle Rempel Garner: Are there any plans to change this?

Mr. Iain Stewart: Do you mean, for people to go south of the border and get a vaccine and then come back across?

Hon. Michelle Rempel Garner: —without quarantining.

Mr. Iain Stewart: Is there any change? No, there is no plan to change that.

Hon. Michelle Rempel Garner: Thank you.

The Chair: Thank you, Ms. Rempel Garner.

We'll go now to Mr. Kelloway.

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

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

My question will be for either Dr. Tam or Dr. Tunis, or actually both.

All of my staff in the span of the last five days have received their first COVID-19 vaccine here in Cape Breton. We've talked here about vaccination numbers increasing across the country.

Could you give the committee a sense of the benchmark you're looking at, in terms of Canadians getting vaccinated, before we can turn to some sense of normalcy? Are you hopeful that Canadians will reach that level?

Thank you.

● (1330)

Dr. Theresa Tam: Mr. Chair, we have used dynamic modelling to look at some of these scenarios.

In the model I have presented publicly, the scenario is that if you have at least 75% of Canadians getting the first dose—and we were at that time looking at adults 18 years of age and over—as well as 20% getting their second dose, if at that time we lifted, and this would be up to the provinces, of course, the more restrictive measures, we wouldn't have as much of a risk of overwhelming our health system or of hospitalizations. That was one benchmark.

The second benchmark would be to have 75% of Canadians getting both doses. At that point, we're looking towards a hopeful fall season, when people can get back inside and have a reduced risk of transmission and can get back to the things we miss quite a lot. We're looking forward to universities, schools and other of those social settings getting back towards normal without overwhelming the health system. That was a benchmark.

Since then, many of the provinces and territories have come out with their reopening approaches. I think that some of the provinces have indicators and targets that are in that kind of ballpark, but they also take into account the infection rates in their own province and so may go higher or lower, depending upon how much of the population may already, for example, have encountered the virus itself. You'll see a bit of shift in those, depending on the jurisdiction, but they are roughly in that kind of ballpark.

Mr. Mike Kelloway: Very good.

Dr. Tunis, do you have anything to add to that or something that you want to comment on?

Dr. Matthew Tunis: I would only add that NACI is also considering the same evidence. They are generally supportive of what Dr. Tam just said.

Thank you.

Mr. Mike Kelloway: Thank you, Doctor.

Chair, how much time do I have left?

The Chair: You have two minutes left.

Mr. Mike Kelloway: Wonderful.

For my next question, I'll stay with Dr. Tam.

Last week, Nova Scotia, along with several other provinces, paused the administration of the AstraZeneca vaccine, as we all know. In Nova Scotia, my understanding is that it was primarily due to the shortage of the vaccine, but we know that it's still a safe and effective vaccine in preventing the spread of the virus.

However, I have had a lot of constituents concerned about their second dose, quite frankly. They feel as though they are in limbo. I know this through calls and emails. I believe there have been some recent international studies on mixed vaccination doses, such as the reports that were released in the U.K., I believe, and in Spain.

Can you tell the committee what Canada learned from these studies?

I know we touched upon it here, but maybe this is an opportunity to do a little bit of a deeper dive in terms of the answer.

Thank you.

Dr. Theresa Tam: Mr. Chair, I'll answer the question in a couple of parts.

One is that there shouldn't be any concern about supply itself. We do know that there are supplies of AstraZeneca vaccine should the second dose be AstraZeneca.

The more important point is the answer to the last part of the question, which is that I think the international data is looking quite promising towards the effectiveness and safety of a mixed schedule—an mRNA vaccine, for example, following the AstraZeneca vaccine. I am optimistic that there's in fact an option there. Again, we await the NACI examination of that data as per the timeline Dr. Tunis mentioned.

I just want to acknowledge that it is, of course, anxiety provoking, and that's understandable. For those who received that first dose, that answer will be available within a reasonable timeframe for that second dose.

● (1335)

Mr. Mike Kelloway: Thank you, Dr. Tam and Dr. Tunis.

That's all from me, Chair.

The Chair: Thank you, Mr. Kelloway.

We go now to Mr. Barlow for five minutes.

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

Just to follow up on previous questions from my colleague, Mr. Stewart, are you saying that there is a strategy to end the hotel quarantines based on the benchmarks that you previously mentioned?

Mr. Iain Stewart: At this time, there is not a strategy to end the government approved accommodations.

Mr. John Barlow: You did say that you were using some benchmarks to set these criteria or these timelines. If we're using these benchmarks, then why would there not be a plan to end the hotel quarantines.

Mr. Iain Stewart: You are absolutely right. We are tracking indicators such as the infection rates in the local populations, as well as the infection rates of people coming across air and land borders. We're maintaining that quite closely. At this time, though, there is not a strategy, to answer your question, to make a change of that nature.

Mr. John Barlow: So there's no plan to end these hotel quarantines. Is it safe to say that these are simply a means to deter travel, and that's really the only basis?

You have no data that tells me that it curbs the spread of the virus any more than someone quarantining at home, and there's no plan to end the hotel quarantine, so is this just a means to deter travel?

Mr. Iain Stewart: I don't agree with those statements, Mr. Chair, and honourable member.

There is a public health benefit. The public health benefit I mentioned earlier in today's proceedings is to stop people from arriving internationally and then getting onto domestic flights while they are in an infected state. I also mentioned earlier that there are substantially more people arriving at airports and are more likely to be infected than those arriving at the land border. Those are the motivating factors behind the government approved accommodations.

Mr. John Barlow: I understand what your saying, Mr. Stewart, but I did ask you earlier and on several occasions in the past why you haven't tabled the data that shows this is working.

Again, today, I've asked that. You're just saying that this is why you're doing it, but there's not plan to end these. We have approved quarantine hotels that are accepting quarantine bookings well into the end of September.

Since you say that you're hoping to have everyone vaccinated by September, why are hotel quarantines going to be in place until the end of September?

Mr. Iain Stewart: The testing data is on our website, I believe, Mr. Chair, and honourable member. We do track that, and we do try to make that information available. We look forward to continuing this discussion as the summer progresses and vaccination progresses. Hopefully it will provide us with opportunities to make adjustments of the nature you're describing.

Mr. John Barlow: Just to move on to the contracts—and I know my colleagues have mentioned the fact that there's no opt-out clause—but is procurement actively negotiating transparency clauses in future or amended contracts related to the COVID vaccines, which would allow for parliamentary oversight, similar to what the U.K. has been able to secure?

Mr. Bill Matthews: There are a couple of comments to make on this, Mr. Chair.

We are negotiating for 2022 and beyond, and we've had some work done there already. There are considerations here in terms of additional transparency, and we're working through right now with our suppliers what transparency might look like.

This is an industry that's very interested in protecting its own interests, and I do have to say that we have to protect Canada's interests as well in future negotiating. We're trying to strike that fine balance, and the discussion continues.

Mr. John Barlow: To that, Mr. Matthews then, if you're looking to improve transparency in this round of contract negotiations, why wasn't that transparency part of the negotiations in the original contract negotiations? This committee had put forward a motion, unanimously supported, to have access to those vaccine contracts, which we still have not seen. There was an order in the House of Commons last October asking for these documents. We still have not seen those contracts. Why now is transparency an issue, but it wasn't previously and still doesn't seem to be an issue for this committee?

Mr. Bill Matthews: I think there are a couple of points here. Especially early on, Mr. Chair, when we were negotiating these a year ago, the suppliers were very much.... It was a non-starter, frankly, when we talked about transparency, and we do have some ongoing discussions about what can be released and what cannot be released. Hopefully, we'll have documents for the committee in the next two weeks or so. We are getting close to answering that question.

It is a two-way street here. The government does want to protect its own interest for future negotiations, and the industry wants to protect its interests. I will say that broader industries are watching how this plays out. We've heard from numerous industry associations, especially the military and defence type industry, who are very.... I guess they want to underscore the importance of Canada's protecting commercially confidential information for these important industries. Everyone's watching this discussion, and I do appreciate that it's maybe taken longer than members would have liked, but we are closing in on it.

• (1340)

Mr. John Barlow: Thank you.

Maybe to CBSA, I know we've talked about opening the border, and I think Mr. Powlowski and many others like me who have border ridings.... Has CBSA had any direction from the government in terms of definitive criteria needed to support the opening of the Canada-U.S. border? Are there specific criteria or a checklist that has to be met before we can open that border?

Mr. John Ossowski: Certainly we would rely on whatever the scientific advice is from our colleagues at Health Canada and PHAC, so understanding the epidemiology and understanding the health care capacity in local areas because—

The Chair: Thank you, Mr. Barlow.

Mr. John Barlow: I'm sorry, but I'm out of time.

Does that criterion exist, yes or no?

Mr. John Ossowski: We have a certain set of criteria that we have started to work with, but it's an evolving scenario.

Mr. John Barlow: So it doesn't right now.

Thank you.

The Chair: Thank you, Mr. Barlow.

We go now to Ms. O'Connell.

Please go ahead for five minutes.

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

I think the Conservative leader might be surprised by some of this line of questioning, because on social media he seems to indicate that border measures need to be stronger, but then here at committee Conservative members argue to loosen those border measures that are in place to keep Canadians safe and stop the spread. So, there might be a disconnect within the Conservative Party right now. That's unfortunate.

Mr. Stewart, I want to talk about those questions a little bit—about crossing the border to get vaccinated.

Correct me if I'm wrong, but I'm going to lay out a little bit of a scenario. If a Canadian wants to cross the border to get a vaccine, doing so requires more contacts presumably than, let's say, if they were to book an appointment locally, go to that pharmacy or facility to get vaccinated and then go home, versus crossing the border whether by land or air, where many more contacts would be involved. Then there is the notion that there wouldn't be a quarantine requirement if they were even able to gain entry into the U.S. for vaccination, which the U.S. has indicated is not an essential medical service. Notwithstanding that, if they did cross that border, I don't understand how the argument to remove any quarantine measures makes any sense given the fact that even when I went for my vaccine or when my parents got their initial vaccine, they were told that vaccines are not immediately effective. They don't offer immediate protection. Dr. Tunis even mentioned studies that discuss the length of time for your body to build up antibodies against the virus.

The notion that the second you get this vaccine, you're protected and are not going to put anybody at risk and therefore don't require testing or quarantining.... Do I understand that correctly? Actually, you're at risk because you've now come into contact presumably with more people than if you went to be vaccinated locally, and secondly you're not immediately immune. Therefore, by not quarantining and not testing, you could actually unknowingly be putting even more community spread out there.

Mr. Iain Stewart: Mr. Chair and honourable member, you have it absolutely right, actually. That is the reason why they would come back and do testing and quarantine, because it usually takes about 14 days—Dr. Tam can speak more authoritatively to that than I can—for our body to mount its immune response after vaccination. They, in effect, are not yet benefiting from that vaccine by way of protection. So, yes, you're quite right.

Ms. Jennifer O'Connell: Thank you.

Just on the AstraZeneca piece, while we've been in this meeting I think Ontario announced its second-dose strategy, and in fact I've already been getting messages from friends who are excited that they've booked their parents for their second dose of AstraZeneca.

I guess this might be a question for Mr. Stewart or Mr. Matthews in terms of procurement. We don't quite know how many people yet will want to receive their second dose. Frankly, some are not eligible yet, just based on timing and the fact it's ultimately up to the provinces and territories to determine that schedule.

Are we actively monitoring the uptake of a second dose of AstraZeneca and are we working with provinces and territories to make sure that, if there are additional needs, whether it's AstraZeneca or, let's say, a Pfizer vaccine, those Canadians will still have access to a safe second dose? I guess the question is, are we confident and comfortable that this momentum with vaccines coming to Canada is going to continue and that we are still going to meet those targets?

• (1345)

Mr. Iain Stewart: First of all, I just want to note that I'm a one-dose AstraZeneca person thus far, and I'm looking forward to a second dose like many other people are.

In that regard, as I mentioned, we have 655,000 additional doses being distributed in real time that will cover all of the demand for people's timelines for second doses all the way through June. As Bill Matthews can speak to, we have other sources of supply lined up in the event there is a desire by the majority of people to continue with the second dose.

As Dr. Tunis was setting out, however, we're also going to have the option—it's quite likely, but not yet substantiated by way of the data—that people could get a second dose of messenger RNA. Therefore, I think everybody who is waiting for their second dose from a first dose AstraZeneca perspective is well looked after. There is supply, we have it now and we will have in fact further options in addition to what's required over the course of the coming weeks.

I don't know, Bill, if you want to add anything on the supply.

Mr. Bill Matthews: Thank you, Iain.

Mr. Chair, the only thing I would add is that the next shipment of AstraZeneca, should it be necessary, would likely be in the last week of June, and we'll play that by ear based on demand from provinces.

We do have enough Pfizer and Moderna on order in case people are interested in getting a second dose of that instead of AstraZeneca, should that be the health guidance, so I feel like we're covered either way.

Ms. Jennifer O'Connell: Thank you.

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

[*Translation*]

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

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

My question is for Mr. Vinette.

Reopening a border like the one between Canada and the United States is not something you can improvise. I imagine you need to start thinking about a reopening plan for non-essential traffic now. We still have a long way to go. Only 34% of people have received a first dose of vaccine. The Prime Minister said he would lift public health measures once 75% of the population have received a first dose.

Is that number part of your criteria in the plan that you have or don't have?

Can you tell us what your forecast is in that regard?

How will you proceed?

Mr. Denis Vinette: I thank the hon. member for his question.

Actually, as soon as the U.S. border measures were put in place, we had already begun to lay the groundwork for the reopening. We didn't think we would still be in this situation today, but we're projecting the volume of people who are going to come to the border. With Transport Canada and the Public Health Agency of Canada, we're looking at what measures will be needed to streamline the processes in place right now, to reopen the border in a thoughtful and orderly fashion, while also talking to our U.S. counterparts to coordinate the measures in place at both our northern and southern borders. So, operations are continuing.

With respect to your question about the vaccination rate, that will certainly be considered, but that information and guidance will come to us from the Public Health Agency of Canada and the people who are studying the medical science on this.

Mr. Luc Thériault: We can all agree that during a global pandemic, reopening a border like this involves very careful planning.

In your scenarios, do you think it would be done by territory or nationally? Would you wait until the situation is stable from coast to coast before reopening the border?

Are you looking at these scenarios and having that kind of discussion?

● (1350)

Mr. Denis Vinette: Yes, absolutely. We are in contact with our Group of Five partners, the United States, Australia, New Zealand and the United Kingdom, to learn from their experience and to guide our approach. We are currently developing various scenarios to guide our approach to border reopening, either on a territory-by-territory basis or a national basis, based on medical science. Our guidelines are set by the Public Health Agency of Canada.

Mr. Luc Thériault: Do you have the manpower you need for a safe reopening?

The Chair: Thank you, Mr. Thériault.

Mr. Luc Thériault: Mr. Chair, some members have had a little more time. That's a worthwhile question, I asked him if he had the manpower needed.

The Chair: Mr. Thériault, you have had four minutes.

Mr. Luc Thériault: Mr. Chair, I saw you raise and lower your card several times when it was Ms. O'Connell's turn. Now that it's my turn, you're giving me two and a half minutes, while members in the Liberal Party have plenty of time to ask their questions.

We will talk about it afterwards, Mr. Chair.

[*English*]

The Chair: Monsieur Thériault, you've had four minutes. Your time is up. We'll go now to Mr. Davies.

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

Mr. Don Davies: I look forward to my four minutes, then, Mr. Chair.

Mr. Stewart, what percentage of people arriving from international air flights ends up in quarantine hotels?

Mr. Iain Stewart: We have that statistic. If I have a minute, I can provide that. If not, we'll follow up with you in writing after the proceedings, sir.

Mr. Don Davies: Thank you.

If in Alberta the province is not enforcing federal hotel quarantine rules, why doesn't the federal government, which controls airports, simply take away their right to receive international travellers and transfer it to a province that will enforce those rules?

Mr. Iain Stewart: Mr. Chair and honourable member, that's a question that's larger, perhaps, and touching on many factors other than just my responsibilities at the Public Health Agency.

Mr. Don Davies: Okay. Thank you.

In her very first news conference since assuming command of the PHAC vaccine rollout, Brigadier-General Brodie announced that Canada will receive 8 million to 10 million fewer vaccine doses than originally expected by the end of June because of delays with shipments from Moderna. Will this shortfall force the provinces and territories to cancel or postpone vaccine appointments that have already been booked?

Mr. Iain Stewart: Mr. Chair and honourable member, the media characterization of the comments she made was the way you just portrayed. Actually, what Brigadier-General Brodie does is speak to what is confirmed by way of shipments, versus what Bill Matthews, who is here with us, would talk about regarding what's expected by quarter, and perhaps he could speak to that delta.

Mr. Bill Matthews: Thank you, Iain and Mr. Chair. I'll be very quick here on this front.

Iain is bang on in terms of what Madam Brodie spoke to. The question mark is, what will Moderna deliver in June? As I mentioned in response to a previous question, we will have clarity on that in the next week or so, and we're happy to share that, but that was the delta that was being referred to. As I mentioned, we're hoping for a shipment of Moderna in the first week of June, but we'll be looking to firm that up shortly.

Mr. Don Davies: Thanks.

The COVAX facility recently announced that it has a supply shortage of at least 140 million doses, in part because of the ongoing COVID crisis in India. The WHO, UNICEF and other international agencies have called on G7 countries to donate excess supplies.

We know that the U.S., France and Sweden have announced plans to donate tens of millions of doses in the coming weeks and that Canada has yet to make the announcement. Instead, we continue to draw doses from COVAX.

Does Canada need to draw on supplies from COVAX to offer a second dose of the AstraZeneca vaccine to Canadians who received it as their first shot? Do we intend to donate any AstraZeneca vaccines not needed for second doses to the COVAX facility, and when?

Mr. Iain Stewart: Mr. Chair and honourable member, thank you for the question.

As you'll remember, earlier in this year we had many meetings where we were under intense pressure to get the number of vaccines out there, and we had strategies to require vaccines for our portfolio-style approach. Now that we are getting further along in our immunization program, as you point out, there are opportunities to make choices. There's nothing for us to say on that topic at this time, but that's an active topic of discussion. Thank you for the question, sir.

Mr. Don Davies: Thank you.

Dr. Tam, is the guidance that the government is giving to Canadians still to take the first vaccine offered to them?

● (1355)

Dr. Theresa Tam: The advice is that every Canadian who is going for a vaccination will be provided with what the province determines to be the appropriate program, but every Canadian should have the ability to have informed consent. As part of that, I think what you might be trying to point out is that there are some differences between vaccines in terms of recommendations pertaining to age groups, for example, or people with other contraindications, for example, and that is done through an informed consent process. You will see in the provinces, including Ontario, that as they are providing that second dose to people who received the AstraZeneca vaccine, that informed consent is very much part of the process.

The Chair: Thank you, Mr. Davies.

That wraps up our round five.

We have four minutes left. I propose that we do a lightning round with one-minute slots per party. If that's acceptable to the committee, we'll go ahead with Mr. Barlow to begin.

Mr. John Barlow: Thank you, Mr. Chair.

To Mr. Ossowski, I'd like to finish up my previous question. You said there are no criteria in place. How are we negotiating the safe reopening of the border with the United States if we have no benchmarks or criteria in place. Canadians need hope. We don't need any more cute one-shot summer hashtags. We need hope. When will the criteria be in place to safely reopen the border and lift the hotel quarantines?

Mr. John Ossowski: We're actively working with those criteria, as I was starting to talk about before: the epidemiological curve; the health care capacity; my officer capacity; and the processes in terms of what will be required to be undertaken. Because obviously we're now asking a lot more questions of folks as they're coming into the country by air or by land than we were before, there are transaction time considerations.

Mr. John Barlow: When do you think—

Mr. John Ossowski: There are a lot—

Mr. John Barlow: I'm sorry. I only have a minute.

Again, the frustration we're all hearing is palpable. When do you think the criteria and those benchmarks will be in place so that those discussions start to happen and we see a path to reopening the border and ending these hotel quarantines? When do you think that will be?

Mr. John Ossowski: Dr. Tam has already expressed the broad criteria here of what we're looking for in terms of safety. That would be the first point that we would be looking for, and then the subsequent measures that I talked about—

Mr. John Barlow: So you don't know. There's no plan.

The Chair: Thank you, Mr. Barlow.

Mr. John Barlow: Thank you, Mr. Chair.

The Chair: We'll go now to Dr. Powlowski.

Go ahead, please, sir, for one minute.

Mr. Marcus Powlowski: My guess is that all of us on this call are like the majority of adult Canadians: We've had one dose, but not our second dose. My understanding is that now Canada is ahead of the United States in getting out the first dose. I know that because Ron MacLean said that on the hockey game last night, and I get all my medical information from Ron MacLean on the hockey games.

My question is for Dr. Tam: What does this mean practically? I was in discussion with an infectious disease colleague yesterday. He said that he has seen quite a few people in the ICU who have had their first dose. On the other hand, the evidence is pretty good that one dose provides a great deal of protection, but what does having one dose practically mean in terms of what we can and can't do in terms of social distancing?

Dr. Theresa Tam: Thank you.

I won't go back to look at the modelling of those criteria for safe lifting, but really, the concept is that as communities, as populations, we need to get the vaccine coverage up. With one dose, that's why we pointed to making sure still that people are vigilant. It's that one dose gives you good protection, but you should get that second dose for maximizing that protection and durability, and in the meantime, you should take all the precautions and follow local public health advice. Don't let your guard down and don't go halfway with your vaccine schedule, which is why this.... It's a prudent, precautionary approach. I think we should have our eye on the puck, as it were, as we skate towards that two-dose for everyone in Canada.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have the floor for one minute.

Mr. Luc Thériault: Mr. Vinette, has the border services agency increased its staffing levels since the first wave? Is the agency planning to increase them to ensure a secure border reopening?

● (1400)

Mr. Denis Vinette: Thank you for the question.

We never stopped hiring frontline officers. We hire about 300 a year, at the CBSA College in Rigaud. We've reassigned staff because people are making fewer trips. Those employees are currently assigned to our commercial operations. We're also doing marine and air audits to meet pandemic requirements.

As our president said, part of the plan is to get those people back to the front lines. We will continue to train our students to graduate and be assigned to the border.

Mr. Luc Thériault: How long does it take to train someone?

Mr. Denis Vinette: It's a 16-week program offered through the CBSA College and it's followed by 12 months of ongoing training in the field.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, go ahead, please, for one minute.

Mr. Don Davies: Thank you.

I was just checking the U.S. numbers. As of May 19, the U.S. had vaccinated 60% of Americans with one dose, and 37% have received two doses.

With these self-congratulations and the government patting itself on the back for finally getting first doses up, I'm just wondering if they're winning a race that nobody else is running in. Obviously, with the United States at 37% of full vaccinations, the U.K. at 31% of full vaccinations and even the EU at 16% of full vaccinations versus Canada's 3%, it means that the U.S. has 13 times the number of people fully vaccinated, the U.K. has 10 times the number of people who are fully vaccinated and the EU has five times.

It appears to me that you'd almost think we did this deliberately, that we decided we'd go for one vaccine because it was the best epidemiological approach, instead of the truth, which is that we did it because we had a shortage of vaccines.

I'm just wondering. Considering that the EU, the U.K. and the U.S. have all proceeded with a full vaccination strategy, Dr. Tam, can you tell me if it's not better to have more of our population fully vaccinated than not?

Dr. Theresa Tam: Thank you for the question.

As I said, we should have everybody getting two doses.

I think the stretched interval has been an extremely good strategy. The U.K. has done the same, by the way, and has seen very good results. According to their study—I was just bringing it up from the recesses of my memory—in fact, if you stretch the Pfizer vaccine dose, even for seniors 80 years of age and older, people will have a greater antibody response at 12 weeks, compared with three weeks.

As you said—and I totally agree—it's not a race with other countries. We need to take care of Canada. All Canadians should get that two-dose vaccine, and we will look towards a much more hopeful and optimistic summer and fall.

The Chair: Thank you, Mr. Davies.

Thank you to all the witnesses for appearing here today to help us with our inquiries. I also thank you for your ongoing dedication 24-7 and commitment to the health and safety of Canadians.

Thank you to the committee for all of the great questions. It's good information.

With that, we are now adjourned.

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