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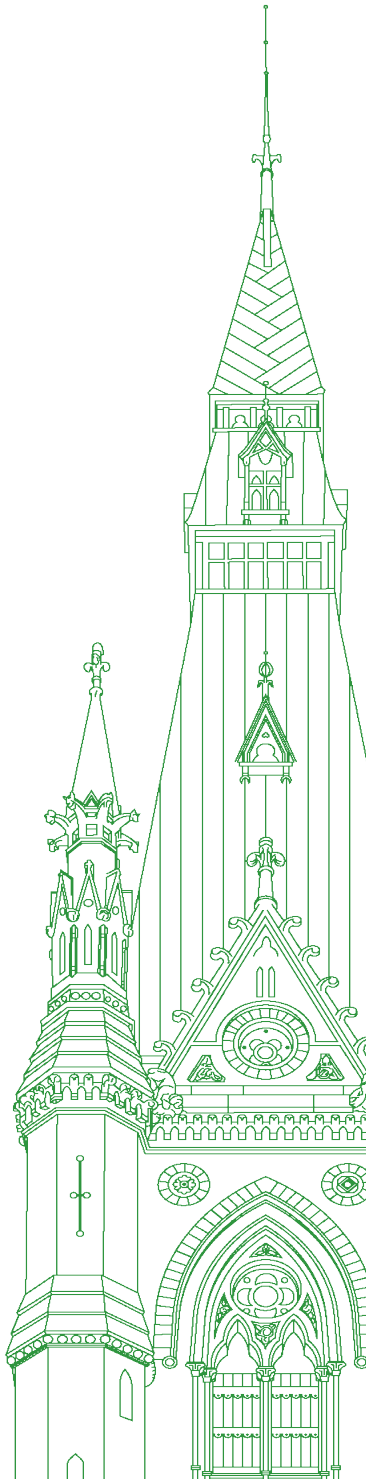

Chair: Mr. Ron McKinnon

Standing Committee on Health

Monday, June 7, 2021

● (1100)

[*English*]

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

Welcome, everyone, to meeting number 42 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic.

I would like to welcome the witnesses. From the Canadian Association of Optometrists, we have Monsieur François Couillard, Dr. Michael Nelson and Laurèl Craib-Laurin. From the City of Windsor, we have Mayor Drew Dilkens. From the Region of Peel, we have Dr. Lawrence Loh, medical officer of health, public health, and Dr. Jennifer Loo, acting medical officer of health and chief executive officer, Algoma Public Health. Furthermore, we have Dr. Christopher Mackie, medical officer of health, Middlesex-London Health Unit. We also have, with UNITE HERE Canada, Michelle Travis, research director; Elisa Cardona, hospitality worker, Local 40; and Kiran Dhillon, hospitality worker, Local 40.

With that said, we will invite the witnesses to make a five-minute statement.

I will display a yellow card when your time is nearly up and a red card when your time is over. If you see the red card, you don't have to stop right away, but do try to wrap up quickly.

With that, I will invite the Canadian Association of Optometrists to begin. Go ahead, please, for five minutes.

Dr. Michael Nelson (President, Canadian Association of Optometrists): Thank you very much, Mr. Chair.

Good morning. Thank you to all the members of the House of Commons Standing Committee on Health, in particular Luc Thériault, the member for Montcalm, for the opportunity to present on behalf of the Canadian Association of Optometrists.

My name is Dr. Michael Nelson and I'm the president of the association. I'm also a practising optometrist in Winnipeg, Manitoba, and I'm joined by François Couillard, our CEO, and Laurèl Craib-Laurin, our senior manager of government and stakeholder relations.

The Canadian Association of Optometrists represents over 5,400 optometrists who serve as Canada's primary eye care doctors. Our experience during the COVID-19 pandemic has been to have an increase in patients complaining of a variety of vision problems. Canadians are realizing the importance of their vision and that they should not be taking it for granted. Optometrists are seeing higher rates of eye fatigue, increased incidence of dry eye disease and a growing rate of myopia. Conditions like diabetic retinopathy, which can lead to vision loss, have worsened as some Canadians have chosen to delay their routine eye exams.

The growing myopia rate is especially alarming for optometrists and should raise a flag for government. Last year, the World Health Organization's inaugural world report on vision included some startling findings. Listen to this: The rate of myopia is expected to rise from 28% in 2010 to 50% by 2050. This is very alarming as myopia increases the risk of glaucoma, retinal detachment and vision loss in adults. While heredity plays a large part in myopia, it is further exacerbated by what we have seen through the COVID-19 pandemic with more and more near and close time and not enough outdoor time. This is especially worrisome for children because of the increased screen time for school and recreational activities.

For those living with diabetic retinopathy, a condition that is particularly predominant in indigenous populations, the problems of accessing care during the pandemic have resulted in worsening eye health.

● (1105)

[*Translation*]

Mr. François Couillard (Chief Executive Officer, Canadian Association of Optometrists): There are some high-level policy issues regarding eye health that deserve the attention of the federal government, as they have major implications not only for the health of Canadians, but also for the economy and productivity of our nation.

A Deloitte Access Economics research paper released last month estimates the total cost of vision loss in Canada was $15.6 billion in 2019. That was before the COVID-19 pandemic.

The lack of a coordinated primary health care system for eye health was particularly evident during the COVID-19 pandemic, which significantly reduced the ability of optometrists to provide care to Canadians. Vision problems affect the majority of Canadians, with six out of 10 Canadians reporting having had a vision problem. Every year, nearly one million Canadians miss work or school, or have their performance affected by vision problems.

We would like to encourage the Standing Committee on Health to conduct a study on vision, once this pandemic is over.

For whatever reason, Canada's many health care systems do not recognize that our eyes deserve the same level of care as other parts of the body. There is an urgent need to prioritize eye health and access to appropriate vision care for all populations.

We have the opportunity to make eye health and vision care an integral part of health care delivery from birth. Seventy-five per cent of vision loss can be treated or prevented, which means that early detection and treatment can improve population health and help avoid more costly future interventions and treatments.

Thank you very much for your attention.

[*English*]

The Chair: Thank you.

We go now to City windy...oh, sorry, the City of Windsor, Mayor Dilkens.

Mayor Dilkens, go ahead, please, for five minutes.

Mr. Drew Dilkens (Mayor, City of Windsor): Thank you very much, Mr. Chair, and it is windy here from time to time today.

Thank you and members of the committee for the opportunity to appear today and make the case for border communities, not just Windsor but across the country, to gain access to surplus vaccines that have been offered by our neighbours in the United States.

In my community prior to the onset of the pandemic, the border between Windsor and Detroit was much like that between Ottawa and Gatineau, in the shadow of Parliament Hill.

Thousands of health care workers live in my community but cross to work every day in Detroit.

At the onset of the pandemic when Detroit was a hot spot for cases—in fact, among the worst in the United States—Canadian nurses crossed the border each day to support the health care system in southeast Michigan. It's no exaggeration to suggest that without Canadian health care workers, entire hospitals would have closed in Michigan, creating widespread problems. In fact, the United States State Department recognized this invaluable contribution, and the U.S. consul general came to Windsor. He and I handed out thank-you gift cards to doctors, nurses and pharmacists who were crossing at the Windsor-Detroit tunnel and the Ambassador Bridge.

That was April 2020.

When the vaccines began to be delivered, the City of Windsor stepped up to support all aspects of the process. Hundreds of city staff have been redeployed to support different mass vaccination clinics across Windsor. We set up a special call centre to help ensure the process was smooth and efficient.

It hasn't been without challenges, the largest of which relates to the mismatch between supply and demand.

In the beginning we had 12,000 seniors over 80 years old on our wait-list. Some had waited for six weeks for the phone call to book their first appointment.

I actually booked 180 of these appointments myself. When I called one 86-year-old, she broke down crying on the phone with joy. She hadn't left home for six weeks. She wouldn't even take out her recycling without bringing her phone for fear of missing the call that would set her on a path to, once again, hug her grandkids.

The problem is that the fear and uncertainty she felt in the beginning was only exacerbated after she received her first shot, because we told her to go home and wait for up to four months now for someone else to call and book the second appointment.

Members of the committee, we can and we must do better until everyone has been fully vaccinated. Today, multiple medical officials in Detroit and the State of Michigan have offered to provide us with surplus vaccines, many of which would otherwise expire and be thrown away because vaccine uptake is slowing just two kilometres away in Detroit.

Last week it was reported that the State of Michigan saw 35,000 doses hit the landfill, and I submit to this committee that those were doses that could have gone into the arms of Canadians.

I appreciate there are a host of issues that would need to be resolved in order to make this sort of international inoculation effort possible. I'm not here to minimize or trivialize the effort that's required to make this happen, but I am here to advocate for that effort to be sped up, because it would help get Canadians access to their second doses faster than would otherwise be the case.

The federal government's COVID-19 testing and screening expert advisory panel report released on May 28 specifically highlights that Canadians with only one dose are at a significant public health disadvantage. I appreciate that a pathway exists for Canadians to get fully vaccinated based on the supply procured at the national level, which is allocated to the province, but this process will take months to hit all eligible Canadians. Multiple offers for surplus vaccines have been made to Canadians from U.S. counterparts today.

An urgent dialogue is required with all respective parties on both sides of the border to find a way to make this happen.

Throughout this pandemic, governments at every level have found ways to move mountains to safeguard the health and safety of the public. Policy initiatives which would otherwise have taken years get resolved in a matter of days, and I commit to doing everything and anything in my power to create the conditions for success.

Last week the board of the Windsor-Detroit Tunnel Corporation voted to authorize the closure of the international tunnel for the purpose of hosting a vaccination clinic at the border line below the Detroit River. I established an online wait-list for Windsor-Essex residents who are ready to stand in line for U.S. surplus vaccines. As of today we have over 11,500 Canadians on that list.

Creative solutions have been found at the Carway crossing between Alberta and Montana, and I congratulate everyone involved on both sides of the border for the creativity employed to make the right thing happen there. Surplus vaccines from Montana are getting into the arms of waiting Canadians. I'm asking for that same type of creativity and effort to be [*Technical difficulty—Editor*] so that we can accomplish our shared binational goal to fully vaccinate our residents so that we can reunite families, reignite our economies, get people back to work, get businesses open, and reopen the world's longest undefended border.

But I need help and leadership from our federal government, and I'm here again asking for that today.

Thank you, and I look forward to the questions and discussions this morning.

● (1110)

The Chair: Thank you, Mayor.

We go now to the Region of Peel and Dr. Lawrence Loh. Please go ahead, sir, for five minutes.

Dr. Lawrence Loh (Medical Officer of Health, Public Health, Region of Peel): Good morning. Thank you, members of the committee, for the opportunity to present today.

I will be focusing largely on my experience as a medical officer of health for the Region of Peel. I'm also honoured to be joined today by my colleagues, Dr. Chris Mackie, Middlesex-London Health Unit, and Dr. Jennifer Loo, medical officer of health for Algoma Public Health. They will be able to complement my observations with their own experiences from other areas of Ontario.

Peel Region is one of 34 public health units in Ontario. It serves 1.5 million people in the cities of Brampton and Mississauga and in the Town of Caledon. As many of you on the committee likely know, Peel Region has been one of the regions most impacted by COVID-19 in Canada, due to population factors such as a large proportion of essential workplaces as well as socio-demographic and economic diversity. We are also home to the country's busiest international airport, which has been a source for introduction of variants of concern into our community.

Throughout the pandemic, local public health efforts are supported through ongoing collaboration with federal and provincial partners, our local municipalities and community partners. Some specific examples of the support we have received in Peel from the federal government include $6.5 million in funding from the Public Health Agency of Canada to support voluntary isolation housing for residents who cannot self-isolate at home; $13.1 million in funding received through the reaching home program to make a meaningful impact on supporting some of our most vulnerable residents; and federal support for long-term care outbreak management from the Canadian Armed Forces to protect some of the most vulnerable seniors in our community.

We've greatly appreciated these and other supports we've received. We recognize there are other areas where collaboration can be strengthened.

In the short term, financial support from both the provincial and federal governments have aided our immediate pandemic efforts. In Peel, those efforts have entailed the redeployment of most of our staff, new hiring and suspension of most of our public health programs. We're grateful for this support.

However, looking to the longer term, the federal government could further assist Peel Public Health and public health units in Ontario by allocating public-health-specific funding in provincial transfers, as most health funding is traditionally used for health care provision. In addition, it could enhance the resources and governance of the Public Health Agency of Canada to better support a national response to infectious diseases, which would include the chief public health officer having the autonomy and authority to direct public health measures, including maintenance of international surveillance programs. It could also provide additional resources to address pre-existing, non-COVID public health crises such as the opioid epidemic, as well as those that will arise due to the delayed provision of public health services. We would be happy to expand upon key COVID issues faced by the public health sector during the question and answer session, as needed.

Another area for review would be outbreak management for first nations communities. My colleagues from Middlesex-London and Algoma who are with me on this call today have reported taking on a primary role at the local level in responding to what is a defined federal mandate. This may require supplementary support and resourcing.

The federal government can also support our pandemic response by enhancing travel and border control measures to further decrease the influx of variants of concern or interest from interprovincial and international destinations.

We support federal and provincial measures to restrict non-essential travel. To emphasize our level of concern, Peel regional council recently called for the suspension of all non-essential travel from interprovincial and international destinations to Toronto Pearson International Airport. As the international situation changes, prompt adjustments to travel restrictions should be implemented.

Dr. Loo will also speak to an additional point, regarding Algoma's experience with the land border. Their experience has underlined a desire for local input into any proposed restrictions that have an impact on our communities.

Parallel to this, it is also important to protect those who are vulnerable and impacted by restrictions. In Peel, this includes international students who arrive in Canada. Many of these individuals are targeted with marketing by unscrupulous landlords and are charged very high amounts to share inadequate living spaces during and after isolation. Support from the federal government could assist in providing arriving students with better information about their isolation options.

We also need to ensure that our workforce is protected. In Peel, an analysis of our large essential work sector found that 25% of work place outbreak cases had reported employees going to work even after symptom onset. Without proper sick leave, essential workers are often unable to isolate or stay home when ill or access vaccination in a timely manner. The previous enhancements to the Canada recovery sickness benefit and Ontario's new worker income protection benefit are steps in the right direction. However, further improvements could include minimizing interruption of individuals' income flow with timely release of funding and removing the the requirement to demonstrate a 50% loss of income prior to application. These changes would remove barriers and help to ensure that our workers can follow public health guidance when they're sick.

● (1115)

In Canada, public health is a shared responsibility between all levels of government. Coordination and collaboration are essential. Ensuring flexibility to meet local challenges is equally important. Moving forward support from multiple levels of government with local action is essential as we move out of the response and into recovery.

My colleagues and I are happy to answer any questions you may have.

The Chair: Thank you, Doctor.

We go now to UNITE HERE Canada.

Ms. Michelle Travis, go ahead, for five minutes, please.

Ms. Michelle Travis (Research Director, Local 40, UNITE HERE Canada): Hello. I would like to thank the committee for inviting us here today.

My name is Michelle Travis, and I'm the research director for UNITE HERE Local 40, the hospitality workers' union.

COVID-19 has had a devastating impact on the hotel workers who were put out of work by the pandemic. Nowhere is this more true than at the Pacific Gateway Hotel, which was taken over by the federal government under the Quarantine Act last year.

Shortly, you will hear from two workers who have been directly impacted by the takeover and are calling for government action.

The government is spending untold amounts of public money on a hotel that recently fired over 140 long-term workers, mostly women. There is no transparency on the terms of the federal takeover or how long it will last.. We have asked for a copy of the agreement between the government and the hotel, but the hotel says there is no contract.

Hard-hit workers deserve to know why the government repeatedly extends its time at, and subsidizes, a hotel that takes advantage of the pandemic to fire much of its staff. Workers should be allowed to return to their jobs as travel restrictions ease. Every day the government subsidizes this hotel more workers risk losing their jobs.

We are urging the government to state its end date at Pacific Gateway, share a copy of their agreement and to please move to another site.

Now I would like for you to hear from Elisa and Kiran.

Elisa.

Ms. Elisa Cardona (Hospitality Worker, Local 40, UNITE HERE Canada): Good morning. Thank you so much for your time.

My name is Elisa Cardona, and I worked full time for seven years as a hostess and server at the Pacific Gateway Hotel near Vancouver Airport.

When the government took over the hotel, they brought in the Red Cross. Some of us were displaced from restaurants, kitchen and housekeeping jobs.

The government has repeatedly extended its takeover of our hotel. We were told they would be out last May, then August, then November, then it got extended to March 30, 2020, and now it's been extended to the end of the summer of this year.

The hotel has used a federal takeover as an excuse to terminate me and 142 of my co-workers. That's over 70% of our staff.

Many of us were fired in the last two months and are women. I'm a single mom raising two children ages 12 and 14, and I have been worrying about my finances and money this past year. It has been incredibly stressful for me and my family. I expected to go back to my job when it was time.

We asked the hotel to allow us to return to our jobs after COVID-19 had passed and when the work becomes available again. They have refused the whole time.

The federal government is subsidizing a hotel using a temporary pandemic to fire and replace us for less. These have been good, family-supporting jobs. Why is the government allowing this to happen?

Prime Minister Trudeau promised us a feminist recovery, yet women are bearing the brunt of firings at Pacific Gateway on the government's watch. A human rights complaint has been filed against the hotel for sex and racial discrimination against women because their jobs have been disproportionately impacted.

How much has the government spent on this hotel while women like me are treated like we're disposable? After the latest round of mass hirings, we went on strike and remain on the picket line. What's happening at our hotel is not acceptable. The government can and should act. That's why we're asking the government to stop subsidizing the Pacific Gateway Hotel.

Thank you.

● (1120)

Ms. Kiran Dhillon (Hospitality Worker, Local 40, UNITE HERE Canada): Good morning, everyone.

My name is Kiran Dhillon. I worked as a room attendant cleaning hotel rooms at Pacific Gateway for 17 years until the pandemic hit.

I raised my children on this job. When the government took over our hotel as a quarantine site, they brought in the Red Cross. Other people were trained to do our jobs.

I was terminated last month along with many of my co-workers. The hotel fired 90% of housekeeping staff. Most of us are women who have been working there for decades. Women at Pacific Gateway are taking the brunt of job losses while the men's jobs are more likely to be protected.

We filed a human rights complaint on the basis of sex and racial discrimination because of how we have been treated. The hotel terminated 74% of its female staff. More of my co-workers could lose their jobs this summer if the government continues to use our hotel.

My co-workers and I want to know when will the government stop using Pacific Gateway and how will the government help women like me return to our jobs so that we aren't treated like we are second class.

People want to travel again. There's no reason why we should lose our jobs during a temporary pandemic.

Thank you so much.

The Chair: Thank you all.

We will start now with Ms. Rempel Garner for six minutes, please.

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): I'll be directing my questions to Mayor Dilkens.

Before I do, I just want to say to Ms. Cardona and Ms. Dhillon that your testimony was shocking and should wake every member of this committee up. I can't believe you had to go through that. I reiterate calls for the government to scrap the non-scientific and discriminatory hotel quarantine program.

I am so sorry you have had to go through that. I'm in shock. It's ridiculous.

Mayor Dilkens, it's my understanding that prior to this meeting—about three minutes before the meeting—you got some correspondence from PHAC that said that if a U.S. pharmacist reached her hand across the border line to give a Canadian a dose that would otherwise go in the garbage, it would be considered importing the drug for sale and would need Health Canada approval. Is this correct?

Mr. Drew Dilkens: That's correct.

Hon. Michelle Rempel Garner: Has the federal government offered you any assistance in getting these doses into Canada?

Mr. Drew Dilkens: No, none whatsoever.

Hon. Michelle Rempel Garner: Would you say that they have been more focused on providing roadblocks to getting these doses into Canada?

Mr. Drew Dilkens: Every effort to find creative solutions to make this work has been thwarted.

Hon. Michelle Rempel Garner: Would you characterize the Canadian federal government as being, in fact, comfortable with 35,000 doses going in the garbage?

● (1125)

Mr. Drew Dilkens: It would appear that way.

We have 35,000 doses that hit the trash in the State of Michigan, two kilometres away from where I'm sitting at this very moment. These were doses that had been offered to us by pharmacists living in my community who work over there. They are just beside themselves thinking that this stuff is going into the landfill when there's such a demand here on our side of the border.

Hon. Michelle Rempel Garner: Would you characterize that as sort of the height of privilege, in terms of watching vaccine inequity around the world, with the Canadian federal government being content to let doses of Pfizer vaccine go in the garbage?

Mr. Drew Dilkens: I just think we can do better.

We have a pathway to do better. It's not like [*Technical difficulty—Editor*] the U.S. side, in every situation at all times. This is being offered to us and for some reason, our government is finding every way to say no to making this happen.

I'm looking for someone who will find one way to say yes. This is a sensible pathway. It's Pfizer vaccine that's manufactured at the same plant in Kalamazoo, Michigan. Let's just find a way to make this happen.

Hon. Michelle Rempel Garner: In front of this committee, the head of PHAC said that every Canadian currently has a pathway to a vaccine and then made this sort of glib comment about the Twitter account, Vaccine Hunters.

Would you characterize that as correct in your community right now? Does every resident in your community have a current pathway to, let's say, even a second dose of vaccine? Could anybody in your community go and get a second dose today in Windsor?

Mr. Drew Dilkens: No. If they could, I wouldn't be here. That's the problem. There's a supply and demand mismatch. This is a pathway to help make our situation better on this side of the border.

Hon. Michelle Rempel Garner: Do you think Health Canada and PHAC are just being obstinate? I don't understand why they're not helping you.

Could you shed some light on that? Are they just being obstructionist for the sake of being obstructionist, in their privilege?

Mr. Drew Dilkens: The part that's difficult for me to understand is that pathways have been found. I'm not asking for something unique here. Pathways have been found at the Carway crossing between Alberta and Montana. In fact, tomorrow and Wednesday, there will be further Canadians crossing at that port of entry to get their vaccine and return to Canada.

I'm trying to facilitate the same type of thing here in my community because the vaccines are being offered. People who live here who are calling me and telling me that this stuff is being thrown in the garbage. They're asking how we can get it into our supply chain so that we can help vaccinate our population.

Hon. Michelle Rempel Garner: Have you had any push-back from anybody on the American side, be it officials or health care providers? Is anyone signalling to you that they don't want to do this?

Mr. Drew Dilkens: I've spoken with the head of U.S. Customs—the one responsible for the port in Detroit. They have concerns with the vaccination on the U.S. side at the port of entry. They said they don't deem that to be essential travel into the United States. That's why we've had to work on other creative ways to try to make this happen. That is why we painted the line in middle of the Detroit tunnel.

Hon. Michelle Rempel Garner: Would you speculate that this is due to the fact that the Canadian federal government really doesn't have any plans or benchmarks for reopening the U.S. border, in spite of people like Republican congresswoman Elise Stefanik saying that they might have to unilaterally open the border?

I'll close with this, since we have you here.

If the Americans unilaterally open the border, as Elise Stefanik has sort of alluded to today, do you think PHAC or anybody would have the resources to follow up with the tens of thousands of Canadians who would almost certainly cross the border to get vaccinated?

Mr. Drew Dilkens: I am the mayor of the closest city to the United States, a major urban area on the other side of the border. When the border opens, if it opens later this month, there will be 10,000 people crossing it in the first couple of hours to get their second vaccine, to pick up packages and, most importantly, to visit loved ones they haven't seen in 15 months. Our system will be absolutely overrun. If the thought is that you have to be fully vaccinated plus a two-week window after your second vaccine to be considered fully vaccinated, the system will be completely overloaded at this point of entry very quickly.

Hon. Michelle Rempel Garner: Do you think any member of this committee should be—

The Chair: Thank you, Ms. Rempel Garner.

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

Do you think any member of this committee should be comfortable with 35,000 doses of the Pfizer vaccine being thrown in the garbage?

The Chair: Ms. Rempel Garner, you do not have 30 seconds left.

Mr. Drew Dilkens: No.

Hon. Michelle Rempel Garner: I did. Thank you.

The Chair: Thank you.

We will 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 who are joining us today.

I'll be directing my questions to Dr. Loh, but I would first like to thank him and his team for all of the hard work they have done in our community during this pandemic.

Dr. Loh, the new delta variant has been found in our community. On June 2 you said that we need to move quickly with second doses in Peel and other hot-spot zones for maximum protection. I agree with you on this need for prioritization.

Have you heard any feedback from the provincial government on prioritizing hot spots for the second dose?

● (1130)

Dr. Lawrence Loh: I'll preface my answer by saying that there may be a difference of opinion, at least amongst the three of us medical officers of health here, in respect of that. My recommendation is not my own professional opinion. It is simply reporting a recommendation made to me by the Ontario science table, which indicates that the delta variant is increasing rapidly throughout the province of Ontario and that the Region of Peel is the furthest ahead in terms the alpha variant being replaced by the delta variant, thus necessitating, potentially, consideration of prioritizing second doses for protection.

Ms. Sonia Sidhu: On April 20 you made the courageous decision to shut down workplaces that see outbreaks of five or more employees in order to avoid workplaces spreading COVID-19 in our community. Do you think there's anything additional that the province could have done to prevent workplace transmission during the height of the third wave in Ontario?

Dr. Lawrence Loh: Workplace transmission has been a significant issue throughout the course of the pandemic. In the Region of Peel, we've always talked about the need for investigations, inspections and protections. In respect of investigations, that really speaks to making sure that workplace outbreak investigations are conducted in a timely manner, and where they cannot be, they'll be brought in under a section 22 order.

It's not just that in and of itself. We know that paid sick days and things like proactive workplace safety inspections are all things that we've had dialogues about with our provincial partners and have seen some movement on, and we certainly would be desirous of continuing to work to really address spread in workplaces in our community. It has really been part of the reason that Peel region's transmission rates have looked the way that they do.

Ms. Sonia Sidhu: Brampton is one of the most racialized communities in the entire country. I'm concerned that many of the policies of the Ontario government are disproportionately affecting essential workers who cannot access sick leave, and those who are living in multi-generational households and workplaces that may not be considered truly essential. Do you think the Ontario government has sufficiently examined the impacts of its policies on the community in Brampton?

Dr. Lawrence Loh: Thank you, Member Sidhu.

I know we've had numerous productive dialogues with our provincial counterparts. They understand and have expressed support for the unique challenges we face in the Region of Peel. Certainly things like paid sick days, proactive workplace inspections, etc., are all things that are needed.

I would also highlight that many of the challenges faced in Peel have also been the result of disparities that existed prior to the arrival of the pandemic in our community, reflecting the socioeconomic and ethnocultural diversity in our community.

Ms. Sonia Sidhu: Thank you, Dr. Loh.

You said in your statement that the most impacted region, Brampton, has been the hardest hit in the entire province of Ontario. We have seen the horrible impacts of the virus on our community's workers and families. Have you provided any advice to the Ontario government that could have prevented the severity of the tragedy, and did they they really want to hear your advice and take it into account?

Dr. Lawrence Loh: As I've mentioned, Member Sidhu, we've regularly provided input to the chief medical officer of health and the ministry on measures that could be used in workplaces in terms of testing and vaccination strategies, etc. To the extent that some of those are taken up in part or in whole, I'd be hard-pressed to remember exactly which and where those policies have landed.

What I do know, like I said, is that the story of Peel has been a story of disparity and ultimately really reflects the socioeconomic and diversity challenges we have faced throughout this response, which have existed long before COVID-19 arrived.

Ms. Sonia Sidhu: Peel was one of the first communities to have a federally funded voluntary isolation centre to help quarantine people who were not able to safely do so at home.

Could you speak to the effectiveness of the service?

Dr. Lawrence Loh: This isolation program has been extremely supportive in the course of our pandemic response. We've had over 2,500 individuals stay in our isolation housing locations, including locations that have been both provincially and federally funded. We are continuing to evaluate the [*Technical difficulty—Editor*].

We certainly believe in improved coordination of funding between provincial and federal levels for isolation housing. This could help to mitigate the administrative burdens on our staff and partners. We are certain that the having had the facility in our region has been helpful in addressing potential spread within households, which has also been another significant driver in our community.

● (1135)

Ms. Sonia Sidhu: In your opinion, has the Ontario government done enough to curb community transmission in the first, second or third waves?

Dr. Lawrence Loh: We've had numerous opportunities with the provincial government and discussions continue. I'm hopeful, looking forward, that we'll be able to do the right thing with the rise of the delta variant, and our ongoing vaccination program.

The Chair: Thank you, Ms. Sidhu.

[*Translation*]

We will now move on to Mr. Trudel.

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

Mr. Denis Trudel (Longueuil—Saint-Hubert, BQ): Thank you, Mr. Chair.

My questions are for either representative of the Canadian Association of Optometrists, Mr. Couillard or Mr. Nelson.

First of all, can you tell me what optometry research is being conducted in Canada, in general?

Mr. François Couillard: Thank you for your question, Mr. Trudel.

I would like to start by saying that there is very little research done in optometry, in Canada. Between 0.5% and 1% of the overall research budgets in Canada are devoted to vision care.

When you look at the work that is being done in the Canadian Institutes of Health Research, or CIHR, there is no entity within these institutes dedicated to vision care. By comparison, the National Institutes of Health in the United States includes an institute specifically dedicated to vision care, but there is nothing like that in Canada.

Much of the research is done by and funded by the provinces. The Quebec government, among others, devotes a lot of funds to it. Private Quebec foundations also do research.

There is some basic research and research into advanced therapies for certain health problems that can lead to vision loss. Clinical trials are also being conducted on new drugs that may help slow the progression of vision loss.

Mr. Denis Trudel: I can't remember if it was you or Mr. Nelson who spoke earlier about the need for increased funding.

If you had this additional funding, in what areas of expertise would you want to see research done at the moment?

Mr. François Couillard: It would really be necessary to determine what the priorities are in Canada. The research would probably be on diseases leading to blindness. As I mentioned, there are new drugs that slow down the onset of blindness. It could also be on vision rehabilitation. These are methods that allow people to regain some of their vision after experiencing health problems.

There also needs to be basic research. We have good institutes in Canada, including the Montreal Clinical Research Institute, where Dr. Cayouette is doing excellent research.

We have two universities that teach optometry: the University of Waterloo and the University of Montreal. Both of these centres do their own research as well. So it's likely that the research would be concentrated in those institutions.

Mr. Denis Trudel: The issue of screen time during the pandemic was addressed earlier, either by you or by Mr. Nelson.

I have quite young children, who are 12 and 17, and I've seen this problem amplified during the pandemic. We know it's one of the factors that creates attention deficit, for example.

Can you tell us how screen time can lead to eye health problems?

Mr. François Couillard: I'll let our clinical expert, Dr. Nelson, reply.

Mr. Denis Trudel: Fine.

[*English*]

Mr. François Couillard: Dr. Nelson, I'll let you answer this one on the impact of screens, please.

Dr. Michael Nelson: Thank you very much.

The pandemic has shown that all of us—kids, adults and everyone—are using our screens much, much more and has highlighted the importance of vision to us. We're having more people coming in with symptoms related to screen use. That's highlighted to us that our vision is important, and Canadians are feeling that this is a valuable area for the federal government to have some leadership on.

If we talk specifically about kids—I talked about myopia—we know there are some studies that are linking increased screen use and screen time with increased myopia or nearsightedness, which can result in vision problems down the road and an increased risk of eye disease and pathology later on.

What this pandemic has been reminding Canadians is not to take their vision for granted. Our vision is important, and we need the federal government to take leadership on this.

● (1140)

[*Translation*]

Mr. Denis Trudel: Earlier, you also talked about the need for funding to support eye health education programs.

Firstly, have there ever been any such programs?

Next, I'd like you to tell us about the ones the Canadian Association of Optometrists would itself like to set up.

Mr. François Couillard: Thank you.

As far as I know, there has never been any such campaign. Anything to do with vision care has really been neglected in the past, if you compare it to dental care, or mental health care, now. For a very long time, mental health was a taboo subject, but now there are a lot of campaigns about it.

We envisage a campaign a bit like the one done in the past to stop smoking. We really need to educate the public and make them aware that some things are good for the eyes and others are not. You need to make frequent appointments with eye specialists to make sure that you are following up on your visual health and to be able to detect problems early on so that they don't become much more serious problems that can cause blindness.

There hasn't been a campaign like this in the past, and that's why we and many of our partners nationwide are trying to develop one.

Mr. Denis Trudel: You also said that loss of vision—

The Chair: I'm sorry, Mr. Trudel.

Mr. Denis Trudel: Is my speaking time up?

The Chair: Yes.

[*English*]

You're over the time, at about six and a half minutes.

[*Translation*]

Mr. Denis Trudel: All right. I'm so sorry.

Thank you very much for your answers, Mr. Couillard.

Mr. François Couillard: Thank you,

[*English*]

The Chair: We will go now to Mr. Davies for six minutes.

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

I will be sharing my time with my honourable colleague from Windsor, Mr. Masse.

Ms. Travis, how many workers are currently affected by job action in the hotel industry in British Columbia?

Ms. Michelle Travis: I'd say thousands of workers are impacted by.... Are you talking about in particular the Pacific Gateway Hotel?

Mr. Don Davies: No, I mean totally.

I understand that a lockout notice was served by the hotel association. How many workers does that affect?

Ms. Michelle Travis: About 2,000, and that includes hotels that are being bargained by the same sort of entity.

Mr. Don Davies: To my understanding—if I can summarize this—the hotels essentially are using the pandemic to lay off workers, let their recall rates expire, and then when the recall rates have expired, they're terminating hundreds of workers, 70% of whom are women and many of whom are people of colour.

Is that correct?

Ms. Michelle Travis: That's correct.

Mr. Don Davies: This government says that it is a feminist government. It claims it wants a feminist recovery.

To Ms. Cardona and Ms. Dhillon, what is the impact on the morale of your sisters when you see the federal government continue to use a hotel that has terminated, laid off and locked out so many women?

Ms. Elisa Cardona: It's a very disheartening feeling to be treated that way when we're in the 21st century and things are supposed to be moving forward for women.

Mr. Don Davies: Ms. Dhillon, do you want to add anything?

Ms. Kiran Dhillon: We think this is sexual and racial discrimination, because out of 142 workers, 90% are women. More workers, again mostly women, could be terminated over the summer too.

Mr. Don Davies: Thank you.

I have one more question before I turn it over to Mr. Masse.

The federal government is using a hotel behind picket lines, operated by an employer who has fired and locked out hundreds of workers—mostly women. They are sending tax dollars—your tax dollars—to that very hotel right now, behind picket lines, a hotel that is operated by an employer who is facing a human rights complaint for sex and race discrimination.

Can you tell us, UNITE HERE members, what advice you would give this federal government in those circumstances?

● (1145)

Ms. Michelle Travis: Elisa, do you want to take that?

Ms. Elisa Cardona: Yes, I can take that. Thank you, Michelle.

I would like the federal government to stop subsidizing hotels that treat women and employees in that manner: with no respect, no dignity and making them feel like they're disposable when our jobs are not disposable and we're some of the most trained people, with high skills.

I don't understand why this specific hotel is getting all this subsidizing from my tax dollars as well as yours, letting people get fired and then getting them replaced by minimum-wage employees.

Mr. Don Davies: Thank you so much. I appreciate that.

Mr. Masse, I cede the floor.

Mr. Brian Masse (Windsor West, NDP): Thank you, Mr. Davies.

That's atrocious and disgusting. I thank the UNITE workers for bringing this forward and for the work they've done previously on Investment Canada as well.

Mr. Dilkens, with regard to the Public Health Agency, I know they've responded to you in a negative way. Can you shed some light on how seamless the integrity at the border is? The City of Windsor owns the Windsor-Detroit tunnel. Can you highlight the logistics and the security that you offer in this program?

Mr. Drew Dilkens: Thank you for the question.

Being on the international border, we are very unique here in that we own our half of the Windsor-Detroit tunnel. The City of Detroit owns their half. It's really the only case like this between the United States and Canada. With the approval of the board, which we got—unanimous approval—we have the ability, as the board said, to close the tunnel down as often as we need for as long as we need to be able to facilitate vaccination at the centre line.

We actually drew the line in the tunnel. The idea here is that on the U.S. side, we have multiple offers from folks who live in Canada, from Canadians, to facilitate and to secure the vaccines. We're trying to find a way to do this that is maybe not the easiest. There are better solutions that are more optimal, but we're trying to find a practical way to deal with all of the logistics on both sides of the border. We can close the tunnel, bring people down and vaccinate them right at the border line. Then they'd be fully vaccinated Canadians.

You know what? Guess what? It would be better for everyone else in Canada who is waiting for a vaccine. We've acquired other vaccines from other sources, and everyone else would move up on the list faster.

Mr. Brian Masse: On top of that, many of those people involved in the process would actually be Canadians, because they work over in the United States. Thousands go over there every single day. We would actually have Canadians inoculating Canadians, but just using surplus U.S. vaccine.

Mr. Drew Dilkens: You're absolutely right. These would be Canadians working in Michigan in health care and administering the vaccines to Canadians on the other side of the line.

Mr. Brian Masse: Lastly, can you confirm the secure operation there? You've provided an international transit system already and other types of secure elements. The Public Health Agency doesn't seem to understand, I don't think, the security that can take place in the operation that you're proposing.

Mr. Drew Dilkens: I'm really clear that we don't want to do this under the cover of darkness. We'll work with the U.S. CBP and the CBSA to find the best way to do this that allows traffic to continue to flow, but at the end of the day, there are ways to do this so that everyone has the security and comfort they need.

The Chair: Thank you, Mr. Masse.

Mr. Brian Masse: Thank you, Mr. Chair.

The Chair: That brings our regular round of questions to an end.

I believe we'll have time for a snapper round of maybe two minutes per party.

On that basis, I will offer it to you, Ms. Rempel Garner, if you wish.

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

The Chair: You have two minutes.

Hon. Michelle Rempel Garner: I'm really having a hard time trying to wrap my brain around the fact that the federal government would fire women through the hotel quarantine program.

Ms. Travis, Ms. Cardona or Ms. Dhillon.... Perhaps, Ms. Travis, this is a question for you. Are you aware if the federal government did a gender-based analysis of the hotel quarantine program? If so, were you consulted on that?

Ms. Michelle Travis: We have no idea whether it did any sort of analysis on that. We reached out to the federal government months ago, and to the Minister of Health last fall, when we suspected that the hotel owner was going to use the federal quarantine as an opportunity to fire much of the staff.

We had one conversation, and we never heard from the government again. It kicked it over to PHAC. Today is a good opportunity to ask PHAC, why is it continuing to use this quarantine hotel? How much longer does it plan to use it? It never provided a contract, and the hotel says there is no contract with the government for the use of this hotel, which is very interesting.

● (1150)

Hon. Michelle Rempel Garner: That's great to know.

Are federal Liberal MPs or ministers staying at this hotel? Are you aware of that?

Ms. Michelle Travis: Right now, it's simply being used as a quarantine site.

Hon. Michelle Rempel Garner: I was just wondering if you guys were aware of that.

I know the government purports to have an anti-racism strategy. Do you believe this program, and the treatment of labour and workers, fits in line with that?

Ms. Michelle Travis: I think the government has put its money where its mouth is. We have talked a lot about having an inclusive feminist recovery. We think what's happening with the Pacific gateway is kind of exhibit A for what shouldn't be happening.

As Elisa and Kiran mentioned earlier, most of the workers who have been fired have been predominately women and mostly women of colour. Some 90% of the housekeeping staff have been terminated in a hotel that has almost 400 rooms, but once the government leaves this hotel, the hotel is going to need staff, because folks will want to travel again.

There is a real deliberate effort here to get rid of long-term staff, and to replace them for less. The government is aware of the problem. Our concern is that it hasn't acted, and there's an opportunity to act.

Hon. Michelle Rempel Garner: Do you think it is complicit in letting labour—

The Chair: Thank you, Ms. Rempel Garner.

We'll now go to Ms. O'Connell, for two minutes.

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

Mayor Dilkens, thank you for coming.

As an Ontario MP, I understand the frustration of the Ontario government with some of the vaccine rollout plans. I'm sure you've expressed that, including some of the four-month timelines, because other provinces had moved sooner to change that, but we're happy to see Ontario starting to put that pathway out for second doses.

I'm sure you've been having some fiery conversations with Premier Ford on that.

With regard to some of the conversations around these doses, while I certainly appreciate and agree that no doses should ever be wasted, the crux of this is that these doses don't belong to Canada. They belong to the U.S. and the U.S. people, and the taxpayers who paid for them.

Although we want to make sure that Canadians can access doses, we would need the State of Michigan, the U.S. government and, frankly, even Premier Ford to support this, which is what we were able to do in Manitoba and North Dakota. All of those levels of government came to the table, so it wasn't about creativity; it was really precise planning.

Do you have the support of the State of Michigan, the U.S. government and Premier Ford for the import of these vaccines like we had in other provinces?

Mr. Drew Dilkens: That's a great question.

Premier Ford has been very supportive of this creative effort to get additional vaccines, which were destined for the landfill, into the arms of patiently waiting Canadians.

I would suggest that if it weren't for active efforts by this federal government to make this almost impossible, this would have already happened, as you see happening in other jurisdictions between the United States and Canada.

That is the most difficult part for me to accept. We are telling everyone that it's a race between the vaccine and the variant—

Ms. Jennifer O'Connell: Sorry, I have limited time.

Mr. Drew Dilkens: —and we're going to lose the race unless we get these vaccines.

Ms. Jennifer O'Connell: If the U.S. and the State of Michigan don't support it, how is that the Canadian federal government—

The Chair: Ms. O'Connell, I'm sorry, but I'm going to have to cut you off there, because we're very short of time.

Ms. Jennifer O'Connell: Sorry, can I get the answer at least?

The Chair: A quick answer.

Mr. Drew Dilkens: I need our government to support it first.

The Chair: Thank you.

[*Translation*]

Mr. Trudel, you now have the floor for two minutes.

Mr. Denis Trudel: I will once again address the representatives of the Canadian Association of Optometrists.

I will ask a somewhat specific question.

On page 10 of the cost of vision loss and blindness in Canada report, it says that the total cost of vision loss in Canada was $32.9 billion in 2019. That is huge!

It also reports that this includes $15.6 billion for the financial costs of vision loss and $17.4 billion in costs associated with lost quality of life.

Could you explain what these figures mean?

Mr. François Couillard: That is a very good question.

I must stress that this report contains a lot of expert information. It was prepared by experts who work for a subsidiary of Deloitte in Australia. It's very accurate, timely data.

At the Canadian Association of Optometrists, we prefer to quote the $15.6-billion figure, because these are very tangible costs. These are health and productivity costs.

The $30-million figure is for quality of life losses. It is not really about a tangible loss of productivity, nor costs. Those who prepared the report have a methodology for quantifying the loss of quality of life.

The Canadian Association of Optometrists prefers to refer to the $15.6-billion figure. This is what we mentioned in our comments.

● (1155)

Mr. Denis Trudel: I'm not sure I understand everything.

Can you explain further what the loss of quality of life associated with vision loss is?

Mr. François Couillard: If I can't go outside, to the cinema or to the grocery shop without being accompanied by a dog, I suffer losses in quality of life.

Those who did this study have a very sophisticated methodology that measures all of these things and quantifies this in absolute dollars.

Again, that's not what we're primarily looking at. We're looking at the first $15.6 billion, which is very tangible and relates to the costs to Canadian health systems.

Mr. Denis Trudel: I see.

You also mentioned that—

The Chair: Mr. Trudel, your time is up.

Mr. Denis Trudel: Already over.

Thank you.

Mr. François Couillard: Thank you for your questions.

[*English*]

The Chair: Now we'll go to Mr. Davies for two minutes.

Mr. Don Davies: Thank you.

Ms. Travis, how long has the federal government been using this hotel behind picket lines?

Ms. Michelle Travis: The government has been in this hotel since March 2020, and workers went on strike on May 3—recently—because there were so many rounds of firings. That was in protest over the firings.

Mr. Don Davies: Have you brought this to the federal government's attention, or any Liberal MPs, that it is operating behind picket lines, giving money to this employer who is acting in this manner?

Ms. Michelle Travis: We have made efforts to reach out to the Minister of Health multiple of times since last fall. We also made sure that they were aware of what was happening in May. We made sure that they were aware of the firings. We made sure that they were aware of the human rights complaint. We've also copied other ministers on our correspondence, and we haven't heard from them.

Mr. Don Davies: That was going to be my question: What has been the response? Have you received no response so far?

Ms. Michelle Travis: No response.

Mr. Don Davies: This government has made a tag line, almost a credo, of being committed to the middle class. What's the impact on wages and working conditions of this hotel strategy?

Ms. Michelle Travis: For years, this hotel has provided good, family-supporting jobs, living-wage jobs.

Kiran and Elisa have worked in this hotel for years. They are women who have worked in this hotel for 40 years and would go back tomorrow if they could. This is a very long-term group of workers, and they've stayed in their jobs because they're good jobs. What the hotel owner wants to do is to terminate most of the workers—they have already terminated most of the staff—and to replace them with folks at minimum wage. The owner also wants to get rid of their union health benefits, eliminate a pension and drastically roll back any sort of economic gains that have been made over the years; and that's not right. We're concerned that the government has not listened to what's happening here, is not acting and is continuing to roll over their stay at this particular hotel. There are other hotels in the area they could be using. They don't have to be using this one.

Mr. Don Davies: Thank you so much.

The Chair: Thank you, Mr. Davies.

Thank you all. Thank you to all of the witnesses for sharing with us your time today and for assisting us in our studies. It is most appreciated. Thank you to all of the members for the great questions. With that, we will suspend and bring in the next panel.

● (1155)

_____(Pause)_____

● (1205)

The Chair: I call this meeting back to order.

We are resuming meeting number 42 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation for Canadians in light of the COVID-19 pandemic.

I'd like to welcome the witnesses. From the Department of Health, we have 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; from the Public Health Agency of Canada, Mr. Iain Stewart, president, Dr. Theresa Tam, chief public health officer, and Brigadier-General Krista Brodie, vice-president, logistics and operations. From the Department of Public Safety and Emergency Preparedness, we have Mr. Rob Stewart, deputy minister.

With that, thank you to all for being here. We appreciate your time.

We will go straight to questions, starting with Mr. Barlow for six minutes.

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

I appreciate everybody's time today.

I'll go to Mr. Iain Stewart first.

Mr. Stewart, the expert panel on COVID-19 testing and screening recommended that the use of the government quarantine hotels be discontinued. Have you given the government advice to allow the hotel quarantine requirements to expire on June 21?

Mr. Iain Stewart (President, Public Health Agency of Canada): Mr. Chair, I will note that I am not able to turn on my video, for some reason. Maybe it's being blocked centrally...?

Mr. John Barlow: I'm hoping my time hasn't started, Mr. Chair.

The Chair: It has, but we'll start you over.

Mr. Stewart, I did see you earlier. It is most helpful if you have your video on. I think it's helpful for the interpreters.

Mr. Iain Stewart: Not to waste everybody's time, I'll ask my office to get the IT people to come to see what we can fix. I'm very sorry, Mr. Chair.

Honourable member, if you would just repeat the question, I can take a shot at it.

The Chair: Mr. Barlow, I will start your time over again, if you wish to go ahead with Mr. Stewart without the video.

Mr. John Barlow: Yes. That's fine with me, Mr. Chair.

The Chair: Okay. Go ahead.

Mr. John Barlow: Thanks.

Mr. Stewart, the expert panel on COVID-19 testing and screening recommended that the use of the government quarantine hotels be discontinued. Have you given the government advice to allow the hotel quarantine requirement to expire on June 21?

Mr. Iain Stewart: We've given ongoing advice around the government-approved accommodations, as you can imagine, and we're taking the testing panel report very seriously. We're giving it full consideration.

Mr. John Barlow: On what day will the quarantine hotel program be ended?

Mr. Iain Stewart: Mr. Chair and honourable member, I'm not able to answer at this time.

Mr. John Barlow: It's good to see your video now, Mr. Stewart.

Mr. Iain Stewart: Thank you, Mr. Barlow.

Mr. John Barlow: You're welcome.

Mr. Stewart, we had some pretty enlightening testimony by a group of hotel employees during the previous panel. I think many of us on this committee found it quite ridiculous the fact that the federal government is subsidizing a company that has fired 80% of its staff, many of them women, as a way to maybe break a union.

With that in mind, Mr. Stewart, was a gender-based analysis completed for the hotel quarantine program?

Mr. Iain Stewart: Yes. We did do a gender-based analysis for our new border measures.

Mr. John Barlow: Was that done for the hotel quarantine program specifically?

Mr. Iain Stewart: It included the totality of the program.

Mr. John Barlow: Would you be able to table with this committee the results of that analysis?

Mr. Iain Stewart: I will do that.

Mr. John Barlow: In that same vein, Mr. Stewart, was an analysis done on how the hotel quarantine program would fit into Canada's anti-racism strategy?

● (1210)

Mr. Iain Stewart: I'll have to look into that one, Mr. Chair, and honourable member.

Mr. John Barlow: Mr. Stewart, we also recently learned that the Prime Minister will not be staying at a designated quarantine hotel when he returns from the G7. What is the anticipated cost of setting up a special hotel or a quarantine program for the Prime Minister and his staff when he returns from the G7?

Mr. Iain Stewart: The information I have at my fingertips on that topic is that the Prime Minister is quarantining and being tested and waiting for his test results before proceeding on to his approved quarantine plan. I don't have details of the nature that you're referring to, honourable member, at my fingertips at this time. We can look into your question and see what the answer is.

Mr. John Barlow: By the sound of your response, Mr. Stewart, he will not be staying in a traditional hotel quarantine. Will he be doing something unique to the Prime Minister and staff then?

Mr. Iain Stewart: I, myself, don't have knowledge of whether a decision has been made in that regard. I know that different ideas and options have been discussed and considered, but I, myself, don't have the information you're asking for.

Mr. John Barlow: Mr. Stewart, I find it strange that the Prime Minister of our country is travelling internationally, which he's asking every Canadian not to do, and that there wouldn't be a very detailed strategy and plan for his quarantine upon returning home. It's bad enough when he is going to be doing activities that he is telling every Canadian not to do.

There isn't a detailed strategy or plan for his quarantine upon returning home. Is that correct?

Mr. Iain Stewart: There is a detailed plan. We provided comment on different approaches. What I don't know is if a specific approach has been taken, and you're asking me for the dollar cost of that. I don't have the dollar cost of that.

Mr. John Barlow: Mr. Stewart, how is it possible that we don't have the detailed plan for his quarantine upon returning home, or is that there and we're just unaware of what it would be?

Mr. Iain Stewart: I'm saying that different options were looked at, and we were providing comment on those different options. I don't know where that has ended up. I can ask and look into that for you.

Mr. John Barlow: Can you provide those options that were expressed or provided, Mr. Stewart? Maybe they could include a financial breakdown of those options, as well, for the committee.

Mr. Iain Stewart: I will see whether that can be provided. As you know, we're not always able to provide advice given to ministers and so on. We will have a look at exactly what you're asking.

Mr. John Barlow: With that, Mr. Stewart, the hotel quarantine program is in place, despite the panel's saying it should be ended. Why would the Prime Minister not be just using one of the quarantine hotels that are already in place?

Mr. Iain Stewart: If that decision has been made and made public, you would be better placed, perhaps, to direct the question to the Prime Minister or his official spokespeople.

Mr. John Barlow: The minister has stated that she has consulted with the provinces on the expert panel's border measure recommendations. What were the results of those consultations? What did the provinces say about the expert panel's recommendation to end the hotel quarantine program?

Mr. Iain Stewart: Minister Hajdu discussed with her health minister colleagues the findings of the report and, in fact, had the panel come and talk about their findings and report. There was conversation afterwards.

Mr. Chair and MP Barlow, I don't remember off the top of my head specific comments back from individual provinces, but I'm sure it's a matter of public record. We can look into it and provide details from that discussion.

Mr. John Barlow: Mr. Stewart, Congresswoman Stefanik, the co-chair of the northern border caucus, recently called for the United States to unilaterally open the border out of frustration with the Liberal government's lack of a plan to do so. Has your department provided any advice to the government on when fully vaccinated people will be allowed to cross into the United States without a quarantine?

Mr. Iain Stewart: As usual, we have done analysis and options on ways to approach this exact topic. That advice has been put forward. That would be, maybe, a question more appropriately put to a minister about what intentions they have. At this point, there's nothing public that I'm able to report on.

The Chair: Thank you, Mr. Barlow.

Mr. John Barlow: Thanks, Mr. Chair.

The Chair: We go now to Mr. Van Bynen for six minutes.

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

Thank you to our witnesses for joining us again today. I know that, over the past few months, some of you have made yourselves available a number of times to answer questions, and I know it's a very busy time for you. I want you to know that the extra effort to meet with us is greatly appreciated.

I want to ask Deputy Minister Matthews a few questions on accountability to taxpayers, specifically on the subject of mobile health units.

There are some that have gone looking for conspiracy and cronyism where there is none, and I will ask you to clarify this for us with a few details.

What were the pandemic circumstances at the time that MHUs were identified as a possible necessity? Why was this anticipatory investment made?

● (1215)

Mr. Bill Matthews (Deputy Minister, Department of Public Works and Government Services): This was done at a time when you were seeing things like emergency rooms overrun, with lack of space being an issue. You saw the cruise ship in New York Harbor, and we did notice that other countries were taking steps to put in place plans for mobile hospital units or health units.

I think the important point here is just how long these things take to design and implement. The design is one piece, but acquiring all the equipment that goes with it is another. You can't just purchase these off the shelf.

What was done at that time was that contracts were put in place for two different designs, one with Weatherhaven that goes inside an existing structure—and that's the one that has been deployed in Ontario—and another model with SNC-Lavalin and partners that is designed.... Sorry, the Weatherhaven one is a stand-alone one; it's not inside a building. The SNC-Lavalin and partners' one goes inside an existing building like an arena or something like that.

We worked to line those contracts up. Then we worked with health officials to design them and get going with procuring the equipment that would be necessary should these need to be deployed. As you know, we have requests from Ontario, and some units have actually been deployed.

Mr. Tony Van Bynen: Just as it was for the rest of the world, this was an issue of thinking ahead and disaster planning.

I know that PSPC was primarily responsible for executing procurements on behalf of the client departments that came to you with the MHU request. Did they provide you with the rationale on why they were needed?

Mr. Bill Matthews: In this case, PSPC actually used its own funding to acquire these, so in part of the estimates last year, PSPC was given additional money voted by Parliament where there was a need for procurement—because we are in direct contact with suppliers and are noticing shortages—to go ahead and procure things. Obviously, we consulted with health officials on the design, but the budget holder was PSPC in this case.

We also used that funding for things like setting up direct flights from China for PPE and contracting warehouse space in China for PPE, so it was to shorten the procurement timelines if we did notice an area of need and did that planning in advance; but, obviously, the detailed design was done in consultation with health officials, as well as experts from National Defence who have experience in setting up mobile hospital units.

Mr. Tony Van Bynen: Given that at the time there were constraints, there were public health concerns and there were questions around resources, you mentioned earlier that there were two suppliers. Can you tell me why they were selected?

Mr. Bill Matthews: Based on assessments, there are not a lot of companies in this business. We had two who have done these types of things before, often through efforts with the military in Afghanistan, as well as for the U .S. military, so we found two suppliers who were well experienced in these areas, both in design as well as in the procurement aspects, because both are important.

Mr. Tony Van Bynen: They were known suppliers who were trusted to do the job.

Can you explain what type of contract this was and why it was most appropriate in the circumstances, based on the product or service needs?

Mr. Bill Matthews: The contract had a couple of elements, Mr. Chair.

Number one is the design, as I mentioned, and number two is to actually procure the equipment necessary to establish these things should they be needed, because, again, you have to have these on hand in advance of any request. As well, you have the storage of the equipment and then the deployment if it should be used, as well as the tear-down once the need has passed. There are those elements. Some of these are to be determined in terms of future use, but those are the basic elements of the contracts.

Mr. Tony Van Bynen: Was that a specific type of contract?

Mr. Bill Matthews: It's effectively a mix of goods and services. It's a total solution approach, where the supplier is indeed responsible for.... We jointly ran on the design, but the actual procurement of the equipment, the deployment, the maintenance and then the tear-down are the responsibility of the supplier.

Mr. Tony Van Bynen: In your experience, would you consider this a tool that's frequently or flagrantly used in procurement?

Mr. Bill Matthews: The total service package across different industries...? Yes. I mean, these are obviously a fairly unique asset that the government has deployed. Again, they do require an awful lot of advance planning, because if there is a need, you have to effectively be out in front of it eight months in advance, but this turnkey-type solution is used in other procurements.

Mr. Tony Van Bynen: In your professional experience, was this a contract that was awarded to the right suppliers for the right job and the necessary product or service?

Mr. Bill Matthews: We are confident that we found suppliers that were capable of delivering and helping with the design, and again, with two different models, which is important. When you look at Weatherhaven, they have a good partnership with ATCO trailers. SNC-Lavalin and its partner PAE had done this work together before, so it was a well-known partnership for the military and well experienced in these areas, and we were quite comfortable with their expertise.

● (1220)

Mr. Tony Van Bynen: Coming back to the issue of financial accountability for goods purchased versus in demand, have the MHUs been deployed?

Mr. Bill Matthews: We've had deployments in Ontario of the units that are stand-alone. I think people may be familiar with Sunnybrook and that deployment. There have also been discussions about potential deployment with other provinces, but to date Ontario is the only province that has actually resulted in a deployment.

Mr. Tony Van Bynen: Do they continue to be available should the need arise?

Mr. Bill Matthews: Yes, they're absolutely still there, Mr. Chair, should there be a call. It's one of these assets that you hope you never have to deploy, frankly, but should there be a need, they're available. There's one of each model available for deployment should it be needed.

Mr. Tony Van Bynen: Would they be available again in the event of a possible future health crisis? That is, do they have an expiry date?

Mr. Bill Matthews: Well, obviously for the equipment, for part of these units, some of it has expiry dates, but the actual "vehicle" itself, I'll call it, is available for some time should it be needed in the future. We're in discussions with our colleagues about eventual home for these things in terms of which department would retain responsibility.

The Chair: Mr. Van Bynen, you're way over the time. I was distracted. I apologize.

We go now to—

Mr. Tony Van Bynen: Thank you.

Mr. Don Davies: Mr. Chair, if I just might add, I wasn't keeping track either, but it seemed like that was a very long time. Can you tell me how many minutes were given to the Liberals there?

The Chair: Mr. Van Bynen had an extra 37 seconds.

Mr. Don Davies: Oh, was that all? Okay, thank you.

The Chair: It's all my fault. I apologize to the committee.

[*Translation*]

We'll now give the floor to Mr. Thériault.

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

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

My question will be directed to Mr. Lucas from Health Canada, and possibly Mr. Matthews at some point.

On May 3, 2021, the department approved interim order number 2 regarding the importation and sale of medical devices for use with COVID-19. This order replaces the first interim order signed on May 23, 2020; it maintains the optional authorization pathway established to facilitate clinical trials of potential COVID-19 drugs and medical devices. It does so by providing regulatory flexibility so that other types of clinical trials can be conducted effectively. The Health Canada page even takes pains to point out that interim order 2 continues to make Canada an attractive place to conduct clinical trials, which will improve Canadians' access to potential treatment options for COVID-19.

Could you explain this regulatory flexibility to me?

[*English*]

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

Indeed, Health Canada did renew the interim order for clinical trials. These were part of a series of interim orders brought in during the course of the pandemic to enable the rapid review of medical devices, clinical trials, vaccines, therapeutic products and concurrent measures to ensure their safety, quality and efficacy.

The clinical trial interim order—

[*Translation*]

Mr. Luc Thériault: What are these regulatory relaxations that make it attractive to conduct clinical trials here in Canada? That is my question.

[*English*]

Dr. Stephen Lucas: Mr. Chair, I'll note a number of areas. These changes allowed for multiple-site clinical trials, shortened review periods and the use of multiple investigators at these sites. They were really intended to enable, as the member noted, the attraction of clinical trials, of which we have over 100 now, which are associated with COVID vaccines and therapies.

On May 25, we also launched a consultation on clinical trials modernization to look at updating the regulatory framework across all product lines. This is building on some of the experience with the interim order, which was renewed in May.

● (1225)

[*Translation*]

Mr. Luc Thériault: Are you planning to extend this regulatory flexibility? Recently, several researchers, companies, patient organizations and others came to the committee to warn against the implementation of the new Patented Medicine Prices Review Board guidelines. They said the guidelines would make Canada and the provinces much less attractive for clinical trials.

Have you ensured that the price we pay for our medicines is not excessive? What steps have you taken to control the price of drugs related to this COVID-19 research here in Canada?

[*English*]

Dr. Stephen Lucas: Mr. Chair, the honourable member asked a few questions. I'll deal with those in turn.

On the first, as I indicated, Health Canada has renewed the interim order for clinical trials associated with COVID-19 vaccines and therapies. This allows for the ability to attract those trials—as indeed has been the case—and to rapidly approve and monitor them using a series of flexibilities. That approach is being embedded along with others to ensure a competitive, innovative environment for attracting clinical trials in the clinical trial modernization consultations that have been launched.

In 2020, we had a significant—above average—number of new drug submissions and over 100 COVID-related clinical trial applications. The government did promulgate the regulations pertaining the Patented Medicine Prices Review Board in August 2019. The coming into force of those is currently slated for the beginning of July.

[*Translation*]

Mr. Luc Thériault: Are you going to postpone that deadline?

You want to put in place a reform to better control excessive prices, but you blame the provinces for not revealing the figures and negotiations related to the price of the drugs they pay. Yet you prevent us from having access to the contracts to find out what price you are paying for COVID-19 drugs.

Isn't that a contradictory approach the government is taking?

[*English*]

Dr. Stephen Lucas: Mr. Chair, I will indicate that the coming into force of the patented medicine price regulations, currently slated for July 1, has been deferred in the past through the pandemic, and consultation on the guidelines.... The—

[*Translation*]

Mr. Luc Thériault: The contradictions—

[*English*]

Dr. Stephen Lucas: —specific factors—

[*Translation*]

Mr. Luc Thériault: The contradiction—

The Chair: Mr. Thériault—

Mr. Luc Thériault: —between what you are preventing us from finding out...

The Chair: Mr. Thériault—

Mr. Luc Thériault: The contradiction regarding contracts—

The Chair: Mr. Thériault—

Mr. Luc Thériault: I will come back to it. You will have had a chance to think about it and give a concise answer to the question, Mr. Lucas, please.

[*English*]

Dr. Stephen Lucas: In regard to the element of the regulations pertaining to confidential rebates, that was addressed and contested in a court decision, which is currently under appeal. As a result of that court decision, that element is not going forward, but is proceeding in the courts.

[*Translation*]

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll now go to Mr. Davies.

Mr. Davies, you have officially six minutes. I will give you another 45 seconds because Monsieur Thériault and Mr. Van Bynen went over their time. I'll make it up to the Conservatives in the next round. Thank you, all.

Mr. Davies, go ahead for six minutes and 45 seconds.

Mr. Don Davies: Thank you, Mr. Chair. That's very fair of you.

Mr. Stewart, why is this federal government, which claims to be feminist and committed to expanding the middle class, using and effectively subsidizing a hotel—the Pacific Gateway Hotel in Vancouver—that is behind picket lines; has fired workers, primarily women and people of colour; is replacing long-term, family-sustaining jobs with minimum wage employees with no benefits; and is facing a gender- and race-based human rights complaint, particularly when there are other hotels in the area that could be used for quarantine?

● (1230)

Mr. Iain Stewart: When we entered into our contract with that hotel, they were not in a strike position at that time. From what you are saying, you are indicating that things have progressed.

We use the hotel facility and we also employ hotel staff in the back office elements of the operation. However, the frontline work is done by infectious control specialists, which hotels do not have.

What I would say is that we'll look into the situation you're describing. However, it's not consistent with my understanding.

Mr. Don Davies: Mr. Stewart, can you produce that contract to this committee, please?

Mr. Iain Stewart: Could we produce our contract with our designated quarantine facility in British Columbia?

Mr. Don Davies: Yes, please. That's with the hotel.

Mr. Iain Stewart: We will have a look at that, sir, and respond to your request.

Mr. Don Davies: Dr. Tam, on May 17—just a couple of weeks ago—the World Health Organization issued a statement to provide clarification and guidance on the issue of expiry dates of COVID-19 vaccines. It said the following:

> Any vaccine that has passed its expiry date, including Covishield, should not be administered. While discarding vaccines is deeply regrettable in the context of any immunization programme, WHO recommends that these expired doses should be removed from the distribution chain and safely disposed.

Why is Canada ignoring that recommendation?

Dr. Theresa Tam (Chief Public Health Officer, Public Health Agency of Canada): Mr. Chair, I think this is more of a regulatory question, but certainly when I—

Mr. Don Davies: Who should answer, then, Dr. Tam, if you can't answer? Who's best placed to answer that question as to why we're ignoring that?

Dr. Theresa Tam: I would suggest Dr. Lucas.

All I would say is that when a regulator accepts a manufacturer's submission and data on extension of shelf life, that is reviewed by the regulator. When the regulator approves of that, the vaccine then is not considered as expired; so I think that's a regulatory issue.

Mr. Don Davies: Dr. Lucas, can you tell me why Canada is at odds with what the WHO is recommending?

Dr. Stephen Lucas: I would simply say that there are no expired doses being used in Canada. Health Canada received a submission in late May from AstraZeneca seeking a one-month extension on the doses that were to have expired on May 31. Health Canada scientific reviewers reviewed in detail the data provided and issued a regulatory decision extending those doses to July 1.

Mr. Don Davies: Okay.

Dr. Tunis, many Canadians have received their first dose of AstraZeneca. Many of them are now coming up for their second dose. Most provinces, if not all of them—I'm not sure—are not using the drug due to VITT concerns and supply issues. Of course, the mixing data, using AstraZeneca with messenger RNA vaccines, is apparently not conclusive to this day.

What is NACI's recommendation to Canadians who received their first dose of AstraZeneca on what they should be taking for their second dose? Should it be AstraZeneca or should it be a messenger RNA vaccine? What data is that answer based on, please?

Dr. Matthew Tunis (Executive Secretary, National Advisory Committee on Immunization): NACI published new advice, as of last week, on the topic of mixing vaccine schedules. NACI has now recommended that either AstraZeneca COVID-19 vaccine or an mRNA COVID-19 vaccine product may be offered for the subsequent dose in a vaccine series started with AstraZeneca. Either may be offered.

The evidence that was used by the committee to issue that recommendation included both safety evidence and evidence on the immune response. There were several studies at the time, one from the United Kingdom, one from Germany and one from Spain. All of them reported a good safety profile when vaccines were mixed between AstraZeneca and mRNA vaccines. There was also one study on the immune response from Spain. I'll note that a number of studies came out preprinted last week as well, two from Germany, on the topic of immune responses when vaccines are mixed.

The committee has made that recommendation based on the risk of VITT, or thrombosis with thrombocytopenia, after first and second doses of AstraZeneca. They also considered the possibility of increased short-term reactogenicity with a mixed schedule and emerging data on the immune response from that mixed schedule that I mentioned. That was all—

● (1235)

Mr. Don Davies: Can I just interrupt, Dr. Tunis, and put something to you? Last week Dr. Andrew Morris expressed concern that individuals cannot really receive informed consent regarding the risk of VITT prior to getting a second dose of AstraZeneca, given the constant changing data being received about the incidence of VITT. He had numbers showing that it's continually changing.

Although there's emerging data, is there conclusive data, at this point, to make an informed decision on the safety concerns of AstraZeneca or on mixed dosage? Or is that data shifting and moving?

Dr. Matthew Tunis: That is an excellent point. I would say that with many data elements in this pandemic and the vaccine responses, that does continue to shift. Yes, on the risk of VITT following AstraZeneca vaccine, we have seen that change over time. It does continue to change. That informed consent process would ideally include a discussion about what is known and also the fact that it has been changing over time. NACI has acknowledged that in their advice to the government, namely, that informed consent should include discussion of that, which does change.

On the topic of the mixed schedules, those are being implemented in a number of countries around the world. The evidence is emerging and will continue to emerge over months as more studies come out exploring that topic, but a number of studies were reviewed by NACI when making this advice, and they continue to emerge.

Again, on the topic of mixed schedules, NACI felt very comfortable recommending, as many other countries have now done, that mRNA vaccines can be used to complete that series. Yes, they acknowledge that the evidence does continue to change and to evolve. We may learn more about whether a mixed schedule does in fact generate a stronger immune response. Those things continue to emerge.

The Chair: Thank you.

Thank you, Mr. Davies.

That brings round one to a close. We'll start round two with Mr. Maguire.

Mr. Maguire, officially you have five minutes. We'll give you five minutes and 45 seconds because of my—

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

I want to ask Dr. Lucas some questions here.

The contract with Switch Health to oversee post-arrival coronavirus tests for travellers has been renewed, despite media reports that the company has bungled the process. I've raised this a number of times in our meetings in the past.

What communications did your department have with the Government of Ontario about an RFP for post-arrival testing?

Dr. Stephen Lucas: Mr. Chair, I'll turn that question to Iain Stewart from the Public Health Agency.

Mr. Larry Maguire: Mr. Lucas, are you not in charge of that?

Dr. Stephen Lucas: In terms of the work on the border testing, that is the responsibility of the Public Health Agency.

Mr. Larry Maguire: Yes, I've been in touch with them many times.

Mr. Stewart, go ahead.

Mr. Iain Stewart: Hello, sir. How are you today?

Thank you for the question.

The contracting aspect would probably be better placed with Bill Matthews, but with respect to Switch Health, as you point out, they are a service provider of the Public Health Agency.

Mr. Larry Maguire: I just asked what communications your department had with the Ontario government about the post-arrival testing.

Mr. Iain Stewart: On the renewal of the contract for post-arrival testing?

Mr. Larry Maguire: Yes, the RFP.

Mr. Iain Stewart: Yes, that would be for Bill Matthews.

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

There have been no direct discussions with the Ontario government that I'm aware of, but I'm happy to check to see if—

Mr. Larry Maguire: Thanks. What communications did your department have then, Mr. Matthews, with the Government of Ontario prior to the RFP being given to Switch Health?

Mr. Bill Matthews: The federal government ran its own procurement process for the testing, and Switch was the recipient of the contract. I'm happy to go back with my staff to see if there was any contact with the Ontario government, but I'm not aware of any. I'm happy to take that back and see if there were others.

Mr. Larry Maguire: Did Switch Health ask anyone in your department to change the day-10 test to a day-8 test?

Mr. Bill Matthews: No, sir.

Mr. Iain Stewart: Excuse me for jumping in, Mr. Chair and honourable member.

That was an operational decision made by the public health officials.

● (1240)

Mr. Larry Maguire: On the contract we were talking about earlier with Switch Health, are they currently legally obligated to ensure that samples collected via the online portal are collected under the supervision of a nurse?

Mr. Iain Stewart: It actually varies by jurisdiction. They are not required to collect the samples under the jurisdiction of a nurse. It varies by province. It may be an appropriate health care professional, and so on. It's different language in different provinces.

That said, of their workforce—this is from memory—about 1,029 are, in fact, nurses. I think there were 29 who are not nurses. After we found out that non-nurses were involved in supervision, even though it wasn't required under the province, we asked them to reassign those staff to other duties to ensure that appropriately trained medical teams were looking over the supervision.

Mr. Larry Maguire: I know this. I'm assuming it's the same in all provinces in Canada. The situation, which I've raised two or three times, with the incompetence being seen in the way these COVID tests are being picked up in rural Canada continues unabated at this point.

PHAC is very quick to call. There is a case that I had in one of my communities as of yesterday that you're familiar with, Mr. Stewart. PHAC was quite ready to call someone to make sure that they were still in quarantine as late as yesterday from that person's May 15 crossing back into Canada, when that young individual concerned had already been vaccinated twice—was fully vaccinated—coming from college in the U.S.

He's had two very negative tests in the last five days, again here in Canada, and he's still in quarantine. He doesn't know what he has to do. He's never been told. He doesn't want an apology that you've offered in response to this situation, and it's not yet been resolved for the future. Can someone contact him? How do you get a hold of regular people who are stuck in this dilemma? He needs to be contacted so that he knows how to get out of quarantine so he can go to work.

Mr. Iain Stewart: Thank you, sir.

First of all, I want to thank you for bringing the matter to my attention, honourable member. As you know, obviously we're very distressed at the situation that we've created for him. Second, we have in fact, in response, set up a change in procedure. Somebody in a similar circumstance now will be offered the opportunity to test locally, instead of continuing to wait in a situation of the nature you described.

Thank you, again, for bringing that to our attention.

Mr. Larry Maguire: He did his day-1 test, and it sat for six days. It was finally picked up after his constantly phoning every day. His day-8 test sat for another week before it was picked up. In fact, it never was picked up. He had to drive it 100 kilometres to Brandon to the COVID testing site. These are the kinds of things that people are faced with in rural Canada, and it's completely against the contract.

That's why I'm asking for information on these contracts, because this is incompetence. The major courier couldn't even find a local address in a small town in my area. Uber, which was put up as an alternative, doesn't exist in rural Canada. What are these people supposed to do with regard regard to the viability of those tests after they've been sitting for six to eight days?

Mr. Iain Stewart: They're supposed to phone Switch Health, and we've changed the operating procedure to make sure that what you just described doesn't happen again.

Mr. Larry Maguire: Believe me, they phone Switch Health every day.

Mr. Iain Stewart: No, effective today, we have changed it so that the situation will not recur.

Mr. Larry Maguire: Okay, I appreciate that, because it has been a huge dilemma in rural Canada, and particularly for many families in my area in southwest Manitoba.

I want to bring that to your attention again and I trust that someone will contact them today, these people in the past, to make sure that they know what to do to get out of quarantine.

Mr. Iain Stewart: Thank you.

Mr. Larry Maguire: Will that occur?

Mr. Iain Stewart: Yes.

The Chair: Thank you, Mr. Maguire.

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

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair. Hello to my colleagues; and again, thank you to the witnesses for being here.

My first question will be directed towards Dr. Tam.

Last week, Nova Scotia premier Iain Rankin and the chief medical health officer, Dr. Strang, announced that, beginning tomorrow, rotational workers with no symptoms, who have been fully vaccinated at least two weeks before arriving in Nova Scotia, will no longer need to self-isolate. The catch is that they must get tested on day 1 or day 2, again on day 5 or 6, and again on day 12, 13 or 14.

My understanding is that those who have one dose and are not coming from an exposure hot spot are required to self-isolate for 7 days after they have proof of two negative test results.

As we start looking at ways to safely reopen our national borders, what would you expect it could look like and what are your concerns around reopening, if any?

● (1245)

Dr. Theresa Tam: Of course, domestic borders are in the realms of provincial jurisdiction, but we are sharing this kind of discussion amongst chief medical officers of health. Even in regard to the international border, while it's in federal jurisdiction, one has to have these discussions with the provinces and territories particularly as it pertains as to whether Canada, in this domestic situation, has its third wave or resurgence under control. Also, we're discussing what it means to be vaccinated fully, those kinds of discussions.

We've also tabled the expert panel's report, not only to the ministers but also the deputy ministers and the special advisory committee. Those kinds of recommendations will be taken into account as the decisions are being made by the federal government on our border pathway forward.

I think some of the public health parameters, vaccine effectiveness information, as well as the other more operational considerations are sometimes quite similar between what the provinces have considered and what the federal government has to consider for the international border. With these elements, there are some parallels that one can draw.

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

Last week, NACI advised that Canadians are able to move forward in terms of mixing and matching doses and that all vaccines approved by Health Canada are safe and effective.

I believe in one of our earlier committee meetings with the folks from PHAC we learned that there were several international studies that were informing NACI's decision. We have Dr. Tunis here, as well as some folks from PHAC, so I'll open this question to you folks.

Can you tell the committee what the new recommendations say, and what are the main takeways from those international studies?

Dr. Matthew Tunis: I'll start with this. Last week, NACI recommended that either the AstraZeneca/Covishield COVID-19 vaccine or an mRNA vaccine may be offered for the subsequent dose in a series started with the AstraZeneca/Covishield COVID-19 vaccine and that the previous dose should be counted and the series need not be restarted.

NACI made this recommendation at the time, informed by several studies from the international landscape, one from Spain, one from the United Kingdom and one from Germany, all of which showed that when you provide an mRNA vaccine after an AstraZeneca vaccine, it is safe. There were actually multiple intervals studied—four weeks and also eight to twelve weeks. At any of those intervals studied, overall the mixed schedule was found to be safe.

They looked at immune response data from that study from Spain as well, which showed that you do, in fact, boost the immune response when the mRNA vaccine is provided after the AstraZeneca vaccine.

Since that time, there have been several studies that have also come out from Germany, looking at the immune response, that replicate that finding as well, that you get a good, strong boost to the immune response when you follow AstraZeneca vaccine with Pfizer.

That was underpinning NACI's recommendations. They had seen studies from multiple countries looking at multiple schedules, looking at safety and now also the immune response, that have demonstrated that this is a strategy that can be used. Provinces and territories are now looking at this and how they integrate that into their second dose approaches across the country.

Thank you.

The Chair: Excuse me, committee, we have the bells ringing for a vote in the House. I need unanimous consent to carry on for another 15 minutes. Do I have it?

Some hon. members: Agreed.

The Chair: Very well. Thank you.

Mr. Kelloway, carry on. You have 20 seconds left.

Mr. Mike Kelloway: Well, I will either surrender my 20 seconds or give them to someone else, but use your discretion.

Thanks to the witnesses, again. It seems like we've been together for more than a year. Thank you for all the work you're doing. It's not easy and I know we all appreciate it and the people who work under you.

The Chair: Great.

Thank you, all.

Thank you, Mr. Kelloway. With the thank you, your time is actually now up.

We go now to Ms. Rempel Garner, please, for five minutes.

Hon. Michelle Rempel Garner: Thank you, Chair.

Dr. Lucas, picking up on a question that my colleague, Mr. Davies, asked you, can you confirm that no doses that have passed the manufacturer's labelled date of expiry have been administered in Canada?

● (1250)

Dr. Stephen Lucas: Yes, Mr. Chair, to the best of my knowledge, that's the case. As I had indicated, the AstraZeneca doses that were to have expired on May 31, subject to a request by AstraZeneca, which provided data to extend that expiry by a month, were reviewed and approved.

Hon. Michelle Rempel Garner: Sorry, so the doses that were originally set to expire on May 31 have been administered. You guys just changed the expiry date. Is that what you're saying?

Dr. Stephen Lucas: Well, we received a robust regulatory package at the request of the manufacturer. It was reviewed thoroughly by the scientific staff. On the basis of that review—

Hon. Michelle Rempel Garner: Okay.

Dr. Stephen Lucas: —the expiry was changed to the beginning of July. Therefore, the doses have not expired.

Hon. Michelle Rempel Garner: Okay. It just that what you had said to Mr. Davies was a little bit misleading. I wanted to get that on the record.

Brigadier-General Brodie, first of all, congratulations on your appointment. It is well deserved.

I am wondering if the government has given you any advice on accepting surplus vaccines from the U.S., such as what the mayor of Windsor is requesting.

Brigadier-General Krista Brodie (Vice-President, Logistics and Operations, Public Health Agency of Canada): Thank you, Mr. Chair, and honourable member.

No, I have not received any advice on that. It's not a responsibility that falls within my portfolio at the Public Health Agency.

Thank you.

Hon. Michelle Rempel Garner: Okay.

Have you talked to anybody within PHAC or Health Canada or the minister's office about accepting these surplus doses from the U.S.?

BGen Krista Brodie: Mr. Chair and honourable member, certainly there are live, ongoing and regular discussions with respect to the donation portfolio and acceptance of other doses, and whether they are coming in based on offers or on APA agreements. So yes, there are many discussions in that regard.

Hon. Michelle Rempel Garner: Are the Detroit doses part of those discussions?

BGen Krista Brodie: Mr. Chair and honourable member, that is not part of the discussions I have had, no.

Hon. Michelle Rempel Garner: Thank you.

Mr. Stewart, picking up on some of the questions my colleague, John Barlow, was asking, has the Prime Minister's Office asked you for any advice regarding the Prime Minister's quarantine requirements?

Mr. Iain Stewart: The Prime Minister's Office has not asked us for advice regarding quarantine requirements. We have had discussions with the Privy Council Office regarding—

Hon. Michelle Rempel Garner: Okay.

In the advice you provided to the PCO, was there anything as to why the Prime Minister couldn't stay at a current designated hotel quarantine site?

Mr. Iain Stewart: We've looked at different scenarios and provided comments. We didn't provide advice of the nature you are requesting, honourable member.

Hon. Michelle Rempel Garner: Is there any reason the Prime Minister couldn't stay at an existing designated quarantine hotel site?

Mr. Iain Stewart: Mr. Chair, I'm not well-positioned to answer an open question of that nature.

Hon. Michelle Rempel Garner: Well, I mean, you are the head of PHAC, so is there any reason—

Mr. Iain Stewart: There could be many reasons, many causal factors. The way you're phrasing the question is just very open-ended.

Hon. Michelle Rempel Garner: Sure. Is there a reason that the Prime Minister of Canada shouldn't stay at a designated hotel quarantine site, but every other Canadian would? What makes him special?

Mr. Iain Stewart: Those considerations might be best discussed with the Privy Council Office. They're more aware of security threats—

Hon. Michelle Rempel Garner: Are there any health...? Are there any—

Mr. Iain Stewart: —and other things that I might not be aware of.

Hon. Michelle Rempel Garner: Okay, security.

Are there any public health reasons for him being unable to stay at a quarantine hotel?

Mr. Iain Stewart: There are a number of options for the Prime Minister that would be consistent with having a test, waiting one day for the results and then going into quarantine. These are the essential elements of our policy.

Hon. Michelle Rempel Garner: But that would be a different process from what every other Canadian would go through. Is that correct?

Mr. Iain Stewart: It depends on which way it were structured.

Hon. Michelle Rempel Garner: Do you think that the Prime Minister's security concerns are greater than those of the women who were allegedly sexually assaulted at a hotel used in the quarantine program?

Mr. Iain Stewart: Which women are you referring to?

Hon. Michelle Rempel Garner: There were reports of sexual assault occurring at one hotel. I'm just wondering if you deem their security concerns greater or lesser than the Prime Minister's.

Mr. Iain Stewart: At this designated quarantine facility, there were no such sexual assaults of the nature you're describing, allegedly, to my knowledge.

Hon. Michelle Rempel Garner: Well, there was a report—

Mr. Iain Stewart: There was a newspaper story—

Hon. Michelle Rempel Garner: I feel like you're gaslighting us.

Mr. Iain Stewart: That was a newspaper story about a designated quarantine facility, is what I'm trying to say, which is a different category of institution.

Hon. Michelle Rempel Garner: A quarantine hotel—

Mr. Iain Stewart: It's not a quarantine hotel. It's a designated quarantine facility.

Hon. Michelle Rempel Garner: Again, would the security concerns of a woman who was allegedly sexually assaulted at a quarantine hotel run by the federal government be greater or lesser than the Prime Minister's?

Mr. Iain Stewart: I wouldn't know how to begin to answer a question structured that way, but thank you, honourable member.

● (1255)

Hon. Michelle Rempel Garner: I think that's the problem.

The Chair: Thank you, Ms. Rempel Garner.

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

Ms. Jennifer O'Connell: Thank you, Mr. Chair. I'm sorry, I didn't know if I'd have a chance there.

Quickly, Mr. Stewart, I'll just pick up on that—or Dr. Tam or whoever can answer.

It's my understanding that the Prime Minister, as well as any security detail, media and staff, is going to follow the quarantine protocol that Canadians would have to follow, which is to return and stay at a hotel to quarantine until they receive their test. Given the fact that travel to these meetings requires security as well as accompanying media, the entire group that would be attending the G7 summit would be subject to quarantine in a hotel just like anybody else under the quarantine protocols. Is that accurate?

Mr. Iain Stewart: As you are saying, the essential elements are that they are tested on arrival, that they're held in a safe space until the results are known and then are released and go into an approved quarantine. There are different ways to do that.

Ms. Jennifer O'Connell: Part of that is just to ensure that for anyone who's travelled internationally and has been exposed, COVID-19 won't then come into our communities, which is ultimately the goal until those test results can be returned. Is that correct?

Mr. Iain Stewart: The essential elements are, as you are saying, that people are tested on arrival, they're held until the test result is provided and then they go into quarantine. I think the answer to your question is yes.

Ms. Jennifer O'Connell: Thank you.

Just quickly, because I don't have much time, the mayor of Windsor talking about getting doses from the U.S. I'm not sure who's been engaged in these conversations, so feel free to jump in if you have. I do recall the conversations about truck drivers, for example, in Manitoba and North Dakota, and that a significant amount of work was done with the premier, the governor and local authorities to make this process happen.

It's my understanding that the U.S. federal government has determined that travel for vaccination is not essential. The Governor of Michigan has not actually offered these doses to Canada. Perhaps it's some pharmacies that may have extra doses and surely don't want them wasted, and I understand that. Ultimately, these doses are owned and paid for by American taxpayers, so unless they are willing to give them to us, whether we say we want them or not, the owners of these doses must actually indicate they are providing them to us. Is that a fair and accurate summary of where the issue is?

It's not the fact that the Canadian government doesn't want to access doses. In fact, we're working with the U.S. federal government every single day to get surplus doses, but that the local government authorities have not authorized Canada to have these particular doses.

Mr. Iain Stewart: Yes. That, in summary, is our understanding.

I would also note, by the way, that about two hours ago we delivered our 30 millionth dose in Canada to the provinces and territories.

Ms. Jennifer O'Connell: Thank you.

Even if Canada's position were, yes, we would welcome these extra doses from Detroit, again, we don't own them, and therefore they can only be provided if the state government and the U.S. federal government authorize that. Essentially it would be an export.

Mr. Iain Stewart: Yes, and they would have to go through the regulatory approvals in that regard. Steve Lucas, of course, can speak more to that.

Yes, you're right. They're owned by the federal government of the United States.

Ms. Jennifer O'Connell: Right. Janssen is an example that for any doses donated or given to us by the U.S., they must also have all of that information reviewed. Canadians expect that for any doses used here. Even if the U.S. has a system that we're comfortable with, we have a regulatory process that has to live up to the standards of Health Canada.

Dr. Stephen Lucas: That's exactly the case, Mr. Chair. Any vaccines imported into Canada need to meet a series of requirements, in addition to being approved for use by Health Canada, including understanding the specific lot number, the doses, the quantities and who the importer is. All of this information is well outlined. We've shared it with the provinces, and it's available on our website. That would need to be provided for any case in which there's authorized importation.

● (1300)

Ms. Jennifer O'Connell: Do you know if Premier Ford has asked the governor—

The Chair: I'm sorry, Ms. O'Connell, but I have to cut you off here. We're really running short on time.

Thank you. I appreciate it.

[*Translation*]

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

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

Mr. Lucas, Health Canada takes pains to point out that maintaining the interim order continues to make Canada an attractive place to conduct clinical trials. You therefore recognize the importance of clinical trials in ensuring that patients have access to treatment options.

What is true for COVID-19 is also true for life-threatening or rare diseases, diseases like cancer or immune system dysfunctions. Do you agree with me?

Dr. Stephen Lucas: Mr. Chair—

Mr. Luc Thériault: Do you agree with me, yes or no?

[*English*]

Dr. Stephen Lucas: Yes, Canada has an attractive clinical trial regime for all health products and has put in place special measures for an interim order for COVID-related products. We have embarked on a modernization of the clinical trials regime.

[*Translation*]

Mr. Luc Thériault: You aren't answering my question.

I don't know if the interpretation of what I said was correct or not.

Dr. Stephen Lucas: I understood your question.

Mr. Luc Thériault: I was asking you if what is true for COVID-19 is also true for other life-threatening or rare diseases. Do you agree with me, yes or no?

Dr. Stephen Lucas: Yes.

Mr. Luc Thériault: Thank you.

I lost some time.

So what is it about this flexibility that would not be found in the guidelines of the Patented Medicine Prices Review Board, the PMPRB? Are you telling us indirectly that you did not control the price of drugs so that they are not excessive, as part of this relaxation? If not, how can the PMPRB reassure a patient with a rare disease? Is such a patient less important than a patient with COVID-19?

Some say that your reform will result in fewer clinical trials.

[*English*]

Dr. Stephen Lucas: Mr. Chair, I think the record shows that Canada is an attractive country for clinical trials. As I indicated, we have a very competitive regime. Special measures were put in place for COVID-related clinical trials, but otherwise, we have a competitive regime, which we are setting out to modernize. The government has invested through the budget $250 million to strengthen the clinical trials research. National networks have been established. These factors have led to the continued submission of clinical trials in Canada.

[*Translation*]

Mr. Luc Thériault: How can we be sure that you have really controlled the prices to avoid their being excessive, since we do not have access to the contracts?

[*English*]

Dr. Stephen Lucas: The Patented Medicine Prices Review Board has a series of tests and regulations in place. New ones were promulgated and are slated to come into force on July 1, 2021. Those elements pertaining to confidential rebates have been the subject of a court decision and will not be part of that package, as that is before the court.

The Chair: Thank you.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

We will go now to Mr. Davies. We are very short on time.

You have two minutes and 30 seconds.

Mr. Don Davies: Thank you.

Dr. Lucas, on May 29, Health Canada announced that it was granting a one-month extension to the shelf life of AstraZeneca vaccines in Canada that were set to expire two days later, on May 31. Are you telling me that AstraZeneca supplied Health Canada with clinical data showing that they had control groups and non-control groups who had been administered AstraZeneca that had been expired for 30 days and AstraZeneca that had not expired, and that these studies showed no difference in efficacy or safety? Is that the data you were supplied with?

Dr. Stephen Lucas: Mr. Chair, I would indicate that the data package pertained to the stability of the vaccines and other data that indicated their continued viability. They were reviewed in detail by the team of scientific reviewers at Health Canada, who rendered a decision through the independent regulatory function here at Health Canada.

Mr. Don Davies: I just find it odd that a maker of a drug happens to just spontaneously supply Health Canada with data saying that the label instructions on medication that it's going to expire no longer applies.

Did any other vaccine manufacturers do that?

● (1305)

Dr. Stephen Lucas: Mr. Chair, to the best of my knowledge, that has not been the case with other vaccine manufacturers. In other health product areas, manufacturers do apply for an extension.

Mr. Don Davies: That's fine. I just want to know about vaccines, sir.

I want to move on.

The COVID-19 testing and screening expert advisory panel has recommended that Canada should have a system in place as soon as possible to validate proof of vaccination for arriving travellers.

Does the federal government intend to establish such a system? If so, can you confirm when it will be in place?

Mr. Iain Stewart: We are looking at options to respond to exactly the scenario you're talking about. Analysis and work is under way in that regard. No decisions have been taken at this time.

Mr. Don Davies: Will Canada make a firm commitment to donate vaccine doses to low-income countries at this week's G7 summit?

Mr. Iain Stewart: Consideration is being given to how best to support international vaccination. Obviously, it's a huge priority to ensure that the world is being vaccinated.

The Chair: Thank you, Mr. Davies.

Thank you to all of the members for all of the good questions. We are short of time.

Thank you to the witnesses once again for appearing before us. I know you're all frequent flyers and it's good to see you all. Thank you for the work you do on an ongoing basis to keep us all safe and secure.

I would like also to thank the interpreters. I know there's a lot of sickness in the ranks. I really do appreciate it. I apologize that we've gone over the time, but thank you for all for your ongoing work—as well as that of all of the House staff.

With that, we are now adjourned.