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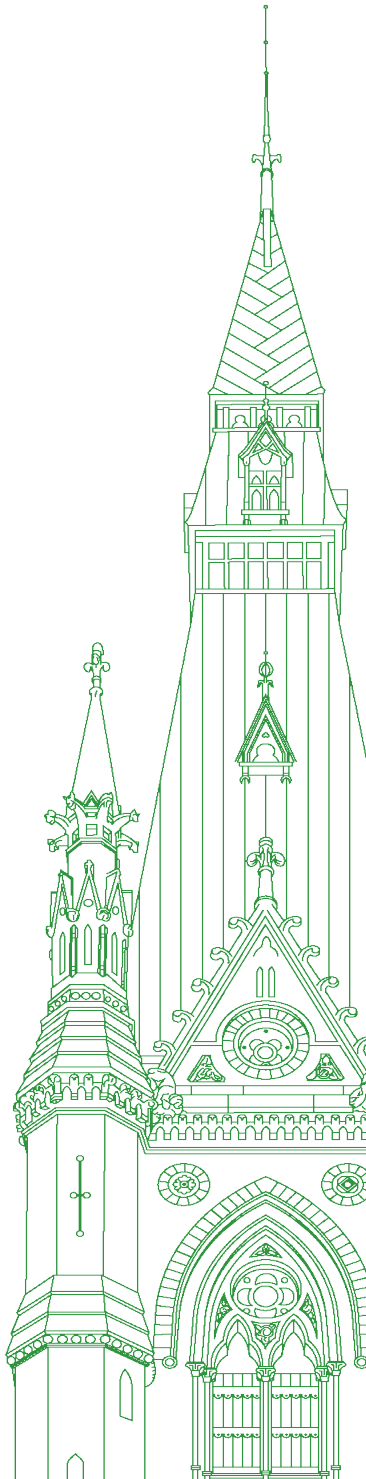

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, February 28, 2022

● (1545)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call the meeting to order.

Welcome to meeting number nine of the House of Commons Standing Committee on Health. Today, we're meeting for two hours to hear from witnesses for our study of the emergency situation facing Canadians in light of the COVID-19 pandemic.

Before I introduce today's witnesses, there are a few regular reminders for hybrid meetings.

Today's meeting will be taking place in a hybrid format, pursuant to the House order of November 25, 2021. Members are attending in person in the room and remotely, using the Zoom application. I think all the members are or will soon be in the room, and the only people on Zoom are the witnesses. I would like to take this opportunity to remind the people who are on Zoom that the taking of screenshots or photos of your screen is not permitted.

The proceedings will be made available on the House of Commons website.

All health protocols prescribed by the public health authorities and the directive of the Board of Internal Economy of October 19, 2021, will be observed and respected.

Before we get to our witnesses today, I'm informed that we have a couple of new members in the room. I would like to welcome Mr. Barrett, who replaces Mr. Berthold, and Ms. Goodridge, who replaces Ms. Kramp-Neuman. I appreciate the time and the work that the outgoing members have contributed to the committee, and I have every confidence that those shoes will be amply filled by their replacements.

However, Mr. Berthold's departure means that we are left with a vacancy in the first vice-chair role. Pursuant to Standing Order 106(2), the first vice-chair must be a member of the official opposition. I am now prepared to receive motions for the first vice-chair.

Go ahead, Mr. Lake.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): I nominate Michael Barrett.

The Chair: It's been moved by Mr. Lake that Michael Barrett be elected as the first vice-chair of the committee. Are there any further motions?

Seeing none, is it the pleasure of the committee to adopt the motion?

(Motion agreed to)

The Chair: I declare Mr. Barrett duly elected first vice-chair of the committee. Congratulations, sir.

Now we'll move on to our witness and their opening remarks. To begin, both the Office of the Auditor General and the Public Health Agency of Canada have five minutes to make their opening statement before rounds of questions, which will occupy the remainder of our two hours.

With us today, we have from the Office of the Auditor General, Andrew Hayes, deputy Auditor General, and Jean Goulet, Carol McCalla and Chantal Richard, principals. From the Public Health Agency of Canada, we Brigitte Diogo, vice-president of the health security and regional operations branch; Cindy Evans, vice-president of the emergency management branch; and Christopher Allison, acting vice-president of corporate data and surveillance branch.

Thank you all for being with us here today. We're going to proceed in the order listed on the notice of meeting.

We're going to ask Deputy Auditor General Hayes to kick us off. You have the floor for five minutes.

Mr. Andrew Hayes (Deputy Auditor General, Office of the Auditor General): Mr. Chair, thank you for this opportunity to discuss our reports on the Public Health Agency of Canada's response to the COVID-19 pandemic. First, I would like to acknowledge that this hearing is taking place on the traditional unceded territory of the Algonquin Anishinabe people.

Joining me today are Chantal Richard, Carol McCalla and Jean Goulet, who were the principals responsible for the three audits I will be discussing.

If I had to sum up our audits of pandemic preparedness, surveillance and response, I would say that, on the whole, the Public Health Agency of Canada was not as well prepared as it should have been to deal with this crisis. However, as we saw across the organizations tasked with pandemic response that we have audited to date, public servants rallied and adjusted their activities in real time.

In our March 2021 report that looked at the preparedness side, we found that not all emergency and response plans were up to date and tested at the onset of the pandemic. Data sharing agreements with the provinces and territories were also not finalized.

In addition, the agency relied on a risk assessment tool that was untested and not designed to consider pandemic risk. As a result, despite growing numbers of COVID-19 cases in Canada and worldwide, the agency continued to assess the pandemic risk as low. The global public health intelligence network did not issue an alert about the virus that would become known to cause COVID-19.

Once the pandemic hit Canada, the Public Health Agency of Canada and the Canada Border Services Agency worked together to implement border restrictions and quarantine requirements. However, we found that the Public Health Agency was unprepared for a nationwide quarantine. For example, it struggled with a paper system to gather travellers' information. This hindered efforts to follow up with individuals at risk of not complying with quarantine orders. As a result, the agency did not know whether 66% of incoming travellers who were required to quarantine in fact did so.

Our December 2021 report showed an improvement in the administration of the 14-day quarantine orders since our initial audit, partly because the agency had moved to an electronic system to collect travellers' information. However, between January and June 2021, the agency was still unable to confirm whether 37% of inbound travellers complied with quarantine orders. That is still a large number of people to lose sight of.

[*Translation*]

This second audit also looked at the enforcement of new testing orders. We found that the agency was either missing or unable to match 30% of COVID-19 test results to travellers arriving in Canada. In addition, the agency lacked records for 75% of travellers arriving by plane, making it impossible to know whether these travellers quarantined at authorized hotels as ordered.

Our audit of personal protective equipment and medical devices released in May 2021 also showed that the Public Health Agency of Canada was not as prepared as it should have been to deal with the surge in requests for equipment from the provinces and territories triggered by the pandemic. This was because the agency had not addressed long-standing issues affecting the management of the National Emergency Strategic Stockpile, though these had been raised in audits and reviews going back more than a decade.

Despite these pre-existing issues, the agency worked with Public Services and Procurement Canada and Health Canada and adapted its activities to help meet needs for personal protective equipment and medical devices across the country. For example, the agency shifted to a bulk purchasing strategy and improved how it assessed needs and allocated equipment, among other changes.

If there is one overall takeaway from these audits, it is that long-standing known issues, such as outdated systems and practices, must be dealt with. This would allow government organizations to be better prepared for unforeseen events such as this pandemic.

This concludes my opening remarks. We would be pleased to answer any questions the committee may have.

Thank you.

[*English*]

The Chair: Thank you very much, Mr. Hayes.

Now, on behalf of the Public Health Agency of Canada, we're going to hear from Ms. Diogo. Welcome to the committee. You have five minutes.

Ms. Brigitte Diogo (Vice-President, Health Security and Regional Operations Branch, Public Health Agency of Canada): Thank you, Mr. Chair.

My name is Brigitte Diogo and, as you mentioned, I'm the vice-president for the health security and regional operations branch. I am happy to be here today to have the opportunity to speak to the committee. I am joined by my two colleagues Cindy Evans, vice-president of the emergency management branch and Chris Allison, acting vice-president of the corporate data and surveillance branch.

As the pandemic approaches the two-year mark, we recognize the resilience of Canadians and the sacrifices everyone had to make in these unprecedented times to minimize the impacts of COVID-19. We are proud to say that the agency has worked throughout the pandemic to take the actions needed to protect the health and safety of Canadians.

[*Translation*]

The pandemic is not over and the agency must remain nimble and ready to respond to new risks in an appropriate and proportionate manner.

I would like to take a few minutes to talk about the Public Health Agency of Canada's efforts since the onset of the pandemic, in close collaboration with federal, provincial and territorial partners, as well as learning from the experiences of our international counterparts.

[*English*]

Over the past 24 months, the Public Health Agency of Canada has been on the front lines of the federal response to COVID-19. The agency has taken an evidence-based, multi-layered approach to public health measures, which have been adapted as we learned more about the virus and the delta and omicron variants that have emerged.

A year ago at this time, we were in the early stages of getting vaccines into the arms of Canadians. Thanks to a solid immunization strategy and federal, provincial and territorial governments working together, as of February 25, more than 80% of the total population is fully vaccinated. That is one of the highest rates in the world. Additionally, more than 55% of the population over 18 years of age have received an additional dose, and clinics are continuing to offer boosters.

[*Translation*]

With unvaccinated individuals who get COVID-19 being 4 times more likely to be hospitalized than fully vaccinated individuals, it is clear that the vaccine roll-out helped to reduce severe illness and save lives.

Throughout the pandemic response, the Government of Canada has adjusted its border measures as new data, and scientific evidence became available, and in response to the epidemiological situation both in Canada and internationally.

[*English*]

The Government of Canada recognizes that border measures can pose challenges for individuals and families, but these measures help to prevent new chains of transmission in Canadian communities and protect Canada's health care capacity and vulnerable populations. As the Auditor General noted, the agency was able to successfully adapt to secure personal protective equipment and medical supplies.

[*Translation*]

Throughout the pandemic, science and collaboration have been fundamental keys to inform the agency's efforts. We have gained much scientific knowledge about this novel virus and its variants to inform our advice and actions, and we have worked closely with other federal agencies, provinces and territories, Indigenous partners and academic and international counterparts on various, innovative research initiatives.

For example, the agency collaborated with other levels of government such as municipal governments, as well as academia, to establish a pan-Canadian network for wastewater surveillance to monitor for early-warning signals of COVID-19 and its variants across the country.

[*English*]

In conclusion, collaboration, leadership, communication, science, surveillance and vaccination have been critical as we manage the pandemic. These same factors will continue to be key as we move forward. While significant strides were made over the course of the pandemic, the agency acknowledges that it was not as prepared as it could have been prior to the pandemic and that there are lessons to be learned.

We remain committed to responding to the Auditor General's recommendation in full within the established timelines. As the omicron wave continues to recede, we need to recognize that COVID-19 will be with us for the foreseeable future.

The Public Health Agency of Canada will continue to incorporate the knowledge and expertise it had gained towards our effort for the long-term sustainable management of COVID-19, and to better prepare for any future public health crisis.

My colleague and I will be happy to take your questions.

Thank you.

● (1550)

The Chair: Thank you very much, Ms. Diogo.

We're now going to begin with rounds of questions, starting with the Conservatives.

Dr. Ellis, please, you have six minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for their opening statements and for appearing here today.

This is for Mr. Hayes on the Auditor General side. On the global public health intelligence network, you stated that there was no alert back in 2020. Sir, could you please tell us the budget for the global public health intelligence network?

Mr. Andrew Hayes: That may be a question best directed to the Public Health Agency. I don't have numbers about their budget for the global public health intelligence network.

Mr. Stephen Ellis: Does anybody on the PHAC side know the answer to that?

Ms. Cindy Evans (Vice-President, Emergency Management Branch, Public Health Agency of Canada): Mr. Chair, we'd be pleased to come back to the committee with that specific number. I don't have that number on hand in front of me.

Mr. Stephen Ellis: Okay, so nobody knows the budget.

For the same outfit, as we talked about, there was no alert. Can you name three changes, sir, that happened over the last two years to the intelligence network to make it better?

Mr. Andrew Hayes: Again, I would ask the Public Health Agency if they might have an answer to that. In our audit, we noted the weaknesses in not providing an alert and identified that, over the course of the last few years, the process has changed for the approval of alerts, and there have been considerably fewer since the process changed.

Mr. Stephen Ellis: Can anybody name three changes that have been made?

Ms. Cindy Evans: Thank you, Mr. Chair.

With respect to the global public health intelligence network, we thank the Auditor General for her attention to this important function.

A number of changes have taken place since the audit and since the independent expert panel. We've developed an action plan to address all of the recommendations. We have improved and streamlined the decision-making process for issuing GPHIN alerts and other GPHIN products and processes.

With respect to the technology, we have migrated the GPHIN system to a new cloud function, as well having moved forward to hire a technical adviser and investing in the training and development.

Those are a number of the changes that have been initiated since the time of the audit.

Mr. Stephen Ellis: Thank you.

Apparently, if I understood Mr. Hayes correctly, 75% of information for travellers coming into this country was not available. Can anybody tell me why we continue with border measures with such a leaky border?

Ms. Brigitte Diogo: Mr. Chair, again, I would like to take the opportunity to thank the Auditor General for the report.

We have made several improvements to the way we collect data. In particular—I think it was in the first report of the Auditor General—we have moved from a paper system to electronic collection of information and are able to share information with the provinces and territories much faster. We have also made some changes internally to improve our compliance and enforcement approach.

Mr. Stephen Ellis: To continue on with that, if I'm correct, it's interesting that rapid antigen tests in asymptomatic individuals have a sensitivity rate of about 44%. Plus, we're only capturing about 25% of the data in travellers. Can anybody tell me why we continue to use a system like that, which penalizes Canadians?

Ms. Brigitte Diogo: Mr. Chair, until recently, the only requirement that we had for people arriving from abroad was to use the molecular test. The change to allow for antigen tests starts today.

With regard to the domestic testing, whether testing on arrival or testing on day eight, this is based on a molecular test and the PCR technology that we have been using.

Mr. Stephen Ellis: Mr. Chair, that's fine. I thank you for answering.

I guess my point is that we're moving to an antigen test that is 44% sensitive in a system that's only collecting 25% of the data. Why would we do that? What's the benefit to our border security? To me, the math doesn't add up. That means 56% of asymptomatic people coming into the country could be told that they have a false negative test, and we're only collecting 25% of the data. Mathematically that makes no sense to me.

Ms. Brigitte Diogo: The change has been made in recognition of the high vaccination rates that have been achieved. Recognizing that this is a change that we just implemented today, the agency will continue to monitor the results and determine whether other changes will need to be made to the regime.

Thank you.

● (1555)

Mr. Stephen Ellis: I thank you for that.

Mr. Chair, I guess I want to ask again why we made a change to the rapid antigen test that we know is not sensitive in asymptomatic individuals, because, if you're symptomatic, guess what? You're not getting on an airplane. The question remains as to why we would recommend this change. Why would we keep it at all? That doesn't make any sense to me. I guess this is the third time I'm asking the same question, so why? I really would like an answer.

Ms. Brigitte Diogo: While the antigen test, Mr. Chair, is not as sensitive as the PCR test, it is still a test that has seen a lot of improvement over time, and the department feels that, based on what we have learned from antigen tests, this is an option that we would like to offer to Canadians who are travelling and returning from travel abroad. In particular, when people arrive in Canada, they will still be subject to mandatory testing. The Public Health Agency will continue to collect data to determine whether adjustments will need to be made to that regime.

The Chair: Thank you, Ms. Diogo.

Thank you, Dr. Ellis.

Next we'll have Mr. van Koeverden, please, for six minutes.

Mr. Adam van Koeverden (Milton, Lib.): Thank you, Mr. Chair.

Thank you so much to all of the witnesses for joining us here today.

I'd also like to welcome our two new members, MPs Goodridge and Barrett. Welcome to HESA. I thank you for being here today.

I also want to thank you for all of your extraordinary work over the last two years. These last two years have been relentless, and all of our staff have been exhausted by them, and I imagine that you and your staff have been too, so I just want to acknowledge how challenging they've been and thank you for your extraordinary efforts.

I have two questions today, and both will focus on the Public Health Agency of Canada. Canada is fortunate to have one of the lowest death rates of all of our peer nation countries. While it's less productive to focus on how our system proved to be resilient and supported the health and safety of Canadians, I'm wondering why, from your perspectives, given that we have seen this pandemic unveil quite a few gaps in our health care system and some issues that we need to address as soon as possible....

It's also true that, from a performance perspective, Canada has demonstrated fairly good resilience against COVID-19. I suppose we all have our reasons to believe that to be the case, but I would like to hear from the Public Health Agency of Canada on why they believe our country has fortunately been among the countries with a lower death rate than many others.

Ms. Cindy Evans: I think one of the primary influences that we've had in Canada has been our ability to very rapidly enact the governance structure that sits under the FPT public health response plan for biological events. That allowed us to very quickly put in place an effective FPT governance for COVID-19. Bringing together the strength of the collaborative effort of the provinces and territories in all aspects from the beginning of January was a very effective measure for Canada and had a very significant influence.

I don't know if my colleagues, with respect to any of the surveillance or borders, would have anything to add in that regard.

Ms. Brigitte Diogo: Thank you, Cindy.

I could add that it's because of the layers of protection that we have built in place, both vaccination and the effort made to ensure that we are monitoring the importation risks and taking action as they become evident. As well, the collaboration with provinces and territories contributed to a pan-Canadian effort to really mitigate the risk, with vaccination being at the core of progress that we have made here to deal with and cope with the pandemic.

● (1600)

Mr. Adam van Koeverden: Thank you.

As a follow-up to that question, if you could put your finger on or isolate one major gap or one major failing that unfortunately cost Canadian lives, where would that gap be? I know it's far more complex than just one issue, but what is a major one that we could address?

Ms. Cindy Evans: I think for Canada, one of the critical lessons learned has been with domestic self-sufficiency in regard to personal protective equipment in particular. We saw some fantastic leaning forward by manufacturers in Canada, in everything from face shields to hand sanitizers, to quickly mobilize manufacturing in Canada. We saw a fiercely competitive global market. In the face of that type of competitive nature, we need to build on and learn from the domestic manufacturing that we put in place today to better situate Canada for the future.

Thank you.

Mr. Adam van Koeverden: I think we're all grateful to see an increase in domestic production of both vaccines and PPE, so thank you for that answer.

Moving on a little bit, again to PHAC, I'm curious to know to what degree the Public Health Agency of Canada agrees with the Auditor General's assessment, findings and recommendations, and what aspects of it they feel are worthy of conversation, perhaps.

Ms. Brigitte Diogo: Perhaps I could start and then turn it over to my colleague.

As we went forward to respond to the pandemic, a number of programs were stood up very quickly. We absolutely welcome the reports and the recommendations from the Auditor General. There is no question that we could have been better prepared. The answer is absolutely yes. Have we learned from the lessons, and are we making adjustments as we go? Absolutely yes. We will continue to implement the recommendations.

From a border management perspective, one of the points the Auditor General raised was about the electronic system and our quarantine management system. How do we position ourselves to be ready for future pandemics? That is something we are very much working on and keeping in mind.

Thank you.

The Chair: Thank you, Ms. Diogo and Mr. van Koeverden.

[*Translation*]

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

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

I thank the witnesses for coming to enlighten us and give us an update on this pandemic so that we can find solutions and face the next pandemic by taking better measures.

My first question is for the Deputy Auditor General, Mr. Hayes.

Mr. Hayes, report number 13 clearly states that several shortcomings were identified with respect to the monitoring and verification of quarantine measures for temporary foreign workers. You mention incomplete or poor quality quarantine inspection, quality issues and delays in outbreak inspections, and a significant backlog of overdue inspections in the agricultural sector.

To what do you attribute these problems?

Don't you think it would have been more effective in terms of controlling the pandemic and the risk of outbreaks if the government had taken over the management of quarantines when the workers arrived, and then sent them on to their facilities or farms?

Wouldn't this have avoided the problems you raise?

Mr. Andrew Hayes: Thank you for the question.

I'm not in a position to comment on the government's choice of policies, but to answer your first question, I would say that the agreements between the federal government and the provincial and territorial governments were important to ensure that we received good information to deal with or manage the pandemic.

With respect to quarantine measures, I would say that the information that comes from travellers is crucial in determining what quarantine measures they should follow.

● (1605)

Mr. Luc Thériault: I was talking about temporary foreign workers.

Mr. Andrew Hayes: Sorry, I misunderstood.

Mr. Luc Thériault: You raised a problem with the management of on-site inspections in each of the living environments.

Firstly, from your analysis, what are the problems due to?

I understand that your role is not to criticize the government's choices, but, according to your analysis, wouldn't it have been simpler to take charge of these workers immediately and then dispatch them to their workplaces, rather than deploy them and then conduct inspections at each of the living environments?

Mr. Andrew Hayes: In our report, we found that the department had not conducted good quality inspections. Foreign workers have been coming to our country for two years and we have not seen any significant improvement in outcomes. The problem lies in the way the department manages its inspections.

Again, I can't say that a different policy would be better. It is important to us that the department conduct good quality inspections.

Mr. Luc Thériault: All right.

I will therefore put my question to the agency's representatives.

I assume you acknowledge the shortcomings raised in the Auditor General's report.

For the coming months and beyond, what lessons have you drawn?

To ensure adequate sanitary conditions while facilitating and simplifying processes for temporary foreign workers, inspectors and employers, what should be done?

Ms. Brigitte Diogo: Thank you for the question.

The current temporary foreign worker program is managed by Employment and Social Development Canada, or ESDC, but the agency has indeed worked closely with that department in the management of the program.

Decisions regarding the management of the quarantine of these workers were made in conjunction with the provinces and territories. Certainly, the best way to manage the risk of infection, even after foreign workers have entered Canada, is to ensure that they arrive at their quarantine location or destination.

We are indeed working with ESDC to make sure that we find ways to improve the processes when these workers arrive and to work with private sector partners to manage the risks and make sure that these workers leave healthy.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Ms. Diogo and Mr. Thériault.

[*English*]

Next we have Mr. Davies, please, for six minutes.

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

To Public Health Agency, the global public health intelligence network has been part of Canada's contribution to the World Health Organization, which has described GPHIN as a “cornerstone” and also “the foundation of the public early warning function at the global level.” They said that approximately 20% of the WHO's epidemiological intelligence had come from GPHIN before it was silenced effectively in 2019. In that year, we were told that a department edict was issued that all such alerts from GPHIN had to be approved by senior managers.

My question is, who issued that edict and has it been reversed?

● (1610)

Ms. Cindy Evans: Mr. Chair, the number is correct. Twenty percent of the information that is fed into the World Health Organization's epidemic intelligence does come from the global public health intelligence network. However, I would like to clarify for the committee that at no point was the global public health intelligence network silenced.

There are a number of products that come out of this program, and the feed to the WHO is one of them, as are the GPHIN daily reports. GPHIN alerts is also a platform that's available—

Mr. Don Davies: I have limited time, I'm sorry.

My question was about the department's edict that all such alerts had to be approved by senior managers. That was the edict, was it not?

Ms. Cindy Evans: Mr. Chair, under the independent external panel review, it was clarified that there was no documentation to identify a specific edict. Nonetheless, the department did undertake to put in place clear standard operating procedures with clarity in terms of the level of sign-off for alerts that are done not at a high, senior management level.

We've brought clarity in the criteria that are used for reports, which align with the WHO's public health emergencies of international consequence.

Mr. Don Davies: Can you explain to me why an emergency alert was not issued by GPHIN about COVID-19?

Ms. Cindy Evans: What the GPHIN review did identify is that the GPHIN program did what it was intended to do. The GPHIN program did identify the outbreak in Wuhan on December 30, 2019, and included that in a report on December 31, as well as in a special stand-alone report. At that time, the information was already circulating with international partners. Adding an additional alert would not have provided additional support to the international community.

The independent review panel did confirm that it saw no evidence suggesting an earlier identification by the GPHIN was possible and that it would not have impacted on the actions taken by the Public Health Agency.

Thank you, Mr. Chair.

Mr. Don Davies: Thank you.

The Office of the Auditor General, as you heard summarized today, issued a number of scathing reports. The deputy Auditor General just stated today that the problems arose because PHAC had not addressed long-standing problems going back a decade. If there was one overall take-away, he said that long-standing known issues must be dealt with.

My question to PHAC is, who has been held accountable for not addressing the problems going back a decade and for long-standing known issues not being dealt with?

Ms. Cindy Evans: We thank the Auditor General for the attention to these important issues. A number of steps have taken place, and our focus at this time remains on continuing the fight against COVID-19 that's hurting Canadians. We've laid out a path towards addressing the recommendations from the Auditor General across a number of the audits. Certainly we are here today to answer questions in terms of that forward-looking plan.

Thank you.

Mr. Don Davies: I don't know if you understood the question. The question was, who has been held accountable for those conclusions? If you don't know, you can just say that you don't know.

Ms. Cindy Evans: Mr. Chair, the Public Health Agency of Canada accepts the recommendations from the Office of the Auditor General, and we thank her for the attention on these important issues.

Mr. Don Davies: Thank you.

One of the reports noted limited public health expertise, including epidemiologists, psychologists, behavioural scientists and physicians at senior levels. The audit also found a lack of emergency response management expertise and capacity within the agency.

What steps has PHAC taken since the publication of this report to ensure that the agency has the expertise and capacity to fulfill its mandate?

Ms. Cindy Evans: The Public Health Agency has increased its resources over the course of the pandemic. That's with respect to epidemiologists and physicians, as well as a number of laboratory technologists.

Certainly we are facing a pandemic that we haven't seen the nature of in a hundred years. While working with our colleagues in the jurisdictions, similarly, both the magnitude and length of the response created pressures on the types of resources we require.

We are pleased that the recommendations from the Office of the Auditor General are certainly moving forward in strengthening the Public Health Agency with respect to our organizational structure to bring clarity and attention to these areas as well in our training programs within the emergency management plans.

We've been quite fortunate with two programs, the Canadian field epidemiology program, which formed a key support during the COVID-19 response, as well as the Canadian public health service. Our ability to utilize those particularly epidemiological resources has certainly served us well, and we will be looking to bolster programs like those as well as others going forward.

Thank you.

● (1615)

The Chair: Thank you Ms. Evans and Mr. Davies.

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis: Thank you, Mr. Chair.

I thank everybody for appearing here before the committee.

As my colleague said, we have limited time, so some of these questions may need simply yes or no answers, or numbers.

This is for PHAC. The Prime Minister has stated that 90% of Canadians are double vaccinated. Your numbers seem to be different from that. Can someone please tell me how many Canadians over the age of 12 have been vaccinated twice?

Ms. Cindy Evans: Mr. Chair, although the vaccine rollout is managed by the Public Health Agency, those officials are not here with us today to respond to the Office of the Auditor General's report, but we'd be pleased to follow up in writing with the committee on that question.

Thank you.

Mr. Stephen Ellis: Fair enough.

For PHAC again, do we have the rights to produce Novavax domestically?

Ms. Cindy Evans: Mr. Chair, respectfully, it's outside of the purview of the the officials here today to speak to the vaccine rollout program—

Mr. Stephen Ellis: Okay

Ms. Cindy Evans: —but we would certainly undertake to provide appropriate information back to the committee in writing.

Mr. Stephen Ellis: And what about antivirals? Do we have the rights to produce them domestically?

Ms. Cindy Evans: Mr. Chair, with respect, it's outside of the purview of the officials here today to speak to the antiviral file. Again, we'd be happy to provide appropriate information to the committee in writing.

Mr. Stephen Ellis: Okay, these are all interesting answers.

What about rapid tests? How many of those are made in Canada?

Ms. Cindy Evans: Mr. Chair, the officials are here today prepared to answer questions with respect to the Auditor General's audit, so unfortunately we don't have an official today who could speak to that. We'd be happy to follow up with the committee in writing in response to those questions.

Thank you.

Mr. Stephen Ellis: Okay.

What about border measures? We've often heard that we've had some struggles with border measures. We've talked about the percentage of sensitivity of rapid tests. We've talked about the leakiness of data.

Now we also know that everywhere in the world there is COVID, so does closing the borders work?

Ms. Brigitte Diogo: The border measures are only one part of the government's response to the pandemic. Certainly based on our data, looking at positivity rates, we have been able to monitor importation risks, and all of this contributes to limiting risk to Canadians. So my answer would be, yes. Like everything else, they need improvement and continuous adjustment, but they have certainly been effective in contributing to slowing down importation risks to Canada.

Mr. Stephen Ellis: Okay, that is interesting.

Ms. Brigitte Diogo: Thank you.

Mr. Stephen Ellis: Do we we have an expert here today who could speak about Novavax? Maybe that's easier.

Ms. Brigitte Diogo: No, Mr. Chair.

Mr. Stephen Ellis: No on Novavax. Okay, and we have no antiviral person and no rapid test person, either.

Do we have someone who knows anything about PPE?

Ms. Cindy Evans: Mr. Chair, I'd be pleased to answer questions regarding the national emergency strategic stockpile and PPE.

Mr. Stephen Ellis: Okay, that would be great.

How many manufacturers of PPE do we have in Canada, including of gloves, gowns and masks?

Ms. Cindy Evans: I can't speak specifically to the number of manufacturers. I will say that 70% of the Public Health Agency's contracts for the N95 respirators are domestic; 50% of the surgical masks that are procured by the Public Health Agency are domestically manufactured; 100% of the face shields procured by PHAC are domestically manufactured; and 25% of the disposable gowns have been domestically manufactured.

● (1620)

Mr. Stephen Ellis: Along that same line, Mr. Chair, we said that 50% of masks and 25% of gowns are produced domestically. Can the officials from PHAC tell me where the rest are made?

Ms. Cindy Evans: They would be sourced internationally. I don't have the specifics on each of the other contracts. They would come from a number of countries, including the U.S.

Mr. Stephen Ellis: Can we have that in writing, please, which countries they come from? Will you follow up on that, please?

Ms. Cindy Evans: Mr. Chair, we'd be pleased to provide available information to the committee in writing.

Mr. Stephen Ellis: Thank you.

Hon. Mike Lake: Mr. Chair, on a point of order, many commitments have been made to get further info. I just want to ensure that as a committee, we follow up on those commitments and get that information that's been promised.

Thank you.

The Chair: Yes.

Dr. Powlowski, please, for six—

Mr. Don Davies: On a point of order, Mr. Chair, may I just add to Mr. Lake's suggestion by asking if we could have that information within seven days?

The Chair: Ms. Evans, is seven days a reasonable turnaround for the information you've undertaken to provide?

Ms. Cindy Evans: Mr. Chair, certainly we'll undertake to provide all information possible within that seven-day time frame and follow up.

The Chair: Thank you.

Thank you, Mr. Davies and Mr. Lake.

Dr. Powlowski, for five minutes.

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

The Minister of Health requested an independent review of Canada's global public health surveillance system, the global public health intelligence network, so I want to ask something about the GPHIN.

It seems that it was working at the time of COVID, and I think someone from PHAC told us that in fact there had been a warning that it had been detected and that there was an outbreak of pneumonias in China. However, the problem seems to be, from the report, that nobody was listening. If I can draw an analogy from medicine, there was a monitor on the patient, but nobody was looking at the monitor.

I'll quote from the report of the independent review. They said:

> A governance structure was in place for oversight of surveillance activities from April 2017 to March 2019. However, key leadership responsibilities were not redistributed following the elimination of the...position.

Later on, they talk about the Centre for Emergency Preparedness and Response lacking information on how information on events is shared, particularly with senior management. Later on, they say it was not always clear who was responsible for what in the flow of information, risk assessment and chain of decision-making.

Again to use that analogy, there was information coming in. You did have a monitor on the patient, but nobody was watching the monitor.

In that independent review, they suggest more effective links between the global public health intelligence network and the Public Health Agency of Canada, the need for a whole-of-agency approach. What has the Public Health Agency of Canada done to address this shortcoming?

Ms. Cindy Evans: Mr. Chair, the external independent panel announced by the Minister of Health in November 2020 released its final report in July 2021. A number of the key findings are, as has been mentioned, that the GPHIN did what it was designed to do, and it also confirmed that it had never been shut down. The GPHIN did identify the outbreak in Wuhan and allowed PHAC leadership to take immediate action, so I would say the leadership was listening and did act immediately.

We notified officials across the government, followed by the public health officials across Canada by January 2. Therefore, very early on, the system was sensitized. Our response effectively began on the first days of 2020. The panel saw no evidence that any earlier identification by the GPHIN of the outbreak would have been possible, based on their assessment of other open-source data systems.

There were 64 recommendations from the independent panel on three different themes: GPHIN roles and purpose; the organization and flow of information; and technology. As has been stated, there were some broader recommendations, including looking at broadening our approach to risk assessment. In that regard, the agency has implemented, in December of the previous calendar year, a centre for integrated risk assessment so that we can move forward on those important recommendations.

I'll just pause and see if my colleague Mr. Allison would like to add anything with respect to the broader surveillance question you've raised.

● (1625)

Mr. Michael Barrett: Thank you, Cindy; and Mr. Chair, thank you for the question.

Not only is there, as Cindy mentioned, the Centre for Integrated Risk Assessment being stood up in December 2021, but also the development of a new branch, the corporate data and surveillance branch, which is responsible for working with partners, including the GHPIN network, and looking at things a bit more holistically, seeing how we can improve our overall surveillance, data integration processes and how we can get to the better public health outcomes that we're all looking for. CIRA, the Centre for Integrated Risk Assessment, is starting to look at these issues now and is developing the frameworks and processes that we need to move forward and do better, both through this pandemic that is ongoing and also into the future.

Mr. Marcus Powlowski: Thank you. I want to get in another quick question.

I think the Public Health Agency of Canada ought to appreciate the essential work that GPHIN does. The Public Health Agency of Canada must know that the international health regulations are being reviewed and that the WHO has initiated a process in writing a new treaty on infectious disease. It certainly must appreciate the importance of these kinds of early warning systems and the fact that many poor countries do not have the resources to do such monitoring.

Certainly many people feel that an essential part of a revision to the international health regulations and a new treaty on control of infectious disease would require developed countries to financially assist developing countries in doing such monitoring. Has PHAC considered this issue and does it have a position with respect to it?

Thank you.

The Chair: Answer very briefly, please.

Ms. Cindy Evans: Thank you, Mr. Chair.

As I mentioned, GPHIN continues to be an important source of information, amounting to 20% of the feed-in to the World Health Organization's open-source data system.

We are very interested in the international discussions on updates and potential changes to the international health regulations, and Public Health Agency officials will be participating in those discussions and certainly are actively interested to follow those.

We agree with the independent review panel's recommendation that GPHIN should continue to include both domestic and international objectives with regard to providing that information.

The Chair: Thank you, Ms. Evans, and Dr. Powlowski.

[*Translation*]

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

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

The latest report from the Office of the Auditor General of Canada states that the agency did not have a record of stay for 75% of those arriving in Canada by air.

The agency therefore did not know whether people who were required to quarantine themselves in a government-approved hotel had done so. There were several failures to follow up on the quarantine of travellers.

Ms. Diogo, given these failures, are we to understand that the measures you thought you were taking to protect us were more like window dressing to reassure the public, not truly effective public health measures?

Ms. Brigitte Diogo: Thank you for the question.

You just referred to the findings of the Office of the Auditor General of Canada. From the agency's perspective, we have different levels of intervention in place, whether it's before people arrive in Canada, when they arrive, or after they enter the country.

As for travellers who had to go and do their quarantine in a hotel, we designed the program so that they could comply with it from the start because...

Mr. Luc Thériault: Excuse me for interrupting you.

Ms. Brigitte Diogo: Yes, Mr. Thériault?

Mr. Luc Thériault: What was the cause of the failures in monitoring quarantines? Was it due to a lack of resources? If not, what was the cause? Once you have determined the cause, what will you do in the future to correct the situation?

● (1630)

The Chair: I will ask you to answer quickly, if possible, Ms. Diogo.

Ms. Brigitte Diogo: Yes.

Based on our data, we do not reach the same conclusions as the Office of the Auditor General of Canada. Non-compliance with quarantine requirements at the hotel...

Mr. Luc Thériault: Did you have a registry?

Ms. Brigitte Diogo: We had asked hotel staff to give us information about people arriving at their establishment. This was the failure that the Office of the Auditor General of Canada reported. We knew from the start who was being sent to the hotel and who did not have a reservation. These cases were reported to the agency as soon as these people arrived at the airport.

The agency had increased its resources to be able to help travellers comply with quarantine requirements. We worked with airports to ensure that people could make a hotel reservation. We contacted everyone who tested positive. They had to go to the hotel to wait for their test results. The agency contacted each of these individuals to ensure that they understood the quarantine requirements.

There are indeed improvements to be made, and we continue to improve our border management system and quarantine tracking.

The Chair: Thank you, Ms. Diogo and Mr. Thériault.

[*English*]

We have Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thank you.

The Auditor General's May 2021 report on securing personal protective equipment and medical devices found that PHAC was not as prepared as it should have been to respond to the COVID-19 pandemic due to "long-standing unaddressed problems with the systems and practices in place to manage the National Emergency Strategic Stockpile". It pointed out "that the unaddressed federal stockpile issues had been brought to [PHAC's] attention through a series of internal audits dating back to at least 2010."

On a scale of one to 10, one being terrible and 10 being perfect, how would you describe the current state of Canada's national emergency strategic stockpile?

Ms. Cindy Evans: We've made significant progress in situating ourselves to be ready to respond to the current COVID situation. We now have an eight-week stockpiled supply of key personal protective commodities, including N95 respirators, surgical masks, gloves and face shields. We've been able to actively respond to 379 requests for assistance from the provinces and territories and other government departments to support them with necessary medical equipment and supplies. As well, we procured over 40,000 new biomedical devices to support the increased needs given that the clinical—

Mr. Don Davies: I'm sorry, Ms. Evans, but I have limited time, which is why I framed my question very precisely. Those numbers are meaningless to me unless I know whether they're good or not. For instance, how many weeks of supply did we have in our stockpile at the time the Auditor General said that we were not doing a good job? You just said we have eight weeks now. What did we have then?

Ms. Cindy Evans: Working with the provinces and territories we were able to put in place a supply and demand model that helped us to establish what the key burn rates were during COVID-19. We worked with the provinces to determine the needs both for their stockpiles as well as for the Public Health Agency. Certainly we had personal protective equipment—

Mr. Don Davies: I'm sorry, I'm going to go somewhere else. I have to say it's unacceptable to get that kind of dissembling to direct questions by the health committee. I just must say that for the record.

Ms. Diogo, what is the current state of knowledge on an infection-acquired immunity?

The Chair: Please give a short answer, Ms. Diogo.

Ms. Brigitte Diogo: I'm not a scientist. I'll defer to the department to respond in writing to that question.

The Chair: Thank you, Mr. Davies.

Next we have Mr. Barrett, please, for five minutes.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thank you, Chair, and thanks to the witnesses.

Through you, Chair, to the witnesses at the Public Health Agency of Canada, a number of Canadian provinces have released step-by-step plans that detail their exit from COVID-19, or an end to COVID-19 restrictions in their jurisdictions. Has the Public Health Agency of Canada prepared a plan like that?

● (1635)

Ms. Brigitte Diogo: Mr. Chair, the agency is working with other government departments and in consultation with the provinces and territories about a phased approach to adjusting the public health measures. We are looking to inform those discussions with what we have learned from the science and data; but currently the border measures and the public health measures, and how to change them, are being discussed with provinces and territories.

Mr. Michael Barrett: Thanks for the answer.

Again through the chair, what benchmarks are being used by the Public Health Agency of Canada to justify the current restrictions or the change to restrictions at ports of entry, to go back to the response from the previous official, Mr. Chair?

Ms. Brigitte Diogo: With regard to a benchmark, we certainly monitor the epidemiology whether it's in Canada or elsewhere. We are looking at importation risk, at the results of our testing regime, at the positivity rates, for example, in the border testing to determine whether readjustments will be made to the measures. We're certainly looking, at the domestic level, at vaccinations and at the impact on the health care system in Canada. Those are some of the elements that go into the modelling that is done to determine whether we have to make adjustments.

Mr. Michael Barrett: While I appreciate the answer, Mr. Chair, I think knowing specifically what the benchmarks are would help inform the Canadian public and certainly members of this committee. We've seen that with some of the provinces in the step-by-step process they've laid out. What do those metrics need to look like? Is it a 100% vaccination rate? Is it a 0% test positivity rate? What numbers have been identified?

Through you, Mr. Chair, I'd quickly ask if the witness would undertake to provide those benchmarks to the committee in writing.

Ms. Brigitte Diogo: Yes, Mr. Chair, we can provide that information.

Mr. Michael Barrett: Thank you, Chair.

My next question is with respect to the requirement for proof of vaccination at our ports of entry. I want to refer to the "Statement on the 10th meeting of the International Health Regulations...Emergency Committee regarding the coronavirus (COVID-19) pandemic", from January 19, 2022. That's from the World Health Organization. It lists and identifies actions that are critical for all countries. One item listed is that countries "NOT require proof of vaccination against COVID-19 for international travel as the only pathway or condition permitting international travel given limited global access and inequitable distribution of COVID-19 vaccines."

It continues, but I'll stop quoting it there. I'll ask, through you, Chair, if the witnesses can tell us why that recommendation has not been adopted. Is Canada going to move away from the requirement for proof of vaccination as one of the other steps they're going to take towards sunsetting or ending the federal requirements?

The Chair: We're out of time, but we'll allow a brief response.

Ms. Brigitte Diogo: Thank you, Mr. Chair.

There is no plan to move away from that requirement at this time. The vaccination has been a foundational piece in reopening to international travel. At this time, it's something we are retaining.

● (1640)

The Chair: Thank you, Mr. Barrett.

Next is Ms. Sidhu for five minutes, please.

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

Thank you to all of the witnesses for being with us.

My question is for Ms. Diogo.

As an official response for PHAC's original branches, could you speak to your agency's relationship with various health systems of the provinces and territories? What were the challenges in inventory control and tracking among governments?

Ms. Brigitte Diogo: Thank you, Mr. Chair.

I believe that's a question for my colleague Cindy Evans.

Ms. Cindy Evans: Mr. Chair, early on in the pandemic, there were some challenges with the provinces and territories being able to very quickly identify their current holdings of personal protective equipment. In that regard, the Public Health Agency moved forward quickly in collaboration with our partners at Public Services and Procurement Canada to engage in bulk procurement so that we could secure for Canada the personal protective equipment needed. Then we had a very transparent allocation framework where 80% of those procurements were moved quickly as they came in to the provinces and territories, with 20% being held back for the national emergency strategic stockpile.

We developed systems to collect information throughout the pandemic in terms of the holdings of the jurisdictions to help understand where the pressure points might be and where we might be at greater risk in terms of the supply coming in. We're fortunate to have very effective governance structures, including the Logistics Advisory Committee, where we could discuss the challenges and facilitate sharing across the jurisdictions where there were pressure points as Canada moved forward to increase its holdings of personal protective equipment.

Ms. Sonia Sidhu: To follow up on that, Ms. Evans, what can be done to get better data surveillance? What is the timeline to identify gaps to be fulfilled?

Ms. Cindy Evans: I'll turn to my colleague, Mr. Allison, with respect to pan-Canadian data strategy.

With respect to the national emergency strategic stockpile, the work that was done to create a pan-Canadian supply and demand model was very effective. That modelling served us well. That is work we will continue in our work with the provinces and territories. As well, we were able to put in place data systems that allowed them to help see which shipments were coming when. That also allowed for good alignment of inventory systems across the country.

I'll let my colleague speak to you about the pan-Canadian data strategy.

Mr. Christopher Allison: Thank you, Cindy, and thank you, Mr. Chair.

Data gaps are a broad complex issue given the way that health is a shared responsibility across provinces, territories, indigenous communities and the federal government. As for solutions, there are no silver bullets. Work has been ongoing to find a way to make sure that public health data is reliable, timely and relevant, that data is getting to where it needs to be. This has been referenced in regard to the Minister of Health in both the Speech From the Throne and the mandate letter for the minister, where we're asked to continue demonstrating leadership in public health by strengthening surveillance and capacity in this space.

The pan-Canadian health data strategy is currently in development. We have an expert advisory group that has released two fantastic reports highlighting the complex work that needs to happen in terms of governance, interoperability, and in our systems and our partnerships in trust with citizens and stakeholders.

That is the high-level road map we are looking towards that's going to bring us forward. At the same time, there's a great deal of work on specific systems and looking at the IMIT capacity effect to make sure that we can work effectively with partners.

Ms. Sonia Sidhu: Mr. Chair, do I have more time?

Quickly, how do you determine how much N95 respiratory stock is deemed an adequate supply? How is it determined who gets access to that stock?

Ms. Cindy Evans: As I had mentioned, we worked with our federal colleagues to create a supply and demand model that looks at a number of factors in the information that's shared with us from the provinces and territories. We look at the epidemiology of COVID-19 and its progression, as well as ICU utilization. As well, we needed to account for where there may be changes in policies in the jurisdictions on usage and how they were distributing the masks. As an example, with omicron, where there was increased transmissibility, we did see an increase in the utilization of N95 masks. Certainly, that helped to inform changes to what we saw as the annual requirements. That would then change what we saw as our stockpile numbers and our eight-week supply based on the data from the height of omicron. When we looked at this in December 2021, it was in the order of 139 million as an annual figures for all of the country, so I'm looking at the eight-week supply and what would be required.

When we saw increased utilization of N95s by the provinces during omicron, while I said we had an 80:20 allocation framework, we did switch to immediately pushing out 100% of the masks coming in the door to the jurisdictions to help address that need. As well, where there were N95 equivalents for masks that were not the preference of the health care system because of the requirements for fit testing, we were able to work with the jurisdictions to have a broader distribution within their systems applied to the health care sector so that we could maximize the use of those other masks.

Those are some of the methods by which we could determine the overall amounts, and working with the transparent allocation framework and the ongoing weekly conversations with the jurisdictions at the Logistics Advisory Committee allow us to get the right amounts out to the right areas.

● (1645)

The Chair: Thank you, Ms. Evans.

Next, Ms. Goodridge, please, for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I want to thank everyone for appearing here today.

I will just second the comments made by my colleague, Mr. Davies, that the inability to answer some of these questions is truly outstanding. As someone who is brand new to this committee, many of the questions I've seen asked came from the brief that was prepared by the Library of Parliament, and you haven't been able to answer some very simple questions. I just want to make sure this is on the record.

To follow up on some of the questions that were asked by Mr. Barrett about whether you looked into the availability to have travel...not necessarily only have vaccinations, I'm just wondering if you could please provide an answer on that, Ms. Evans?

Ms. Cindy Evans: Mr. Chair, I'll turn to my colleague, Ms. Diogo, with respect to a travel-related question. Thank you.

Ms. Brigitte Diogo: Thank you.

The question is whether we are only looking at vaccination. Vaccination is a fundamental element, but we also ensured that in doing so we have captured exemptions in the regime to allow for equity concerns and to ensure that people were able to enter Canada when needed.

I hope I answered your question.

Mrs. Laila Goodridge: Could you please give a little more detail regarding the exemptions and what data you guys used to come up with those exemptions?

Ms. Brigitte Diogo: With regard to exemptions, we keep in mind that pediatric vaccines are not available, so in the regime we have allowed for unvaccinated children to be able to enter with parents who are vaccinated. Canada has expanded the list of vaccines that are acceptable for travel to Canada, and we continue to expand that list.

The question about temporary foreign workers is one where we have ensured that vaccination is not a barrier to employers having the help they need. We have also—

Mrs. Laila Goodridge: I have one question, then. What data did you guys use to build those arguments to support the exemptions?

Ms. Brigitte Diogo: The data used includes previous pilot projects that have been done and looking at the testing regime. We looked at importation data in terms of COVID-19. We've looked at the information related to vaccine availability around the world in other countries, so—

● (1650)

Mrs. Laila Goodridge: All right. That's wonderful.

Because we do have a very limited amount of time, would it be possible to table some of this information with the committee so we can see the rationale that was used to help formulate the decisions made by PHAC here?

Ms. Brigitte Diogo: We can certainly table information. It would be helpful to have more specific information. I mean, there are—

Mrs. Laila Goodridge: Very specifically, I would like you guys to provide in writing a response to the question that was asked by Mr. Barrett immediately before I was able to ask questions.

Ms. Brigitte Diogo: Okay, Mr. Chair. We'll follow up in looking at the transcript in terms of the question that was asked and ensure we provide the information we have available.

Mrs. Laila Goodridge: That's fantastic.

I have one quick question, because I believe I have about 30 seconds left. Do you have the number of weeks that the stockpile will last, yes or no?

Ms. Cindy Evans: Mr. Chair, we now have an eight-week supply of key commodities and personal protective equipment.

Mrs. Laila Goodridge: What was the number prior to this COVID-19 pandemic?

Ms. Cindy Evans: Mr. Chair, personal protective equipment was not a commodity requested of us. Of the provinces' jurisdictions, we did not have an eight-week supply prior to the pandemic.

Mrs. Laila Goodridge: How many weeks' supply did we have prior to it?

Ms. Cindy Evans: I'm unable to answer that question, Mr. Chair.

The Chair: Thank you, Ms. Goodridge and Ms. Evans.

We have Mr. Jowhari, please, for five minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair.

Thank you to the witnesses.

I'd like to start by asking PHAC this, specifically Mr. Allison. In the Office of the Auditor General's report number 8, the following was recommended:

> The Public Health Agency of Canada should develop and implement a long-term, pan-Canadian health data strategy with the provinces and territories that will address both the long-standing and more recently identified shortcomings affecting its health surveillance activities.

The agency agreed to that recommendation, and I also believe that it created a corporate data and surveillance branch in October 2020. In the response from the agency—and I'm referring to page 48 of report number 8—it was indicated that "A long-term strategy is under development and is on track for completion by December 2021."

Mr. Allison, are you in a position to be able to give us an update on where this strategy is? What are the short-term, medium-term and long-term objectives? Do you have a road map you can share with us, with some timelines?

Mr. Christopher Allison: Thank you, Mr. Chair.

Absolutely. The pan-Canadian health data strategy, which I did mention before, is the long-term road map that we're looking at. It's been developed in consultation with provinces and territories. Currently, two reports have been published by the expert advisory group. A third report is due in the spring of 2022.

With regard to the high-level milestones for the group, first, one of the key items was the creation of the corporate data and surveillance branch. The plan to establish the governance for the long-term pan-Canadian health data strategy has also been put in place. The launch of the expert advisory group has been put in place and, again, the development is set for April 2022.

The short- and medium-term priorities that have been outlined under the strategy are being defined by March 2022, and the intent is to bring this to a conference of deputy ministers of health in May 2022. The overall work is happening and is proceeding at pace. There are also task-limited time groups that are working on specific sub-items under the pan-Canadian health data strategy.

If the esteemed members of the committee have not read the first two reports, they are excellent and do highlight an ambitious but achievable path towards having an effective public health data ecosystem and effective sharing across provinces and territories.

● (1655)

Mr. Majid Jowhari: Thank you, Mr. Allison.

I'll go back to you again, sir. The following recommendation is in paragraph 8.80:

> The Public Health Agency of Canada should appropriately utilize its Global Public Health Intelligence Network monitoring capabilities to detect and provide early warning of potential public health threats and, in particular, clarify decision making for issuing alerts.

In the response, naturally the agency once again agreed, and said it "will work to make further improvement to GPHIN" and to one of the program components—the alert process, specifically, which continues.

Can you tell me why, specifically, the alert process, and what improvement has been done? Do we have any indication that we need to issue any potential alerts?

Mr. Christopher Allison: Mr. Chair, I'm going to pass that question over to my colleague, Cindy Evans.

Ms. Cindy Evans: Thank you.

The external review panel did include, in its recommendations, that we should include early warning signals, currently known as alerts, which should remain a core function of GPHIN's operations. As I mentioned, that is one of several products that comes out of the GPHIN program.

What we have done since the audit was done, and since the review, is to improve and streamline our decision-making process for the GPHIN alerts and other GPHIN products and processes. In looking in detail at the report that came from the independent review panel.... They also suggested that we look at the terminology that we're using around the use of alerts, and work with international colleagues to make sure there's alignment in the nature of alerts and the degree to which an assessment forms part of those alerts.

We have undertaken some work to bring that clarity, but, in my view, it was also a nod from the external panel in terms of the importance of early warning in general, and events-based surveillance systems, and the role that they can play in pandemic preparedness.

Thank you.

The Chair: Thank you, Ms. Evans.

[*Translation*]

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

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

Report number 10, entitled “Securing Personal Protective Equipment and Medical Devices”, published by the Office of the Auditor General of Canada, states that the most significant risks were linked to contracts with an advance payment clause. It also states that measures were taken to recover amounts when services were not rendered.

Ms. Evans, could you update us on the status of the cost recovery process?

[*English*]

Ms. Cindy Evans: Questions related to the contracts and advance payments would best be answered by my colleagues at PSPC.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, because the sound was cut off, I was unable to hear the answer.

[*English*]

The Chair: Okay.

Ms. Cindy Evans: I'm happy to repeat my answer.

The Chair: Just one moment, Ms. Evans. It's probably a technical problem on our end, so we'll need to get it resolved and then we'll start over.

Ms. Cindy Evans: I'll wait for your signal, Chair.

The Chair: Does it work now? Okay.

We'll reset the clock, Monsieur Thériault.

[*Translation*]

You have the floor for two and half minutes.

Mr. Luc Thériault: Ms. Evans, could you repeat the answer, since I was unable to hear it?

[*English*]

Ms. Cindy Evans: With respect to the process for advance payments and the contracts, my colleagues at PSPC would be best placed to answer those questions.

[*Translation*]

Mr. Luc Thériault: Will my question be answered?

The Chair: Ms. Evans specified that it falls under the responsibility of another department.

Mr. Luc Thériault: All right.

The problem was that interpretation wasn't working.

The Office of the Auditor General of Canada's report identifies management problems with the National Emergency Strategic Stockpile. There were problems at the beginning of the pandemic. These problems, which were present in 2018, were already there in 2010, according to what was revealed.

What steps have you taken to address these issues affecting the stockpile and personal protective equipment?

● (1700)

[*English*]

Ms. Cindy Evans: Mr. Chair, first, I'd say that the national emergency strategic stockpile is similar to our colleagues' one in the United States. It's seen an evolution in its mandate and the scope of the programming. Certainly, from its inception in 1952 when it was focused more on health care supplies, there's been an evolution where post the 9/11 crisis, the mandate has been expanded to look more towards medical countermeasures for chemical, biological, radiological and nuclear.... With the post-SARS environment we looked more at scoping in the antivirals. Personal protective equipment had not formed a large part of the mandate or need for the national emergency strategic stockpile.

Despite this, with the onset of COVID-19 and the fierce global competitive market that we saw, the federal government leaned forward to do bulk procurement of personal protective equipment and was able to actively bring in a significant number. We were able to purchase 3.8 billion units of personal protective equipment to supply the provinces and territories.

[*Translation*]

Mr. Luc Thériault: Did...

The Chair: Thank you, M. Thériault.

[*English*]

We have Mr. Davies for two and a half minutes.

Mr. Don Davies: Thank you.

Ms. Evans, I think it would be helpful to ask you to undertake to provide the committee with a breakdown by category and number of everything that was in the national emergency strategic stockpile as of December 31, 2019, and then perhaps with a breakdown of what category of supplies the stockpile now has and in what number. That may help us get the answers we need.

Would you undertake to provide the committee with that, please?

Ms. Cindy Evans: Mr. Chair, our national emergency strategic stockpile forms part of our emergency critical infrastructure, and there are a number of holdings that we don't disclose to the public for national security reasons.

That being said, in 2021 we did revisit our disclosure policy and looked at the unprecedented COVID-19 response. As a result, there are some information holdings that may be disclosed, and we certainly could share some of the types and global quantities of the personal protective and medical equipment and supplies that were purchased as a result of COVID-19. We'd be happy to provide that information to the committee.

Mr. Don Davies: Thank you.

In answer to my colleague you made it quite clear that we have eight weeks of supply now, but I don't know of what. We had less than eight weeks of supply before COVID; I don't know of what. Do you know how many weeks of supply we had under the eight weeks prior to the COVID pandemic? Are you just unable to tell us, or is that a number you can provide to the committee when you go back and research?

Ms. Cindy Evans: Mr. Chair, with respect to the question, when I speak to the eight weeks of supply of personal protective equipment, there are five key commodities that are quite important for a respiratory illness like COVID-19. Those are N95 respirators, surgical masks, gloves, face shields and disposable gowns. We do have over an eight-week supply of those key commodities. We are not able to provide that measure for the pre-COVID environment for the personal protective equipment.

Mr. Don Davies: Sorry, can I ask why? Why can't you? If you can give those numbers now, why can't you tell us what the numbers were for those categories prior to COVID?

Ms. Cindy Evans: With respect, Mr. Chair, I'm unable to provide that number to the committee.

Mr. Don Davies: I understand that. I'm asking why. Is it because you have the number and can't because it's a national secret or because you don't know?

Ms. Cindy Evans: Mr. Chair, the supply and demand modelling that was done was very effective, as were changes with the epidemiology, which enabled us, working with the provinces and territories, to identify what the national burn rates and needs are, and we did not have that supply-and-demand model in place prior to COVID-19.

Mr. Don Davies: It sounds like we didn't have any of the supplies in place prior to 2019.

The Chair: Thank you, Mr. Davies.

Thank you, Ms. Evans.

Next is Mr. Lake, please, for five minutes.

Hon. Mike Lake: Thank you, Mr. Chair.

I'm going to start with a caveat that's all too important these days to mention. I am pro-vaccination. I've been vaccinated, and have taken three shots of Pfizer. My family is all vaccinated, and I'm glad they are.

That said, like most people in this committee room, I know people who have chosen not to be vaccinated for whatever reason. It might be deep convictions. To use the words of the Prime Minister back in May of 2021 when he said, “we're not a country that makes vaccination mandatory”, I'm curious to know what advice was given between May of 2021 and three months later, when obviously there was a course reversal.

Did the Public Health Agency give advice on mandatory vaccines versus non-mandatory vaccination? Is there any evidence that the Public Health Agency presented that caused the Prime Minister to change his mind?

● (1705)

Ms. Cindy Evans: Mr. Chair, with respect, the officials today are here prepared to answer questions in relation to the Office of the Auditor General reports, and while the vaccine rollout is part of the Public Health Agency's official role, we don't have officials here today to speak to those broader questions. Thank you.

Hon. Mike Lake: In terms of evidence on the government policy on mandatory vaccinations versus non-mandatory vaccinations, can you get us that information in writing?

Ms. Cindy Evans: Mr. Chair, with respect, certainly it wouldn't be our place to speak on behalf of the Prime Minister in terms of the information on the vaccine rollout. That was managed by the Public Health Agency in collaboration with the provinces and territories. We would be happy to provide key metrics around that program.

Hon. Mike Lake: That would be perfect, yes. Evidence that shows that mandatory vaccination policy is more effective than a non-mandatory vaccination policy would be helpful.

Ms. Cindy Evans: Mr. Chair, if I could just interject, what I said would be available from the Public Health Agency would be metrics around the vaccine rollout program and our ability to work with the provinces and territories to ensure that Canadians had access to vaccines and the description of the rates in Canada.

Thank you.

Hon. Mike Lake: That's fair. We can maybe call other witnesses who can attest to that.

I'm curious about researcher advice on negative effects of a mandatory vaccination policy—again, “mandatory” being the key word. No one at this table is debating the effects of vaccines, but was there any research done or any advice given on the mental health effects of losing one's job, maybe losing one's house or even taking a vaccine that someone might believe is going to hurt them, the mental health effects of those things?

Ms. Cindy Evans: Although mental health related initiatives are not managed directly by the Public Health Agency officials who are here today, we can certainly say that the mental health and well-being of Canadians is a top-of-mind priority for the Government of Canada, and we're aware of the impact that the pandemic has had on mental health across the population, including those disproportionately impacted by COVID-19, so we'd be happy to follow up to provide specific information in writing to the committee that is available to us.

Hon. Mike Lake: Was there any consideration or advice given regarding an approach that would not have made vaccines mandatory? If the government had stuck with the May 2021 assertion of the Prime Minister that “we're not a country that makes vaccination mandatory”, I'm wondering if, at that point in time, the Public Health Agency provided an evidence-based approach to the government on how to move forward in the vein that the Prime Minister said he was pursuing back in May 2021.

Ms. Cindy Evans: Mr. Chair, with respect, at this time officials who are running the vaccine rollout program are not at the committee today.

If there are questions related to the application of vaccine policy in terms of our border measures, certainly Ms. Diogo could undertake to answer those questions, but, as I believe I've stated, the broader questions with respect to the vaccine rollout program can't be answered today. I would add as well with respect to the choices made by individual provinces in setting their vaccine requirements, certainly we wouldn't be in a position to speak to those issues.

Hon. Mike Lake: Mr. Chair, perhaps we could make sure that we have officials at future studies who can answer those questions at future meetings.

How much time do I have, Mr. Chair?

The Chair: Eight seconds.

Hon. Mike Lake: I will cut off there and will pursue the rest of my questions in my next round.

The Chair: Thank you very much, Mr. Lake. That's greatly appreciated.

Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you, Mr. Chair.

May I ask first of all to cut me off at 30 seconds before my time is up, so that I can share it with Mr. van Koeverden? I just wanted to indulge you on that.

● (1710)

The Chair: I can do that, Dr. Hanley, but I will tell you that it does appear that the Liberals are going to get another turn, so he can have five minutes in the next slot if you would prefer.

Go ahead.

Mr. Brendan Hanley: Okay, then I will take it back.

For members around the table, I will take a few seconds to give a quick plug for tomorrow's launch of the 44th Parliament's Parliamentary Health Research Caucus. Dr. Ellis is co-chair of that caucus. The theme is “Game Changers in Health Research and Health Innovation”. It's a virtual panel to be held at 4 p.m. I would highly recommend that you look at your email for the invitation and that you attend.

Next, I'd like to add my thanks to the witnesses. As someone who is in daily contact with either my CMOH counterparts around the country or with Public Health Agency officials, I know how hard you have all worked. I think the public may not recognize the role that provincial and territorial public officials and public servants play in providing that analysis, surveillance information, policy advice, procurement advice and many other roles that enabled us to get through this pandemic with relative success despite the hardships that Canadians have endured. I just wanted to add my thanks here.

One of my questions is about pandemic preparedness as a whole. When we look at, as an analogy, climate change disasters, we are looking at what were once 1 in 500-, 1 in 200- or 1 in 100-year events now becoming much more common. I fear the same may be true of pandemic-level events. I think these reports are very important to help us build capacity in vital areas of public health protection.

I have a question perhaps, through the Chair, for Ms. Evans.

When you look at pandemic preparedness as a whole, and given these reports, where do you think the highest priorities are?

Ms. Cindy Evans: Mr. Chair, in 2017, the Public Health Agency had to work with provinces and territories to create the FPT public health response plan for biological events. That would include things like pandemics.

We had started in 2019 working with the jurisdictions to put in place an exercise program so that we could get to a high degree of detail in terms of testing this program. We were fortunate to have a very robust initial planning conference in October 2019. However, unfortunately, COVID-19 arrived. At the request of the provinces and territories, we were delivering under that plan in real time, and so it was not the time to be doing exercises.

For us, a key priority will be learning the lessons from COVID-19 and looking at that plan as well as other capstone plans, our health portfolio emergency response plan and our strategic emergency management plan, to see where there are any gaps and where they need to be updated. Further, I would say that we are working in concert with our key partners across the federal government, including with Public Safety, the Canadian Armed Forces and Indigenous Services Canada.

We agree. We expect that in relation to climate change we're going to be seeing more natural disasters. We also need to keep our eye on the pandemic response, so it's incumbent on all of us to look to see what the upstream activities are that we could do, working with the jurisdictions, including municipalities as well as indigenous communities, to both prepare and to mitigate the impacts of emergencies, including pandemics.

Mr. Brendan Hanley: Thank you. That's very helpful.

Following on the questions on GPHIN and signals and risk assessment, I have a question perhaps for Mr. Allison.

Especially in the early days of the pandemic, when the risk was really portrayed as low for quite a long time, what metrics were applied to risk assessment, and how do you think we can learn from assessing the risk of what turned out to be a highly-infectious and rapidly-evolving virus with wide geographic spread?

We certainly don't want to overcall risk, but we don't want to under-call it either. I'm really interested in your thinking as we move towards the CIRA, the Centre for Integrated Risk Assessment. What are your thoughts are on the metrics and how much we have learned?

The Chair: Answer as briefly and succinctly as you can, please, Ms. Evans or Mr. Allison.

● (1715)

Ms. Cindy Evans: We thank the Office of the Auditor General for flagging this important recommendation so early on in the pandemic. We did rapid point in time assessments from January to March 2020, which identified the impact of the virus as low. Our risk assessments were based on the WHO's rapid risk assessment guidance.

We looked to update. In June of 2020, that rapid risk assessment tool used was revised and updated. Similarly, improved tools were used to look at the variants of concern including, most recently, the omicron variant of concern. We will be working through our new Centre for Integrated Risk Assessment on the rapid risk assessment tools.

It's quite critical that we work with provinces and territories, as well as our international partners, to look for synergy across the methodologies that are used. However, we agree that there's work to be done.

The Chair: Thank you, Ms. Evans and Dr. Hanley.

We have Mr. Lake, please, for five minutes.

Hon. Mike Lake: Thank you, Mr. Chair.

Before I do this last round, let me recognize that the pandemic has been hard on everybody. I recognize how hard all of you are working and have been working for the last couple of years. You may not be able to answer some of the questions I ask, but I'm going to ask them anyway, because I think they're important to Canadians.

Allison, I think you're the chief data officer. Can you point to any data that you have found to back up the Prime Minister's comments that of the people who choose not to be vaccinated, many are misogynists and racists? Is there any data to back that up?

Mr. Christopher Allison: The work that we're doing in the corporate surveillance and data branches really supports the data and analytics and the risk assessments that are happening in other parts of the organization. I'm not aware of any data that we have related to the question.

Hon. Mike Lake: With regard to communications, we all want—at least I do, and I imagine all of you do—to see more Canadians get vaccinated.

Is there any evidence to suggest that referring to people who choose not to be vaccinated as “misogynists” and “racists” helps to convince them to choose to get vaccinated?

Ms. Cindy Evans: With respect, I believe my colleague has already responded to the question to the best of our ability to answer it.

Thank you.

Hon. Mike Lake: It's part of your job, I imagine, to convince people to choose to be vaccinated. Have you found those comments to be helpful in your work to assure Canadians that vaccines are safe?

Ms. Cindy Evans: With respect to the vaccination program, as I've stated, the officials who led the vaccine rollout are not here at the Standing Committee of Health today.

We'd be pleased to speak to the data with regard to the success of the vaccination effort, including, most recently, through the omicron aspect of the outbreak and the impacts on hospitalization and ICU utilization.

If there are specific questions, we'll be happy to do our best to answer those, but as I've stated, the officials who led our vaccine rollout program are not at the committee today.

Hon. Mike Lake: Thank you. We'll look forward to hopefully having them at committee soon.

I'm going to pass the rest of my time to Dr. Ellis.

Mr. Stephen Ellis: Thank you, Mr. Chair.

I have a couple of questions about data again. What are the metrics that we're going to use in Canada that would suggest we've moved from the pandemic to an endemic state of COVID-19?

Maybe Mr. Allison can answer that. I understand you're the chief data officer for the Public Health Agency of Canada.

Ms. Cindy Evans: I'll start the answer and if my colleague has additional points to add, I'll turn to him.

We've not yet reached an endemic state in Canada—

Mr. Stephen Ellis: Excuse me, ma'am. I don't want to be rude, but tell me what the metrics are. What are we going to use? It's just three things, because we know about vaccines, how many people have been immunized and those kinds of things. Answer quickly.

Ms. Cindy Evans: In looking at the endemic state, we would be looking at the load on the health care system and its resilience to the demands. We would also be looking to be in a position to provide Canadians with clear and sustained communication.

We expect, based on our modelling, that we would enter the transition period towards the endemic state over the next number of months, but the transition is unlikely to be linear and there remains the potential for a resurgence and variants throughout.

Our experience with the omicron variant of concern is a lesson learned for all in terms of being prepared for worst-case scenarios.

● (1720)

Mr. Stephen Ellis: I understood that.

When might Canadians have access to that plan? Canadians have no idea when this is happening. Canadians don't know anything about the metrics.

When might PHAC roll out that plan for Canadians? It's very important: Canadians need some hope.

The Chair: Please be very quick.

Mr. Stephen Ellis: The chair says be quick. Let me have the date.

Ms. Cindy Evans: The epidemiology of the COVID-19 virus is what will determine when we move to an endemic state.

Mr. Stephen Ellis: I just want the date for the plan.

Ms. Cindy Evans: If you'd like to hear about it with respect to our border measures, I could ask my colleague Ms. Diogo to speak to that. In terms of—

Mr. Stephen Ellis: There is no plan.

Ms. Cindy Evans: As I said, the virus and the epidemiology in Canada will dictate when we have reached an endemic state. When we have some—

Mr. Stephen Ellis: I understand that. I know I'm dogging you here, but I'm not asking you when you're going to declare that it's happening. I asked you that and you said you couldn't answer it.

When are you going to give Canadians a plan? That's my question. It's simple.

The Chair: That's the last question and I'll let you answer it without being interrupted, Ms. Evans.

Go ahead.

Ms. Cindy Evans: I'll turn to my colleague, Ms. Diogo, if there is additional detail with respect to the public health measures associated with the border that she is in a position to share.

Ms. Brigitte Diogo: Thank you.

There is no date for a plan that I can give to the committee, Mr. Chair. The chief public health—

Mr. Stephen Ellis: Thank you. I don't need any more.

The Chair: You go ahead and finish your answer, Ms. Diogo. He doesn't get to decide when you're done.

Ms. Brigitte Diogo: The chief public health officer provides updates to Canadians on a weekly basis on how Canada is faring against the virus. She continues to update on the key metrics we're monitoring. These will let us know whether we are getting closer to the endemic stage and what the future would be in terms of changing the border measures.

The Chair: Thank you.

Mr. van Koeverden, you have five minutes.

Mr. Stephen Ellis: On a point of order, Mr. Chair, I would like in writing that information tabled to the committee, if we could, please, sir.

The Chair: What information is that?

Mr. Stephen Ellis: I want what Ms. Diogo said.

The Chair: Ms. Diogo, are you in a position to complement your answer with some written materials?

Ms. Brigitte Diogo: Mr. Chair, I indicated the updates that the chief public health officer provides on the modelling. There is certainly information that has been communicated publicly. We can make sure that modelling update is provided to the committee.

The Chair: Thank you.

Mr. van Koeverden, you have five minutes.

Mr. Adam van Koeverden: Thank you, Mr. Chair.

I do want to remind every member of this committee that answers appear in the blues. If you're speaking while your question is being answered, it's not just rude; it's also inappropriate to suggest that they provide an answer in writing afterwards. If you're interested in the answer, just listen to the answer.

I also want to thank the witnesses for your patience today. I apologize that this meeting has gotten to the point that it has.

I have a question for my colleagues and not for the witnesses. If you'll indulge me, I'd ask for unanimous consent. I'm raising a motion:

> That, pursuant to Standing Order 108(2), the Committee invites the Minister of Health, the Minister of Mental Health and Addictions and Associate Minister of Health, as well as officials, to appear for two (2) hours regarding the 2021-2022 Supplementary Estimates (C), the 2022-2023 Main Estimates, and the 2022-2023 Departmental Plans for the Department of Health, the Canadian Food Inspection Agency, the Canadian Institutes of Health Research, and the Public Health Agency of Canada and that the meeting take place on Monday, March 21st, 2022.

[*Translation*]

M. Thériault, do you want me to read the motion in French?

Mr. Luc Thériault: Thank you, but that's not necessary.

Mr. Adam van Koeverden: All right.

[*English*]

The Chair: Colleagues, there's a request here for unanimous consent. This motion really isn't up for debate, because it hasn't provided the requisite notice. If we have unanimous consent, we can deal with it now. If we don't, we'll consider it a notice of motion and it can come forward at a later date.

Mr. Michael Barrett: I have a point of order, Mr. Chair.

● (1725)

The Chair: Yes.

Mr. Michael Barrett: Could Mr. van Koeverden, through you, indulge me and just repeat the list of witnesses one more time? I don't expect that unanimous consent will be withheld.

Mr. Adam van Koeverden: I'd be happy to:

> the Committee invites the Minister of Health, the Minister of Mental Health and Addictions and Associate Minister of Health

—which is two people, not three, for the sake of clarity—

> as well as officials, to appear for two (2) hours regarding the 2021-2022 Supplementary Estimates (C), the 2022-2023 Main Estimates...on Monday March 21st, 2022

The Chair: Do we have unanimous consent with respect to that motion, or shall we take it as notice? I see heads nodding around the room.

[*Translation*]

Mr. Thériault, do you agree?

Mr. Luc Thériault: I do not agree.

[*English*]

The Chair: We do not have unanimous consent, so we'll take it as notice of motion.

Go ahead, Mr. van Koeverden.

Mr. Adam van Koeverden: Thanks, I'll table it in both official languages after the meeting.

Over to the meeting at hand, apologies for the delay.

My first question is with respect to the health data collection being supposedly inadequate according to the Auditor General's report.

First to the deputy Auditor General, could you be specific with respect to what areas require improvement please?

Mr. Andrew Hayes: I would start by saying that it is important to update and to ensure that the agreements between the federal government and the provinces about data sharing are effective.

Secondly, we need to ensure that there's an information system capable of collecting and storing all of the information from provinces that is required to be able to oversee and act in response to the pandemic is also important.

Finally, as we mentioned in our report, we need to test these systems and plans and agreements to make sure they operate effectively and, furthermore, that the resources needed are there, which is another important step.

Mr. Adam van Koeverden: Thank you very much.

Today we've touched on, and I suppose over the last two years we've all become experts on, health care jurisdiction. I'm curious to know how the Public Health Agency of Canada has worked with provinces and territories to provide additional support and how we can look toward more supports in the future in various and specific ways. I'm thinking of long-term care, but particularly others from your perspective that are most important, to ensure the resilience of our health care system on an ongoing basis.

Ms. Cindy Evans: We have been actively engaged with the provinces and territories, as well as indigenous and municipal governments.

During the COVID-19 federal response, we put in place a single window at the Public Health Agency [*Technical difficulty—Editor*] to reach out to us for the surge supports that would be available to them. We had over 150 operational calls with the jurisdictions to help them to get access to the resources available to them. That can include things like contact tracing supports and supplies from the national emergency strategic stockpile. As well, we were able to deploy epidemiologists. Just as an example, we were able to send epidemiologists to a James Bay area region that had several first nations communities, including Kashechewan, which saw over 10% of their population infected and several residents requiring hospital interventions.

The government also put in place a safe voluntary isolation sites program that allowed for over 60 isolation sites in 47 communities to be funded, which supported over 17,000 individuals. These are the types of activities that helped to [*Technical difficulty—Editor*] break transmissions.

One of the key learnings for this has been the ability to work with the jurisdictions, but also to put innovation and virtual supports in place. On the contact tracing, for example, we were able to support the programming with virtual call centre supports and similarly able to support other jurisdictions with remote epidemiological outbreak management.

There were quite a number of areas where we were able to work in concert with the jurisdictions. I think the gains that have been made in infection prevention and control programs as well have been another area where we've not only had an opportunity to step into an outbreak but also to help them lay a path forward in a number of areas to put key programming in place that would help mitigate further infections.

● (1730)

The Chair: Thank you, Ms. Evans.

Colleagues, we started five minutes late, so I propose that we give Monsieur Thériault and Mr. Davies a turn and then ask for adjournment at that time. I hope that's okay.

[*Translation*]

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

Mr. Luc Thériault: Thank you.

Obviously, my refusal was due to the form, and not the substance, of the motion. It may be presented Wednesday, and we will see at that time.

Ms. Evans, going back to the management of the National Emergency Strategic Stockpile, as part of the measures taken to replenish its supplies, do you favour local suppliers?

[*English*]

Ms. Cindy Evans: Mr. Chair, what I think has been important in the COVID-19 response, where we've seen a fierce, globally competitive market, is the benefits of having domestic supplies available to the jurisdictions. In a number of areas, we are now well situated, for example, with N95 respirators, with domestic manufacturing in Canada. We saw manufacturers leaning forward with the call from the federal government in terms of supports needed.

[*Translation*]

Mr. Luc Thériault: Do you favour local suppliers, yes or no?

[*English*]

Ms. Cindy Evans: Mr. Chair, I'm unable to answer that question, with respect.

We would follow the appropriate procurement policies. If there is a more detailed response required, then I would have to defer to my colleagues at PSPC.

Thank you.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, there was no interpretation for the last part of Ms. Evans' answer. I hope my time is not up.

[*English*]

The Chair: Okay.

Is it working now?

Ms. Evans, could you please repeat your last answer?

Ms. Cindy Evans: Thank you.

Mr. Chair, I'm unable to answer that question as it's posed, but what I can say is that domestic manufacturing capacity is—

[*Translation*]

Mr. Luc Thériault: Thank you.

Excuse me, but if you are not able to answer that question, I will ask another.

To avoid the recurring problems with expired inventory, what have you put in place to apply proactive management? For instance, do you plan to renew or dispose of it through our health networks or charities, rather than waiting for it to be expired and throwing it away?

Could you at least answer that question?

[*English*]

Ms. Cindy Evans: Mr. Chair, the member has raised an important issue with respect to the life-cycle management of products through the national emergency strategic stockpile.

Certainly, our first line of deployment is to the provinces and territories for use within their health care systems, but where we see that stocks may expire before we're able to deploy them, we would follow the policies that are laid out by the Treasury Board in terms of appropriate divestment and deployment. We would, for example, look to transfer to other federal departments, usually through the Government of Canada surplus. We have an ability to sell them at fair market value.

As well, we look to do donations to other levels of government and recognize charitable organizations. That's another opportunity for a broader reach within Canada to make sure the supplies can be effectively used.

Conversion to waste, using the most environmentally sustainable method possible, is the choice that would be made following an attempt to look at all of the other avenues for effective use within Canada.

The Chair: Thank you, Ms. Evans.

The last round of questions will be from Mr. Davies for the next two and a half minutes.

Mr. Don Davies: Thank you.

Ms. Diogo or Mr. Allison, in January, the WHO director general has noted the following:

> No country can boost its way out of the pandemic.
>
> And boosters cannot be seen as a ticket to go ahead with planned celebrations, without the need for other precautions.

Last month, the European Medicines Agency said that there was still no data supporting the need for a fourth COVID vaccine dose. It further stated that even if multiple boosters do prove to be necessary, they would need to be spaced out in the style of annual flu jabs, rather than delivered every several months. Finally, it warned that overly frequent booster doses could potentially lead to—quote—"problems with immune response".

As Canadians near the end of the third booster program, what is the plan to deal with COVID-19 going forward?

Mr. Allison or Ms. Diogo, if you can't answer, that's fine. I'm not sure if it's beyond your scope.

● (1735)

Mr. Christopher Allison: Mr. Chair, as my colleague mentioned earlier, the representatives who are responsible for the vaccination program are not here, so unfortunately we will not be able to respond to that question.

Mr. Don Davies: That's fair enough.

Lastly, I'm confused because, unless I heard incorrectly, Ms. Evans stated that a warning was issued by GPHIN on December 30, 2019, yet the Auditor General's March 2021 report found that Canada's GPHIN failed to issue an alert to provide an early warning of the novel coronavirus.

I'm reading from a July 30 article in The Globe and Mail that said:

> Canada's Auditor General is planning to investigate what went wrong with the country's once-vaunted early warning system for pandemics after the unit curtailed its surveillance work and ceased issuing alerts more than a year ago, raising questions about whether it failed when it was needed most.

They said that according to 10 years of documents obtained by The Globe and Mail, the system went silent on May 24, 2019, after issuing more than 1,500 alerts.

My question is for the deputy Auditor General. Did you find any alert issued by GPHIN in December 2019 about COVID-19?

Mr. Andrew Hayes: No, we did not. We found that they were doing their daily reports, but they did not issue an alert, which is a different kind of warning system.

Mr. Don Davies: Thank you.

Ms. Evans, did I misunderstand you? I want to give you a chance to clarify that.

Did you say that GPHIN did issue an alert on December 30? I know you said it wouldn't have made a difference.

Ms. Cindy Evans: Mr. Chair, thank you for the question.

As I stated earlier, and I'm happy to restate the answer, there are a number of different products that come out of the GPHIN program, one of them being the GPHIN daily report.

What I had stated is that the GHPIN daily report did identify the cases of mysterious pneumonia later identified as COVID-19, and that early signal to senior management galvanized the system immediately and this—

Mr. Don Davies: Can you tell us why an alert wasn't issued then?

Ms. Cindy Evans: By December 31, the significance of the event was clear in the public health surveillance community and partners internationally were already aware of the signal. There were other event-based surveillance systems that had issued similar to the GPHIN daily report on that same day, and the external independent panel had identified that there would have been no opportunity for the GPHIN to identify this signal earlier than it had.

Absolutely, in the daily report from the GPHIN on December 31, that signal was identified to senior management within the agency, which immediately galvanized our response from the very beginning of 2020.

The Chair: Thank you, Ms. Evans, and thank you, Mr. Davies.

That concludes our questioning.

To all the witnesses, thank you so much for being here. Thank you for your patient professionalism. We understand that many of the questions that were posed probably should be posed to other officials within your department. We will endeavour to identify them and have them come back so that we can pose the same questions to them, but we absolutely appreciate the work that you do. We appreciate your being here and the professional and patient manner in which you have dealt with the questions.

Thank you so much for being with us.

We are ready for a motion for adjournment. Is it the will of the meeting that we do now adjourn?

Some hon. members: Agreed.

The Chair: By consensus, the meeting is adjourned.