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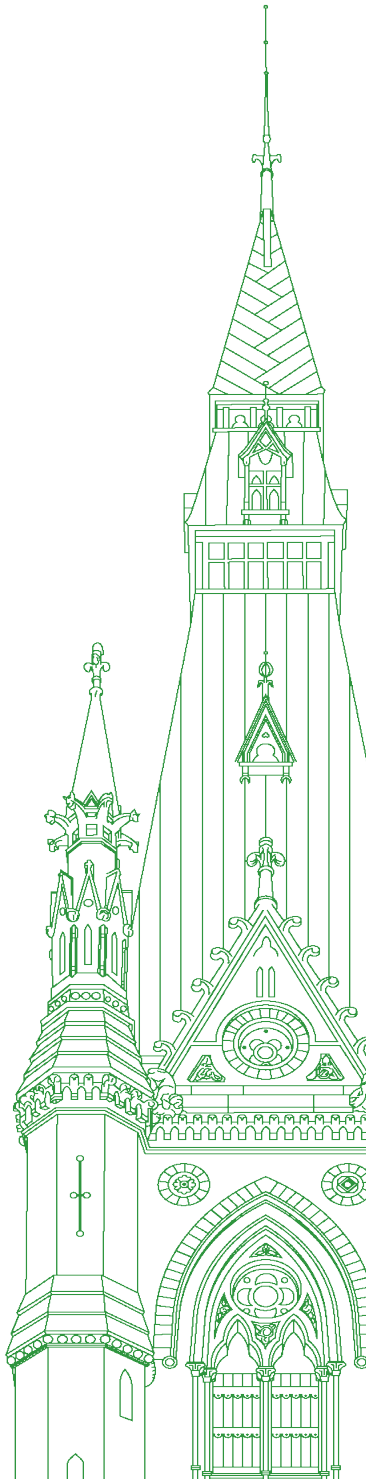

Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, March 23, 2022

● (1550)

[*English*]

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

Welcome to meeting number 12 of the House of Commons Standing Committee on Health. Today we meet for two hours to hear from witnesses on our study of the emergency situation facing Canadians in light of the COVID-19 pandemic.

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

Today's meeting is taking place in a hybrid format, pursuant to the House order of November 25, 2021. Members are attending in the room and we have one attending remotely—Mr. Davies, I believe—using the Zoom application. We will, of course, keep a consolidated speaking list and try to pay attention when you indicate that you want to be on it, Mr. Davies.

Of course, you are aware that screenshots should not be taken during the meeting. The proceedings will be made available via the House of Commons website. In accordance with our routine motion, I'm informing the committee that all witnesses have completed the required connection tests in advance of the meeting.

With us here today, we have, as an individual, Dr. Shirin Kalyan, adjunct professor of medicine at the University of British Columbia.

[*Translation*]

We also have Ms. France-Isabelle Langlois, executive director, and Ms. Colette Lelièvre, responsible for campaigns, both from Amnistie Internationale Canada francophone.

[*English*]

From the Canadian Mental Health Association, we have Margaret Eaton, the national chief executive officer. From the Canadian Psychological Association, we have Dr. Karen Cohen, chief executive officer. From the National Advisory Committee on Immunization, we have Dr. Bryna Warshawsky, medical adviser. From the Ontario Association of Radiologists, we have Dr. David Jacobs, president and diagnostic radiologist.

Thank you to all the witnesses for taking the time to appear today. We have a very esteemed and plentiful panel, and we certainly look forward to the discussion.

We are going to begin with opening remarks from each witness in the order they appear in the notice of meeting, so that makes you first, Dr. Kalyan. You have the floor for five minutes.

Welcome to the committee. Please go ahead.

Dr. Shirin Kalyan (Adjunct Professor of Medicine, University of British Columbia, As an Individual): Thank you, honourable chair and committee members, for the opportunity to speak today.

The thoughts I'm presenting are my own, as an immunologist, and not necessarily those of my affiliated organizations. I submitted notes that contained further data and references for the issues I'll be addressing today—

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, on a point of order.

The volume is far too loud for me to hear any of the interpretation. The volume should be turned down in the meeting room.

The Chair: We're going to fix this problem.

[*English*]

Dr. Kalyan, if you could start again from the top, we'll restart the clock and hopefully the volume is a little more regulated.

Dr. Shirin Kalyan: Did you want me to speak louder?

The Chair: We have you coming through the speakers, but you're being simultaneously translated, and both need to work.

Try again, and if there is a problem, I'll interrupt again.

Dr. Shirin Kalyan: Okay. Take two.

I thank everyone for the opportunity to speak today. The thoughts I'm presenting are my own, as an immunologist, and are not necessarily those of my affiliated organizations.

I have submitted notes that contain further data and references for the issues that I'll be addressing today. They involve Canada's vaccine mandates and the manner in which they have been implemented, which includes the lack of recognition of infection-acquired immunity and the suboptimal data collection and availability required to evaluate the efficacy and consequences of the public health policies and mandates to guide evidence-based decision-making.

Any time a medical intervention is mandated, it needs to meet a fairly high bar for its justification. We should have a solid understanding of both the safety and the efficacy of the intervention. Its purpose needs to be clearly stated. We need to ensure that we have in place ongoing surveillance to evaluate how well it is working to achieve its stated purpose.

With that base, a vaccine mandate may be justifiable if there is clear evidence that the vaccines we're using reliably prevent disease and its transmission; we have a clear grasp of their safety profile, which should be acceptable for prophylactic use for the disease in question; the mandate is not overly broad or unreasonable; and those subjected to the vaccine mandate can provide informed consent, which requires their understanding their own personal long- and short-term potential risk from vaccination in view of their own personal risk of severe disease from infection.

It is clear, especially with omicron, that the vaccines we have cannot really be relied upon to prevent either transmission or infection. As an example, the first omicron case in Israel came from a triple-vaccinated doctor returning from a conference, who passed it on to another triple-vaccinated physician. The omicron spread into many countries has been through fully vaccinated, often boosted, individuals. This really questions the validity of the current vaccine mandates for travel within and outside of Canada. Data from Ontario and other jurisdictions from around the world show that vaccine efficacy drops below zero after the end of the second month in those who are fully vaccinated. Boosters appear to show a similar rapid timeline for waning.

With this evidence, we should have moved quickly to lift heavy-handed measures and explain the evolving evidence. This is necessary for public trust. It is also good for public health to have a well-informed populace. Having a false sense of security has obvious negative consequences.

When it became evident during the delta wave that the mRNA vaccines had poor durability in their ability to prevent infection and transmission, the messaging justifying mandates shifted to the prevention of hospitalization and serious disease. If that was the new purpose, then Canadians with infection-acquired immunity should have had their superior immune protection recognized from the outset. The data have been unequivocally clear that those who have had COVID-19 and recovered are better protected—as would be expected—from infection, serious disease and death compared with those who are fully vaccinated. They would also be less likely to transmit infection if they get reinfected, as a greater mucosal immunity limits viral replication better, unlike those who are fully vaccinated and who experience a first breakthrough infection and can have viral loads very similar to immune-naive individuals.

Recent data from the U.S. CDC confirms that vaccinating those who have infection-acquired immunity really provides them no real additional benefit. Thus, these already immune individuals are primarily being exposed to unnecessary risks, as rare as they may be. They're also more likely to experience adverse effects following vaccination.

This lack of risk stratification for the blanket vaccine mandates has also been poorly considered for emerging vaccine-associated serious adverse effects. When the signal for vaccine-linked myocarditis appeared, it was repeatedly conveyed that the risk was far less than after COVID-19 infection. Data show that, actually, for males under 40, the risk of myocarditis is in fact greater after vaccination than following infection. The error in the statements previously made with respect to this risk was never publicly corrected, which means that these individuals haven't been given the opportunity to provide proper informed consent. We are requiring those who are probably among the least likely to experience serious disease to be subjected to a medical intervention for which they bear the greatest potential risk of a non-trivial nature.

As we move into the endemic phase of COVID-19 with omicron, I hope we take the opportunity to investigate how we could improve our strategy, especially around blanket mandates, for future pandemics, because they do have consequences.

● (1555)

I'll close now with a statement made recently by the head of vaccine strategy of the European Medicines Agency, the EMA, who had spoken directly to the lack of data and sustainability of continuing down the path of multiple boosters as a rational approach to the pandemic at this time. The EMA is aware that such an approach may actually do more immunological harm than good, and it is their position that further data is needed for the omicron variant, particularly with respect to the utility of the current vaccines and whether different types of vaccines are needed now.

Given the evidence, and its lack, I feel this is the most reasonable and responsible approach.

Thank you again for the opportunity to speak to these issues.

The Chair: Thank you very much, Dr. Kalyan.

[*Translation*]

We now turn to the representative of Amnistie Internationale Canada francophone.

Ms. Langlois, you have the floor for five minutes.

Ms. France-Isabelle Langlois (Executive Director, Amnistie internationale Canada francophone): Thank you, Mr. Chair.

Good afternoon, ladies and gentlemen. Thank you for inviting us to appear before the committee.

The health and lives of Canadians, in the context of a pandemic, depend on the health of all humanity.

Amnesty International, as a global human rights organization, has been involved since the earliest moments of the pandemic to call for unwavering international solidarity from all countries, including Canada.

Under international human rights law, states have an obligation to provide the financial and technical support necessary to implement the right to health, particularly in the case of the international spread of a disease.

We therefore call on Canada to strongly support the proposal for a temporary waiver of intellectual property protections for health-related technologies related to COVID-19 put forward by South Africa and India in October 2020 at the World Trade Organization, or WTO.

However, we are deeply concerned about a draft text that has been leaked to the media, which proposed a compromise for this waiver between the European Union, the United States, India and South Africa, and which appeared to be under consideration last weekend.

As currently drafted, this text will never ensure the supply and transfer of technology that is necessary for equal access to COVID-19 care resources and the protection of the right to life and health. We therefore urge Canada not to endorse this text.

The original waiver sought by India and South Africa from the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights, the TRIPS Agreement, is intended to democratize the production of medicines needed to combat COVID-19 until global herd immunity is achieved.

The World Health Assembly has recognized the role of "extensive immunization against COVID-19 as a global public good for health in preventing, containing and stopping transmission in order to bring the pandemic to an end [...]."

However, pharmaceutical companies around the world are continuing business as usual, thus limiting production and supply capacity.

We will have to live with COVID-19 for years to come. Everyone must have access not only to vaccines, but also to treatments. We need to democratize production, especially now that new treatments are becoming available.

By supporting the lifting of intellectual property protection for vaccines and other products to fight COVID-19, Canada will put the lives of people around the world, and of Canadians, ahead of the profits of a few pharmaceutical giants and their shareholders.

The only way to end the pandemic is to end it globally. The only way to end it globally is to put people before profits.

International human rights standards to which Canada adheres and international trade regulations make it clear that intellectual property protection must never come at the expense of public health.

The COVID-19 pandemic crisis is also a human rights crisis. It cannot be overcome without a genuine commitment to one of the United Nations, or UN, Sustainable Development Goals, namely "reducing inequalities and leaving no one behind". Based on the premise that no one will be safe until everyone is safe, Canada has an opportunity today to make a decision that can help achieve this goal.

Amnesty reiterates its express request to the Canadian government to support the original waiver request in its entirety and to show exemplary leadership in international solidarity.

Thank you for your attention.

● (1600)

The Chair: Thank you, Ms. Langlois.

[*English*]

Next is the Canadian Mental Health Association's national chief executive officer, Margaret Eaton.

Ms. Eaton, you have the floor for the next five minutes.

Ms. Margaret Eaton (National Chief Executive Officer, Canadian Mental Health Association): Thank you so much.

Hello. I'm Margaret Eaton and I'm the national CEO of the CMHA. The CMHA is the most extensive community mental health network in Canada, founded in 1918. We have 330 community locations in 10 provinces and the Yukon territory. We reach over 1.3 million people each year and we employ 7,000 Canadians.

CMHAs are independently governed charities that deliver free mental health supports to anyone who needs them, from counselling and psychotherapy, substance use treatment and youth programs, to housing and employment services. CMHAs keep people out of hospitals by intervening early to promote mental health and prevent mental illness.

Our recent research shows that most Canadians worry that COVID will never go away: 64% of Canadians are worried about new variants and 57% are worried about COVID-19 circulating in the population for years to come. The chronic stress of dealing with the pandemic is taking its toll. It makes basic decisions harder, it saps our energy and it leaves people tired and burned out.

As you know, we've all been in the same storm for the past two years, but we haven't all been in the same boat. Forty per cent of Canadians say their mental health has declined since the onset of the pandemic, and this spikes in vulnerable groups, such as those who are unemployed due to COVID-19, those who had a pre-existing mental health condition, people who identify as LGBTQ2+, young people, people with a disability and people who are indigenous. Vulnerable people have experienced much worse mental health over the last two years.

These significant inequities have made it impossible to ignore the long-standing service gaps and systemic barriers in our mental health system. Our research shows that almost one in five Canadians felt they needed help with their mental health during the pandemic, but they didn't receive it because they didn't know how or where to get it, there was no help available or they couldn't afford to pay for it.

Millions of Canadians rely on free mental health and addiction services and supports provided by the not-for-profit sector, but these organizations are strained to the breaking point. Community and mental health care workers receive lower wages, have higher work demands, experience compassion fatigue and are more likely to experience burnout than other health care workers.

Despite these difficult conditions, they have creatively and compassionately met people's needs. When there was no housing available and food banks were closed, CMHAs purchased tents and had food boxes delivered. Some CMHAs called their entire wait-lists to see how people were doing and offer whatever supports they could. Some launched new crisis lines and chat services to give isolated people a friendly conversation and a wellness check-in.

However, this emergency mode isn't sustainable, either for our staff or for our clients, who need stable, long-term help.

Two years in, we've moved from crisis to chronic. Even if the immediate impacts of COVID-19 are subsiding, the mental health effects persist and will likely continue for years to come. The community mental health and addiction sector cannot meet these growing needs with the current patchwork funding and disjointed service delivery model. It's time to overhaul our mental health system.

CMHA calls on the federal government to do these four things: one, establish long-term and stable federal funding for key programs, services and supports delivered by the community mental health sector; two, invest in mental health promotion and mental illness prevention programs and strategies; three, publicly fund community-based counselling and psychotherapy; four, invest in housing, income supports and food security.

We must integrate community mental health services into the health care system, and we must ensure that provinces and territories are held accountable for how federal funds for mental health are spent.

We have a critical window of opportunity to transform Canada's mental health system. Let's not miss it.

Thank you.

● (1605)

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

Next is Dr. Karen Cohen, chief executive officer of the Canadian Psychological Association.

You have the floor.

Dr. Karen R. Cohen (Chief Executive Officer, Canadian Psychological Association): Thank you very much for the invitation to appear before you today.

The psychological factors implicated in the COVID-19 global pandemic are several.

First, successful management of health and illness depends on how people think, feel and behave as individuals and in groups. Wearing masks, keeping physically distant and getting vaccinated all involve making decisions and changing behaviour. Psychological science is critical to the success of public policies intended to bring about these changes.

Dr. Kim Lavoie, a Canada research chair in behavioural medicine, has shown that to increase vaccine uptake, different approaches are needed, depending on why someone has resisted vaccination. Dialogue and education may work for people who are afraid of or who lack trust in vaccines, whereas mobile vaccine clinics work with people who haven't gotten vaccinated because they can't leave work or get to a clinic. How health providers talk to their patients who resist vaccination will impact whether they change their minds. Policies affecting people will be more effective if they take into account how people think, feel and behave.

Second, while too many Canadians have contracted the COVID-19 virus, every Canadian has lived its psychological, social, and economic impacts. Recent surveys of the psychological impacts have shown that nearly half of Ontarians said that their mental health has worsened since the pandemic began, which is up from 36% when the pandemic started. More Canadians continue to report high levels of anxiety and depression now than when the pandemic began. More Ontarians are accessing mental health support now than at any other time during the pandemic, but 43% have said it is difficult to get help.

While self-reported mental health problems and reaching out for professional help may have increased, timely access to psychological services has not. Having asked about barriers to accessing psychological services, a 2021 CPA-Nanos survey showed that more people cite financial factors than stigma. Unless the psychologist is salaried in a public institution like a hospital, their services are not covered by medicare.

As public institutions face budget pressures, there are negative impacts on the number of salaried positions and on conditions of work. Increasingly, psychologists work in the private sector, where their services are inaccessible to those who cannot afford them. Even when psychological services are covered by private health insurance plans, the median amount of coverage is $1,000 annually, which is less than a third of what it costs for the average person to have a successful treatment outcome.

The CPA, in collaboration with provincial and territorial psychological associations, has just issued a paper entitled “New Federal Investments in Mental Health: Accelerating the Integration of Psychological Services in Primary Care”. We outline ways in which some provinces have addressed this service gap and how the federal mental health transfers can further reduce this gap.

Finally, even as Canada addresses the funding barriers Canadians face in accessing psychological services, there are other barriers that need attention. For effective mental health human resource planning, we need to collect better data. While we have some data about the demographic and practice characteristics of health providers whose services are delivered under medicare, we know very little about health providers like psychologists, whose services are delivered in the private sector. A large class of students training to become psychologists is 10, compared to the hundreds of students in medical or nursing classes. To better meet the diverse mental health needs of Canadians, we need to train more psychologists.

The pandemic has shown us that much health care can be delivered virtually. The regulation of Canada's health providers is done provincially and territorially. Entry-to-practice requirements vary from one jurisdiction to another, and a health provider cannot necessarily provide services outside of their province of registration. While the agreement on internal trade and the Canadian Free Trade Agreement mandated health regulators to ensure mobility, these federal directives did not give regulators the authority to set common licensing requirements. When it comes to health care, the pandemic has underscored the limitations of systems that are provincially and territorially based rather than nationally based.

In summary, global health crises have mental health impacts, and the successful management of any global health crisis depends on psychological factors. To address these, we must develop pandemic policies that are informed by psychological science, redress funding barriers to accessing psychological care, and attend to the training and regulation of Canada's health human resources.

Canada has no health without its mental health.

Thank you.

● (1610)

The Chair: Thank you, Dr. Cohen.

Next, on behalf of the National Advisory Committee on Immunization, is Dr. Bryna Warshawsky, medical adviser.

Dr. Warshawsky, the floor is yours.

Dr. Bryna Warshawsky (Medical Advisor, National Advisory Committee on Immunization): Thank you very much, Mr. Chair.

I have no opening remarks, but I'm happy to take questions at the appropriate time.

Thank you.

The Chair: Well, that gives us an extra five minutes for questions. Thank you.

Representing the Ontario Association of Radiologists, we have Dr. David Jacobs, president and diagnostic radiologist.

Dr. Jacobs, you have the floor.

Dr. David Jacobs (President and Diagnostic Radiologist, Ontario Association of Radiologists): Fantastic. Thank you so much.

I was just admiring the previous speaker's opening remarks. I think that's brilliant, and I'll do that next time.

What I'm going to do is just give you a very brief look into health care through the eyes of my specialty, which is diagnostic radiology, and how it has impacted patients and health care in general.

Diagnostic imaging and interventional radiology is a subspecialty in medicine. We interpret images—CT, MRI, mammography—and we also perform procedures like breast biopsies, basically biopsing any solid tumour from head to toe, angiography and other interventions.

Our services were highly used during the pandemic. Prior to the pandemic, we had wait-lists that far outstripped what was end-dated by government. What we found during the pandemic, despite a large drop in utilization of hospital services outside of COVID-19, was that the wait-lists skyrocketed. There were a number of reasons for that. Again, I want you to think of this. It wasn't just with diagnostic imaging, but with medicine as a whole. Wait-lists for all interventions and all specialist appointments skyrocketed during the pandemic.

Really what it came down to was access—access to imaging, access to health care. When we went into pandemic mode, we forgot many of the lessons we had learned with the first pandemic, with the first outbreak of SARS. Now, this has been a much more dramatic pandemic than the initial SARS, but what we didn't do was a very good job of compartmentalizing risk and need. What we ended up doing was basically shutting the system down. We assigned the same level of risk to all procedures and to all interventions.

Right now we have over one million Canadians on wait-lists for CT and MRI. Over the course of the pandemic, our wait-lists ballooned for MRI from what was unreasonable but acceptable—three months or so for an MRI examination—to over nine months for some centres.

Delayed diagnosis had a major impact, so as we saw waves of COVID going through the population, one of the unfortunate things we saw was malignancies coming in that were very much delayed. From what we had seen early in the pandemic or just prior to it, when we did the follow-up studies, because of lack of intervention and delay in the ability to get the imaging that was necessary, what we saw was that cancers that started off as resectable, as treatable, became unresectable or palliative in nature in terms of what we could offer the patient. That is unacceptable.

The causes are multifactorial. Some of the causes that we could change are not shutting down low-risk procedures like medical imaging, CT scans and MRIs. We basically turned a key, turned everything off, and shut down the system. We can't do that again. It had a major impact on screening services such as mammography. We had 300,000 women who were not screened. That will, unfortunately, result in an increase in the number of breast cancer-related mortalities in the years to come. Approximately 6.5% of all screened women will have a finding on their study that will require a further workup, so I'll let you do the math on that.

The other issues uncovered were human resources issues. As we came out of waves, money was sent to increase the number of studies that we could do to play catch-up, but what we found was that we simply didn't have the human resources to catch up on those studies. Mostly it had little to do with radiologists and physicians. It had more to do with support staff. Clearly we are not training enough technologists for radiology, nurses for the floors, the ORs and the ICUs. We really need to think about how we manage human resources and what kind of slack we have in the system.

● (1615)

The other issue I want to talk about is stalled health initiatives. In this two-year period, as in any two-year period, we would see movement forward and progress on how we care for patients, not just in terms of technology but in terms of the organization and how we structure a patient's trip through the health care system as there are more innovations.

One thing that stands out, from a diagnostic imaging point of view, is that over the course of the pandemic we had some studies that came through that showed breast screening should actually be done for women ages 40 to 50, which currently we don't do because of a previous flawed Canadian study. We had been trying to implement that, but over the two years we weren't able to. That's one example of many where we were so focused, laser-beam focused, on COVID-19 that a lot of other important health initiatives fell by the wayside.

I'm happy to discuss any of these, but really, I think the fundamental point is that when we face another wave, when we face another pandemic, what we have to remember is that there is more to medicine than simply the pandemic. The pandemic was incredibly important, and in many ways very well taken care of, but we neglected other areas of health care. We can't do that again.

● (1620)

The Chair: Thank you, Dr. Jacobs.

That concludes the opening statements. We're now going to move to rounds of questions, beginning with the Conservatives.

Mr. Lake, you have six minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): Thank you, Mr. Chair.

This is a really interesting panel. I'm making notes here. It's interesting to listen to Dr. Cohen talk about how we increase uptake and the different approaches to increase uptake of vaccines. After having listened to Dr. Kalyan, it sounds like she's suggesting that maybe getting the vaccine right now isn't a great idea for omicron. I may have that wrong. Both have significantly stronger credentials in health care than I do. I think it creates a good opportunity.

We have NACI here, represented by Dr. Warshawsky, who didn't make opening comments. I'm going to go to her first because I'm interested to hear what she thinks about what Dr. Kalyan had to say.

Dr. Bryna Warshawsky: The national advisory committee has made recommendations with regard to booster doses. It has strongly recommended that booster doses be offered for people 50 years of age and over and certain other high-risk groups, and has a discretionary recommendation for those 18 to 49 years of age, as well as for high-risk adolescents 12 to 17 years of age.

NACI is currently also looking at its booster dose recommendations for additional booster doses and also whether to strengthen its booster dose recommendations. NACI is constantly looking at the evidence and the epidemiology to make its booster dose recommendations.

Thank you.

Hon. Mike Lake: Does NACI have a position on whether vaccines should continue to be mandated at a federal level for the folks they're mandated for right now, for two shots?

Dr. Bryna Warshawsky: NACI doesn't make recommendations with regard to mandates. That's provincial, territorial and federal jurisdiction. NACI provides recommendations with regard to what vaccines should be used and how they should be used for Canadians, but mandates are not within its scope.

Hon. Mike Lake: Dr. Jacobs, I'll go to you and just ask you if you have any opinion to offer. I know that, in following you on social media, you're very pro-vaccine. Are there any thoughts on Dr. Kalyan's position as it relates to omicron? It's a good opportunity to have a back-and-forth.

Then if Dr. Kalyan wants to weigh in, I'd be glad for her to have the opportunity to do so.

Dr. David Jacobs: I think Dr. Kalyan has made some very good points. We have to look at that, but I also have to look at it from a pragmatic point of view in terms of what I see in the hospital.

To Dr. Kalyan's point in terms of mandates, yes, omicron was highly contagious and, no, the vaccine didn't do much in terms of preventing the spread of COVID. If it did, it was minimal. Omicron spread very rapidly. For delta and other previous strains, there was a more robust prevention of transmission, but for omicron there wasn't, and that takes away some of the need for a vaccine mandate, except—and this is a big exception—that what we saw in the hospital were patients who were immunosuppressed, elderly—so de facto immunosuppressed—and patients who did not receive a full vaccine regime. They were the ones who were getting very severe COVID pneumonias. I saw a lot of people come in with COVID in the omicron wave, but it was predominantly the ones who were unvaccinated, immunosuppressed or the frail elderly who were getting desperately ill from it.

From a larger population point of view, I can't make those arguments—that's more the world of NACI—but from an individual recommendation, for those three groups it would have been much better for them to have been vaccinated and boosted than not.

● (1625)

Hon. Mike Lake: Dr. Kalyan, do you want to weigh in on this too?

Dr. Shirin Kalyan: Yes. Thank you very much.

The clinical trials that were done never really assessed the ability of the vaccines to prevent transmission. I haven't come across a component vaccine that is intramuscularly injected that can be very effective in preventing transmission of respiratory viruses long-term, so I think that understanding and having vaccine literacy is really helpful for the population.

If we had an intranasal live attenuated vaccine, which would be a better type of vaccine, especially for young, healthy kids, for that more comprehensive trained innate immunity and launching an appropriate type of immune response to a certain type of bug, that would probably be a better approach to take.

We didn't understand, I think, when the mandates were put in, because we didn't have a lot of.... The vaccines we're using, we actually have very little clinical experience with. We have never used them outside of emergency use authorization. I think that was the surprise for me as an immunologist. We started mandating the use of these vaccines without having clear data. The companies themselves are just starting to release the anonymized patient-level data. They wanted to not release that for the next 75 years, but we're starting to get more of that clarity on the type of efficacy that the vaccines really have in a placebo-controlled trial.

I would of course want to look at the risk-benefit, and that's where the risk stratification would have been really helpful to identify. We know that, by May 2020, when we didn't have vaccines, 95% of COVID-related mortality was in those over 65 years of age. I think that if we had focused on protecting the most vulnerable, it would have gone farther than putting blanket mandates on everyone, because that actually has the potential to increase vaccine hesitancy...and trust in vaccines and the public health care system in general in terms of recommendations.

I do believe that we should be focusing on providing immune protection and being transparent and looking at the evidence when we have an immune escape variant like omicron. How much data do we have that giving multiple boosters is going to be helpful or is good for people? We really need to diversify.

The first time I spoke to the committee members was back in June. I had really strongly suggested that we diversify the portfolio of the type of vaccines we have available for Canadians. We put all our eggs in one type of basket. We're still in a similar position. With omicron, it's a far less severe type of infection. I understand that people who are frail and who don't have good immunity require some more protection—

The Chair: Thank you.

Next is Dr. Powlowski, please, for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I wanted to question Dr. Kalyan, too.

I wasn't sure on your testimony, where you seem to question the mandates. Admittedly, the vaccines aren't good at preventing the spread of omicron, but you acknowledge that the reason for the mandates was kind of shifted to preventing hospitalization, ICU admission and deaths.

Do you not agree that this is a valid concern and that the government ought to be taking actions to try to prevent hospitalization, ICU admissions and death? As Dr. Jacobs has told us, the fact is that all of that also undermines the ability of the health care system to provide other health services. Am I wrong?

You're giving me the impression that you think we shouldn't have any mandates at all and you don't buy the fact that.... There's tons of evidence about the vaccines decreasing hospitalization and ICU admissions, even with omicron. Kaiser Permanente said that people are 64% to 73% less likely to be hospitalized if they've been vaccinated. From a South African study, it's a 70% reduction in hospitalization for fully vaccinated people. This is omicron. Also, in Quebec, people who hadn't been vaccinated were seven times more likely to be hospitalized and 14 times more likely to end up in ICU.

This seems to me like a pretty good reason to be promoting vaccinations, and social distancing if necessary. Those are pretty significant numbers. Even as of March 14, there were 435 people in ICUs across Canada and 4,200 hospitalized COVID patients.

Maybe I'm misinterpreting you.

● (1630)

Dr. Shirin Kalyan: No, you are interpreting the data from non-randomized placebo-controlled trials. I'm not saying vaccines will not prevent hospitalizations, but I don't think coercion is the best way to get people to behave the way you want them to.

I think there are lots of health-promoting activities. If you suggested that people stop smoking, that people exercise, that they reduce their weight.... There are many things that would reduce a hospital surge, but we never really did a more holistic approach to improving people's health, including mental health.

I believe that if people are equipped with the information and understand their own risk profile, it is far more effective than putting a blanket vaccine mandate, especially for people who already have immunity. That's really where I'm coming from. We need better risk stratification.

Canada has never had a policy around which they would mandate vaccines. There is provincial legislation for certain childhood vaccines, but people have the opportunity to opt into that.

I really believe that informing people rather than forcing them to do something is always more effective for health care.

Mr. Marcus Powlowski: I don't know....

Maybe I'll give Dr. Warshawsky from NACI an opportunity perhaps to reply to Dr. Kalyan, unless she does not want to enter into this debate.

Dr. Bryna Warshawsky: I can just provide some of the facts that NACI has been looking at with regard to vaccine effectiveness. We do know that for two doses, the vaccine effectiveness against infection decreases over time and it can end up being quite low. With three doses, we do see protection against infection of around 60%. That does decrease as well over time.

With severe disease, we see vaccine effectiveness for two doses at around 65% to 85%. When we add the booster dose, we get protection against severe disease, like hospitalization, in the high 90s. That may decrease over time. That's something we are watching closely.

Thank you.

Mr. Marcus Powlowski: Maybe I can turn my questioning to Madame Langlois from Amnistie internationale.

You mentioned the movement and the ask for the WTO to drop the patent protection on COVID-related items. You mentioned that there was recently a suggestion of a compromise between India, South Africa, the EU and the United States, which you don't support. However, I haven't heard of this compromise. Maybe you could tell us what the compromise was and why you don't support it.

[*Translation*]

Ms. France-Isabelle Langlois: What this compromise entails is too great. Indeed, the time frames will be even longer, and the number of countries that could have access to the revenues or technology will be further reduced. This even affects countries that have the potential, such as Kenya and other Asian countries.

In addition, there is a further restriction on lifting patent or intellectual property protection only for vaccines, when there are all sorts of other technologies and products that are and will increasingly be available to treat or prevent COVID-19. These products are all the more important because they will be effective in reaching the most remote and poorest populations in the world.

It is known that managing the cold chain with regard to vaccine storage is complicated. It is even more complicated to manage in African countries, for example, especially in remote areas in Africa. Therefore, the lifting of patents should cover all products or treatments that are developed by pharmaceutical companies to treat, prevent or cure COVID-19.

The original proposal was made in October 2020 and it is now March 2022. During this time, we are continually dealing with other waves and losing time. So we need to move forward.

● (1635)

The Chair: Thank you, Ms. Langlois and Mr. Powlowski.

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

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

I thank all the witnesses for their enlightening testimony.

My first question is for the representatives of Amnistie Internationale Canada francophone.

Ms. Langlois and Ms. Lelièvre, I want to thank you for being with us to present a much more global reflection on the pandemic. I just want to point out in passing that my colleagues Mr. Powlowski, Mr. Davies and I made a public appearance on May 7, 2021, in support of the proposal to lift patents and the proposal that had been made by South Africa.

In the first wave, we were all saying to ourselves that, in order to respond adequately to the pandemic, everyone had to be vaccinated if we were going to make sure that it ended or moved into an endemic phase. We then realized that in the field of research, there were data exchanges. It was quite beautiful to see and there was hope. All of a sudden, vaccines were found, and the beautiful solidarity turned into the stockpiling of vaccines, hoarding, and the less affluent countries were forgotten, so that we go from wave to wave, from variant to variant.

Could you tell us succinctly what the state of the global immunization situation is now, in March 2022?

Ms. France-Isabelle Langlois: The situation...

Mr. Luc Thériault: Let me ask you my second question right away. You can answer it at the same time. That way, we'll get to the heart of the matter.

Can you explain why you favour the lifting of patents rather than voluntary licensing, as suggested by several countries and the president of the European Commission?

Ms. France-Isabelle Langlois: The vaccination situation in the world is totally inequitable. In the more affluent countries, the European countries, Australia, Israel, Canada and the United States, the population is overwhelmingly vaccinated because the vaccines are accessible. The unvaccinated are those who are difficult to reach for all sorts of reasons that other witnesses have already mentioned, or they are people who simply do not want to be vaccinated.

In the poorest or lower-middle income countries, the situation is different. According to the latest figures we have obtained, just 4% of the population in these countries in total have had access to vaccines and may be adequately vaccinated. We are talking about two doses of vaccine here.

As I said earlier, even if vaccines were available locally, it would be difficult to vaccinate remote populations in Africa because of the heat. The reluctance that we see here, we see elsewhere. The longer it takes to vaccinate people in low-income countries, the more reluctant they will be to take the vaccine. There is really work to be done on this.

That being said, the more protected we feel here, the more we forget about the rest of the world and the more we forget that we are interconnected. Until there is vaccine equity or access to treatment for all—of course, I'm not just talking about vaccines—the virus will continue to circulate and come back in waves continuously for many years. Let's hope, however, that someday this will end.

That is the status of the vaccine situation around the world.

Could you repeat your second question?

● (1640)

Mr. Luc Thériault: My question was about favouring the lifting of patents over voluntary licensing by laboratories to have their vaccines produced by other laboratories.

Why is the lifting of patents more favourable than voluntary licensing, as the president of the European Commission suggests?

Ms. France-Isabelle Langlois: We favour the lifting of patents to make the process as fair and transparent as possible for everyone. We want the revenues to be shared so that countries can produce vaccines, where it is possible to do so.

In fact, pharmaceutical companies are resisting the pooling of patents and revenues from drugs and vaccines. So we can't rely on it being done on a voluntary basis.

Mr. Luc Thériault: In terms of the supply chain, doesn't the fact that we can produce vaccines on site facilitate the distribution of vaccines? I am thinking, for example, of the problem related to refrigeration.

The Chair: I would ask you to give a short answer, if possible, Ms. Langlois.

Ms. France-Isabelle Langlois: Indeed, Mr. Thériault, the more vaccines are produced locally, the faster they will be distributed. However, there will still be logistical challenges, particularly for vaccines that require a significant cold chain. For example, in Dakar, Senegal, the distances between regions are great, the roads are complicated, the equipment must be able to keep the vaccines at the right temperature, and so on. All of this presents significant challenges.

So we need to go beyond vaccines. There really needs to be international solidarity in all respects, whether it's logistics, production or technology transfer.

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

[*English*]

Next we have Mr. Davies for six minutes.

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

Thank you to all the witnesses for being here.

Dr. Kalyan, you referred in your opening statement and remarks to infection-acquired immunity. How clear is the data regarding its strength and durability, and how does it compare to vaccine-acquired immunity?

Dr. Shirin Kalyan: It's actually the gold standard. When we recognize the immunity we get from infection, that's what vaccines are trying to mimic. That's why our biggest successes around eradication have been from live attenuated vaccines, such as the smallpox vaccine, because they most closely mimic that infection.

We know that for COVID, it's been unequivocal that people who have had COVID and recovered are better protected from infection obviously, from serious disease and hospitalization, with the caveat that they survive the first infection. Given COVID particularly, we know the risk factors associated with serious outcomes. There are a vast number of people who have already had COVID-19. I think that with omicron, we'll probably be in a better place as more people get that natural immunity.

Mr. Don Davies: You've also touched on vaccinating those with infection-acquired immunity. I believe Dr. Tam and NACI—and I'll certainly let NACI have a chance to comment on this—recommend vaccination for people who have infection-acquired immunity.

What is your position on that?

Dr. Shirin Kalyan: I don't think they should be subjected to the mandate for this, because their immunity does last longer than vaccine-induced immunity. That has been shown in epidemiological studies, and also recently from the U.S. CDC data from California and New York, which showed that there was no benefit with respect to hospitalization for people who have had infection-acquired immunity getting vaccinated.

I know we've heard a lot about this hybrid super-immunity you get from being vaccinated even if you've had COVID, but that short-term spike in serum antibody levels is not really worth a mandate.

● (1645)

Mr. Don Davies: I want to talk about the issue of waning.

We know that we get a vaccine and it seems to be very effective at preventing hospitalization, serious illness and death for a period of time. I think in your opening statement you said that data from Ontario shows there's a negative vaccine efficacy by the second month in those fully vaccinated, and boosters show similar rapidly waning timelines.

Can you expand on that, particularly what is meant by “negative vaccine efficacy”? How long do the vaccines stay effective?

Dr. Shirin Kalyan: With regard to the vaccine efficacy definition, even in Pfizer's, Moderna's and all the vaccine trials, the original definition was for the prevention of infection, not serious disease. From Ontario's data and also the U.K.'s surveillance, they found that people who have two doses, who are fully vaccinated with the mRNA vaccines as well as the viral vector vaccines, after 60 days or so their vaccine efficacy—so you're looking at the number of cases compared to those who are unvaccinated—actually drops below zero. That's been a consistent finding.

It is not so unusual with an immune escape variant. When you're focusing all your immune attention to one particular antigen of a virus, you're obviously going to be selecting for one that is not recognized by the population's immunity against that particular pathogen. That's why I think component-type vaccines are more likely to select for immune variants, as opposed to whole...either live attenuated or perhaps.... Whole vaccines are harder to make.

Mr. Don Davies: You've anticipated where I was going next, which is on the types of vaccines.

Can you briefly review for us the different types of vaccines and provide your assessment of the current Canadian options for those different types of vaccines?

Dr. Shirin Kalyan: Yes. Unfortunately—and this is what I had spoken to previously—we didn't have capacity. I'm glad to hear that we have invested in having our own GMP manufacturing capacity. Hopefully, they'll get the expertise that's needed to make the type of vaccines that we feel would benefit Canadians.

We have the whole type of vaccines. A live attenuated vaccine is best, actually, for children, because it exercises the immune system really well. It's a version of the bug that has been attenuated so it's not as infectious. It sort of handicaps the bug in you and launches an appropriate type of immune response to it. Examples of that are the smallpox vaccine and the measles vaccine. Those are really effective. You don't need to go down this multiple dose issue.

Then you have the whole inactivated vaccines. You basically take the bug, you kill it in some way, and then you add hopefully an adjuvant. To me, the type of adjuvant that you have—I think this is not really recognized as well—is really important for the type of immunity you launch. We've been using alum. It's not really an adjuvant but part of the ingredients for its adjuvant. But anyway, that's going down a long path.

Next are the component vaccines. You take pieces of a bug, add an adjuvant, and use that to stimulate an immune response against these immunogenic types.

The new nucleic acid delivery platforms are ones we'd never really used previously, so there was a learning curve for them. Essentially, these types deliver genetic material. The ones we're using now encode the original spike protein of the Wuhan strain of SARS-CoV-2.

Now, as with any new knowledge, I'm not really sure what the adjuvant for the mRNA is. I know that they say it has its own adjuvant, but it doesn't really trigger the type of immune response you would typically have to a virus or how it's presented to the immune system, because you can't really target it to specialized cells. You're assuming its uptake is around the muscle and is being presented there, so that might contribute to the variable durability of it.

The Chair: Thank you, Dr. Kalyan and Mr. Davies.

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

● (1650)

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Mr. Chair, I think it's Mrs. Goodridge.

The Chair: Okay.

Mrs. Goodridge, you have the floor.

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

Thank you, Dr. Kalyan, and thank you to all the presenters. You guys have raised some very valid and interesting information for us to consider.

Dr. Kalyan, you talked in your opening remarks about how these mandates are impacting public trust. As an MLA and now an MP for rural northern Alberta, I know it's something that I've been hearing quite a bit about. People are really starting to question whether these mandates should be in place, specifically for domestic travel. While many of my colleagues around the table might be able to travel by car to some locations, if someone in my constituency wants to go to Toronto, that's 3,600 kilometres. It's not really all that attainable by car.

Could you possibly expand on the idea of how these public health mandates are now impeding public trust? What kinds of ripple effects does that have?

Dr. Shirin Kalyan: I'm an immunologist, so my expertise is not entirely around how one makes decisions around public health. But as a person, I feel that if I don't understand what the mandates are trying to achieve...and it was never really clear to me what the purpose of the mandates was, especially around freedom of movement.

To me, if you're trying to prevent transmission—and obviously the vaccines are not doing that right now—then I think imposing that on people doesn't really make sense. You can see why it would increase resentment and mistrust. Those sorts of heavy-handed measures don't serve any purpose other than to build resentment and anger at a time when we could use more positivity, I think, than negativity.

It's been a hard time for everyone. I think we would want to make life as easy as possible and less filled with resentment at this time, to really all recover together from this pandemic. I really think these mandates at this time should be lifted, especially for travel.

Mrs. Laila Goodridge: Thank you so much.

I'm going to shift gears a bit. Dr. Jacobs, you were talking about how wait-lists have skyrocketed. I'm one of probably thousands of Canadians who had a COVID baby. I had to use quite a bit of diagnostic testing, which is pretty normal for most pregnant women. Just getting the routine ultrasounds was very challenging.

Have you heard of any cases of people forgoing routine or other diagnostics that impacted their health?

Dr. David Jacobs: Yes, absolutely. The obvious one is breast imaging. Over the course of the pandemic, as I said, we had 300,000 women who decided not to get screened. That will have an impact on future breast cancer mortality.

The other thing we saw was more complex. What we were seeing was people not going to the emergency room, despite having illnesses. Somebody who would normally come to the emergency room with some right lower quadrant pain was holding out, and by the time they got to the emergency room, a week later than they should have, they had a ruptured appendix. It goes on and on and on. We were seeing many more late-stage cancers because people were just letting it grumble at home.

A two-year period is a very long period to sit on any pathology. You have to then take that forward. If we have a nine-month wait-list for MRIs, that's an additional wait for people who have already delayed their treatment and their diagnosis. This will have a knock-on effect, to be certain.

Mrs. Laila Goodridge: For me, there was a six- to eight-week delay to get the dating ultrasound that needed to be done before 12 weeks. By the time I found out I was pregnant, I was seven weeks along, so it was virtually impossible to get the dating ultrasound. That's just one small example. It really required some creative thinking to get that diagnostic testing. It's so critically important.

Do you have any messages for people who are delaying getting a mammogram? It's so critically important. You have the floor. I'd really like it if you could say something to women to get breast cancer screening.

● (1655)

The Chair: Do it as succinctly as possible, please, Doctor.

Dr. David Jacobs: Without a diagnosis, there can be no treatment. Without treatment, you can't have your health.

You shouldn't delay. It's very safe to go to the hospitals now, whether it be for breast screening or anything. We're at the nadir of the omicron wave. Don't delay your care any longer. Come in. You're quite safe.

The Chair: Thank you.

Thank you, Mrs. Goodridge.

Mr. van Koeverden, you have five minutes.

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

I'll just start by reading a quote from the Canadian Society for Immunology:

> The Canadian Society for Immunology supports unbiased, well-informed and non-politicized scientific debate as vaccine rollouts occur with unprecedented speed; however, we strongly condemn concerted disinformation campaigns that misuse selected scientific data to advance political or economic ideologies. These activities not only undermine the scientific process but also actively impair public health efforts and prolong the pandemic at great cost to us all.... Based on the overwhelming evidence for vaccine safety and efficacy, we urge all Canadians to get fully vaccinated as soon as possible.

Dr. Kalyan, do you disagree with that statement?

Dr. Shirin Kalyan: I certainly don't disagree with the feedback for having good, rigorous scientific discussion. I think that has been lacking.

Mr. Adam van Koeverden: My question was pretty simple. Do you agree that Canadians should get fully vaccinated as soon as possible?

Dr. Shirin Kalyan: I believe it's the individual's decision. I believe in education and understanding of the different types of vaccines and their efficacy and safety. They should make that decision for themselves, along with their doctors.

Mr. Adam van Koeverden: Thanks, Dr. Kalyan.

Not to put you on the spot or anything, but if you'll indulge me, can I ask you if you've received a vaccine?

Dr. Shirin Kalyan: I prefer not to respond to that question.

Mr. Adam van Koeverden: Okay. Thank you very much.

Yesterday, 35 Canadians died from COVID-19 and about 4,000 are in hospital today. That's the same as the average between December 10 and March 10.

My question is for Dr. Warshawsky. The typical duration of acute COVID-19 illness is two to six weeks. However, some patients have described debilitating symptoms persisting or occurring for weeks or months after acute illness. These longer-term symptoms are often referred to as “long COVID”, and we know that this condition can affect both adults and kids. Affected individuals are commonly referred to as “COVID-19 long haulers”.

I have a couple of questions. Do you believe that the COVID-19 vaccines available to Canadians can help mitigate long COVID? Do you think they have a good impact on preventing long COVID symptoms in Canadians?

With the information with respect to the number of Canadians who have died from COVID-19 and how many are hospitalized, do you believe this pandemic is currently in an endemic phase?

Dr. Bryna Warshawsky: Thank you very much for the question.

The National Advisory Committee looks at the effectiveness of vaccines. As we know, if you don't get infected with COVID-19 because of vaccination, then you are not at risk for post-COVID syndrome or long COVID.

By being vaccinated, you are preventing getting infected, to the extent that vaccines are able to do that. We do know that three doses of vaccines do offer reasonable protection against infection. It does decrease over time, but definitely when you get your third dose, you're better protected than when you have your second dose. It's around 60% protection initially after vaccination with that third dose. The extent to which the third dose will protect you from infection, it will also protect you from post-COVID syndromes.

There are also some studies that are looking at the fact that even if you do become infected when you're vaccinated, in general you're less likely to get post-COVID syndrome compared to an unvaccinated person.

Mr. Adam van Koeverden: Thank you, Dr. Warshawsky.

I have a question for anybody who would like to take it.

If Canada had the same death rate from COVID-19 as peer countries like the United States and the U.K., instead of a devastating 27,000 Canadians who have died from COVID-19, we'd be looking at closer to 90,000, and potentially even more like 100,000 Canadians, who would have passed away in the last two years from COVID-19.

How do we account for this difference? Obviously there are multiple factors.

The question is open to the floor. What have we learned?

● (1700)

The Chair: Who wants to take that one?

Dr. David Jacobs: I can take that, if you want.

The Chair: Go ahead, Dr. Jacobs. You have a minute.

Dr. David Jacobs: We've learned that vaccines work. Public health interventions work. Masking works. We generally have a very compliant society. We have a society that cares for its neighbours. We have a society that cares for the health of the elderly. We have been very compliant, both in getting our vaccines and in getting our booster shots.

I want to take this away from the basic science research and bring it back to the clinical world. When you have your vaccine, if you do get COVID, you do not get as sick. If you are unvaccinated, you are disproportionately going to get extremely sick.

By our ability to counter misinformation and by caring for our neighbours, as Canadians are known to do, we have been able to keep our death rates much lower. The vaccines have been a medical miracle. The fact that we got them as soon as we did is fantastic. They did exactly what we needed them to do.

Mr. Adam van Koeverden: Thank you, Dr. Jacobs.

Do I still have some time, Chair?

The Chair: No, you don't.

[*Translation*]

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

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

Ms. Langlois and Ms. Lelièvre, in a December 6, 2021, article, Mr. Fabien Paquette of Pfizer Canada says that, according to the industry, lifting the patents “...is more likely to generate undue pressure on demand and already tight raw material management, limit production capacity for highly efficient sites, and discourage the innovation that has served us so well in the development of vaccines in record time.”

What do you think of this kind of argument?

Ms. France-Isabelle Langlois: This is an argument typical of multinationals and pharmaceutical companies that seek profit at all costs. We don't give much credence to this kind of argument.

My colleague Ms. Lelièvre may want to add a comment.

Mrs. Colette Lelièvre (Responsible for Campaigns, Amnistie internationale Canada francophone): Good afternoon.

The argument suggests that pharmaceutical companies would receive no compensation, but this is not true. Any waiver adopted by the WTO is accompanied by financial compensation. So the companies would still be compensated. As far as we know, there are a number of waivers pending at the WTO, and this has not prevented research and development.

In addition, public funding has been provided for the development of most vaccines. In this sense, one can now ask questions about how these vaccines are used. At least one can ask who can receive them, given the global situation. We are facing an exceptional pandemic, and it requires the implementation of exceptional measures.

The arguments put forward by Mr. Paquette are not helpful from a public health point of view. This is indeed the crux of the matter.

The Chair: Thank you, Ms. Langlois and Ms. Lelièvre.

Mr. Thériault, you only have 10 seconds left. You can make a brief comment, but you don't have enough time to ask another question.

Mr. Luc Thériault: If you don't mind, I'll save those seconds for later.

[*English*]

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

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

Dr. Warshawsky, I think I had promised to come back to you. What is your position and the position of NACI on using boosters for those who have infection-acquired immunity?

Dr. Bryna Warshawsky: NACI does recommend that people who have had infection should be vaccinated.

They have recently come out with some suggestions with regard to the time period between infection and vaccination. They have said if you've had an infection and you haven't yet completed or started your primary series—your first few doses—you should wait eight weeks from that infection to get the first or second dose of your primary series. That's to allow that infection to help mount a good response from the infection, but then to enhance it with a vaccination, because we know that protection from infection can be variable. If you have a mild infection, you may not mount as good an immune response. We know that for protection against omicron, if you've had an omicron infection, you don't mount a very good immune response against other types of COVID-19, against other variants.

It is very important to be vaccinated after you have been infected, but NACI recommends these intervals. They suggest to wait eight weeks for your primary series, and then for your booster, they suggest to wait three months between the infection and your booster or at least six months between your primary series and the booster, whichever is longer.

● (1705)

Mr. Don Davies: Dr. Kalyan, having heard that, what does the data say to you about boosting people with COVID-acquired immunity?

Dr. Shirin Kalyan: There is really no data. That's why the EMA and the WHO have not recommended getting boosters, especially with the original strain of the vaccines, because you're essentially.... It's like recovering from the flu and then you get a vaccine for the previous strain and boosting that response. I don't have any data to suggest this would be a good idea.

What the data shows for people who have had COVID and recovered is that their immunity is pretty reliable.

Mr. Don Davies: In terms of boosting, we know that the vaccines wane. You have great coverage for a while but they wane. The European regulators have indicated that we can't be boosting ad infinitum and that it may actually eventually be harmful. What is their long-term game plan?

Dr. Shirin Kalyan: That's what I was hoping, that we would take a more responsible approach and wait for data. At this time, what they are seeking to do is diversify their portfolio of the types of vaccines available. I know there are a lot in the pipeline still. One of the miracles of the mRNA vaccines was based on the fact that you can just pump them out super fast, and that gave them an advantage so they could be a good filler. But at this point in time, if they were so good at coming up with new vaccines, then you would have thought that they would have already developed a variant-specific one, because right now, omicron is spreading because these vaccines don't show. It's an immune escape variant.

I think requiring more data and seeing whether or not it makes sense to actually vaccinate people who have already had omicron and recovered, and see what the benefit of that is, makes sense to me at this time.

The Chair: Thank you, Dr. Kalyan and Mr. Davies.

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

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

On behalf of this committee, I'd like to apologize to Dr. Kalyan for the intrusive nature of my colleague's questioning with respect to asking you to provide individual health information. I apologize for that.

Given that, Dr. Kalyan, maybe you could outline “informed consent” for this committee. I think that perhaps is germane. I know that you spoke a bit about it in your preamble, but maybe you could give us just three or four points around informed consent, if you would, Doctor.

Dr. Shirin Kalyan: It's the fundamental piece of any kind of medical intervention that a person understand their own personal risk from the intervention and their own personal risk from the disease in question. I'm not sure if everyone has been given.... Because it's an evolving science, especially around the new platforms, which are very promising, we don't have very good longitudinal data. That's still coming in, so to provide actual informed consent is challenging right now, because people's risks are very disparate for the disease, as well as the adverse effects.

We saw that quickly. We moved quickly with the adenovirus vector vaccines. We saw that VITT, especially in women, became less used in Canada, but we haven't really moved as quickly on the mRNA vaccines for young men, for example, and advising them appropriately.

Mr. Stephen Ellis: Thank you, Dr. Kalyan.

I'm going to shift gears a bit to go to Dr. Cohen, if I might.

You talked a tiny bit about increasing vaccine uptake with dialogue and education and also about how health care providers speak to individuals. I'm wondering, Dr. Cohen, if you might comment on the federal government's use of disparaging and dividing language with respect to how that might increase uptake, if you would.

● (1710)

Dr. Karen R. Cohen: I think one of the key messages for some of the research that looks into why people are hesitant to get vaccines is that there's not a single reason. Dr. Lavoie's research suggests that there are a few categories of people who resist vaccines. It might be that some folks need more information. For some folks, it's much more practical: They have difficulty leaving work or getting child care to go and get vaccines.

For others, it really might have to do with confidence. The way in which health care providers speak to their patients about their concerns really impacts how they follow up on their advice. I'm sure my medical colleagues here would agree with that. The better someone understands their disease and their treatment options, the better-informed the decision they're going to make.

I think the important take-away of the behavioural science research is that there are many reasons why people may be hesitant to get a vaccine, and what you do about it depends on the reason they have.

Mr. Stephen Ellis: Thank you, Dr. Cohen.

Is it safe to say that perhaps calling them names is not that useful?

Dr. Karen R. Cohen: Well, for many psychosocial reasons, calling anyone names is not useful.

Mr. Stephen Ellis: Thank you, Dr. Cohen. I appreciate that.

I'll go back to Dr. Warshawsky, if I might.

My colleague talked a bit about doses in the future, vaccine durability and how many doses we're going to need. Dr. Warshawsky, could you speak a bit, if you would, about the future of vaccines and what that may look like in terms of variants? How many doses are we talking about? I believe Israel is on dose number five.

Dr. Bryna Warshawsky: Thank you very much, Mr. Chair.

At NACI, the National Advisory Committee on Immunization, we monitor the authorized vaccines or the vaccines that we expect to be authorized and make recommendations with regard to those vaccines. We're currently looking at the current vaccines and how we can best make use of them.

As new technologies become available—if we get future technologies that may, for instance, look at mucosal vaccination or vaccines that enhance other parts of our immune response such as T cell immunity—as those vaccines become authorized in Canada, NACI will look at those vaccines as well and make recommendations with regard to them.

We know that the whole scientific community is watching to see what the next types of vaccines will be. They're watching what the manufacturers will put out with regard to potentially multivalent vaccines—vaccines that cover the wild-type strain and the omicron strain—and whether those may be more beneficial for future boosting. As those become authorized or the manufacturers put those forward for authorization, we will then, within the national advisory committee, look at those as well and make recommendations in the context of the epidemiology and the other vaccines available for Canadians.

Mr. Stephen Ellis: Thank you, Doctor. I appreciate that.

Madame Langlois, I'm not sure if this is within your ability to answer, but can you comment a bit on Canada's contribution to the COVAX program and on how we've done with respect to that?

[*Translation*]

The Chair: I would ask you to respond briefly, if possible, Ms. Langlois.

Ms. France-Isabelle Langlois: I will hand over to my colleague Colette Lelièvre.

Mrs. Colette Lelièvre: I don't have the latest figures, but Canada is still considered a country that participates in the COVAX mechanism to a large extent. It has pledged a huge number of doses.

I know there are still challenges with the doses pledged to the mechanism and the timelines for delivery of those doses internationally. I don't know where that stands now, but I know they are significant challenges.

We would like to see more predictable and regular deliveries. We would also like to see Canada use mechanisms like COVAX to distribute vaccines that were over-ordered in Canada, because this allows for equitable distribution among countries that have limited means to purchase vaccine doses for their own populations.

I don't know if that answers your question, but that is what we know at the moment on the issue.

The Chair: Thank you very much, Ms. Lelièvre and Dr. Ellis.

[*English*]

Next is Dr. Hanley.

Go ahead, please, for five minutes.

● (1715)

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

Thanks to all the panellists.

Dr. Warshawsky, first of all, having been in the game for a while, I want to recognize the incredible work that you and other members of NACI have been performing during the last two years, often under incredible pressure. I wonder if, sort of at a high level and as briefly as possible, you could comment on some of the challenges associated with translating data during a pandemic into policy and vaccine recommendations.

Dr. Bryna Warshawsky: Thank you very much for the question.

Definitely one of the challenges has been the paucity of data. At the beginning, we often don't have a lot of data. We have the clinical trials, but they are done in specific populations in relatively small numbers. We have to make our best recommendations with the available information, and then continue to monitor the ongoing information that comes from real-world use—effectiveness trials and safety trials in the real world. Then we incorporate that back into our recommendations and revise them if needed.

It has been an ongoing iterative process of trying to make the best recommendations with the available information and then staying on top of all the evolving information and modifying as needed.

Mr. Brendan Hanley: I must say that I think you've been very nimble in doing that.

Could you also summarize, according to your understanding, the current state of understanding of natural immunity versus vaccine immunity with regard to the omicron variant?

Dr. Bryna Warshawsky: Yes. Thank you for the question.

If you've had omicron as your only infection, you mount a response against omicron, but it doesn't provide a very broad response against other types of variants—past ones for sure. We don't know what the future will look like. However, if you have vaccine-induced immunity and infection on top of that, in whatever order—and in fact, they say if you've had three exposures to either vaccine or a combination of vaccines and infection—that gives you the most solid protection. So it seems to be the three exposures to the SARS virus or vaccine that give you really good, solid protection.

Relying on infection alone, there's variability. It may not last, and it may not be very broad. You really get this solid protection when you have either three doses of vaccine or a combination of vaccine and infection.

Mr. Brendan Hanley: That certainly speaks to the complexity behind this and to how easily one can be misled by sweeping statements on natural immunity versus vaccine immunity.

I wonder if you could talk briefly about the additional value of recent vaccine products, particularly the virus-like particle vaccines and what potential they will offer in months and years to come in terms of broadening our array of vaccines.

Dr. Bryna Warshawsky: Thank you very much for the question.

As you know, two new vaccines have been authorized recently. One is a protein subunit vaccine, which is the Novavax vaccine. The other is a virus-like particle vaccine, which is the Medicago vaccine. Medicago's is a new technology based on growing the vaccine in plants, so that's a very interesting new technology.

NACI has made recommendations with regard to both of those vaccines. It has expressed a preference for the mRNA vaccines, which we have been using for a long time. We have a lot of comfort with regard to their effectiveness and their safety. While data accumulates for the other vaccines, we have certainly said that if someone doesn't want an mRNA vaccine, then the Novavax and the Medicago vaccines are options that they can take. We have a lot more experience with the mRNA vaccines right now, so the preference is for those vaccines.

As mentioned before, we'll get more information about these newer vaccines and NACI will adjust its recommendations as needed.

Mr. Brendan Hanley: Thank you very much, Dr. Jacobs, for your really interesting presentation. There's a lot I could ask.

Perhaps the most useful question might be how you as a hospital are looking at what you've learned to prepare for what might be the next threat, whether that's another variant or another virus. How are you, as a hospital, using this experience to incorporate the ability to see patients?

● (1720)

The Chair: Give a short response, please, Dr. Jacobs.

Dr. David Jacobs: We must preserve our capacity to treat all patients. We must increase our capacity to treat patients who are sick from severe viral illnesses. That, basically, has to impact how we think about the virus and our ability to adjust our risk tolerance. It also mostly has to do with manpower issues.

Going through it very briefly, we are desperately short on ICU nurses. We need to have some sort of program whereby we can have nurses who are able to slip into the ICU as necessary. That's very difficult, because it's highly specialized care. The alternative is to have an overabundance of ICU nurses, which is a very expensive proposition. We have to choose, though. We can't not have one or the other.

With regard to keeping our capacity, we have to recognize that low-risk procedures have to continue throughout the pandemic. We can either do those in facilities outside of the hospital, or we can recognize that the risk is quite low and just soldier on, knowing that there will be some patients who are exposed to whatever virus comes next or whatever wave comes next. We can't just stop cold anymore.

This is a very complex issue. I'm not sure that we're going to have time to dive into that right now.

The Chair: Maybe someone else will lead you to continue the discussion. Thank you, Dr. Jacobs.

Next we're going to go to Mr. Lake, please, for five minutes.

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

I'm going to dive into something that's complicated. I have to try to get my own head around the way I frame it.

When we're talking about the evidence base around vaccine mandates, oftentimes we're having debates here in the House about mandates, but not so much the evidence base around vaccines. I think there's a fairly widespread—maybe not unanimous, but very widespread—agreement among 338 members of Parliament around the evidence on vaccines.

My question is for Dr. Warshawsky. Does NACI advise the government on evidence around vaccine mandates particularly, or is the decision to mandate vaccinations more of a policy decision based on the evidence around vaccines?

Dr. Bryna Warshawsky: Thank you for the question.

NACI does not make recommendations with regard to mandates. NACI gives expert advice with regard to the use of vaccines—which products and which populations—but mandates are a federal, provincial or territorial decision.

Hon. Mike Lake: The decision to mandate, though, would be more of a political decision, based on the advice you give around the efficacy of vaccines.

Dr. Bryna Warshawsky: That's right. NACI would provide information on how well vaccines work and what their recommendations are for vaccines, but they wouldn't provide information or advice on whether to mandate or not. That would be within the realm of the provincial, territorial and federal policy-makers.

Hon. Mike Lake: Okay.

My next question is around the most effective arguments to convince Canadians to get vaccinated. This can be for anybody on there. What, in your view—and maybe this goes more directly to the doctors on the panel today—would be the most effective arguments to convince Canadians to get vaccinated, that is, folks who, for whatever reason, haven't at this point in time?

Maybe, Dr. Jacobs, you could start, because you've spoken to it a little bit and it sounds like you're very adamant that it's important for people to get vaccinated. What would be the most effective arguments to convince those who aren't?

Dr. David Jacobs: At this point, many of the people who are not vaccinated are in small groups, smaller communities, and I think that if we're really going to get those people to get vaccinated, we have to reach out to them with very specific programs. Whether it be a religious group or a cultural group, you have to get in there and give them the information they need to make an informed decision. It's a ground game at this point.

Earlier on, we were always a little handicapped by patient privacy. If I could have shown people what I saw on imaging, if I could have talked to people directly about cases, I have no doubt in my mind that many people would have run out the next day and gotten vaccinated. I saw things that I have never seen in my career—and I've been doing this for a couple of decades now. I saw people on ventilators with torn-out lungs. That's not something that you see normally.

This has been an incredibly serious illness, but because of patient confidentiality, because of patient privacy, we're not able to speak freely about the impact on patients. I wonder whether, if we had had some way of getting around that, we would have been able to better share the seriousness of the illness. But it's always a balance.

● (1725)

Hon. Mike Lake: So it's fair to say that if Canadians better understood the health impact, they would make better decisions.

Does anyone have any evidence that the argument that most people who have chosen not to be vaccinated are misogynists or racists...? Is there any evidence that points to the fact that many Canadians who aren't vaccinated are, to quote the Prime Minister, misogynists and racists? Is there any evidence that points in that direction?

The second part of that question would be, is there any evidence that making that argument convinces people who haven't chosen to get vaccinated already to get vaccinated?

Dr. David Jacobs: It was a uniquely unhelpful thing that the Prime Minister did when he said that. It was politically driven. It did not help anyone in the health care industry. It did not convince anyone to change their mind.

The people who remain unvaccinated right now are very much a mixed bag of people. Some of them are unvaccinated because they have looked at the research and they disagree with the findings the majority of health care workers and scientists have come to in terms of conclusions. There are other people who are just simply afraid. There are other people who have been misinformed by social media. It's quite a wide array of people, and name-calling is not helpful.

The Chair: Thank you, Dr. Jacobs and Mr. Lake.

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

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair, and thank you to all of our witnesses for joining us today and for their comments.

I'd like to take the conversation in a bit of a different direction. I'd like to talk about a potential pandemic that is not virus-based and we may not have a vaccine for it to be able to debate on. I'd like to talk about mental health.

Ms. Eaton, welcome to our committee. In your opening remarks, you talked about the fact that 64% of the people in Canada are worried about new variants. I actually had an opportunity to read the survey that was put out by the CMHA. My compliments, it was a great job. In that survey, the findings also pointed to some other types of threats or concerns, such as climate change and concerns people had about their employment.

Can you shed some light on these findings and share with us some of the percentages or some of the data you found?

Ms. Margaret Eaton: Thank you so much.

When we looked at sources of stress, we saw that 30% of Canadians were feeling worried about money, even though this was later—the findings were taken just before omicron. They were also very worried about the mental health of their children—21% mentioned children. Sixteen per cent of people were worried about having enough food. When we looked at those vulnerable populations in particular, we also saw suicidal ideation was up.

In a normal year, 2.5% of Canadians have suicidal thoughts. The average number across the last two years was 8% to 10% of Canadians having suicidal thoughts. If we looked at those vulnerable groups that I mentioned—indigenous people, LGBTQ—we saw that number go above 10%.

People are really struggling through this time.

Mr. Majid Jowhari: Thank you.

You pointed out four recommendations as you were providing your testimony. The first one was around long-term funding. I just want to go back to the government record over the last six or seven years. In 2017, I believe, we allocated $5 billion over 10 years, and in budget 2021, there was an allocation of about $100 million over two years specifically around innovative mental health intervention for populations disproportionately impacted by COVID-19.

In your statement, you also had a caveat about how we have to work with provinces on a jurisdictional basis to make sure that these funds are properly allocated. Can you expand on that, please?

● (1730)

Ms. Margaret Eaton: Yes. We were delighted that the federal government had identified, a few years ago, billions of dollars to support mental health; unfortunately, we don't really have much information about how that money was spent. We know that there is underspending on mental health, and when we look at investment in community mental health, we see it's even lower.

We were very excited to see the creation of a mental health transfer and the opportunity there to fund community mental health through the mental health transfer. We're very excited by the idea that there would be standards set around mental health, and that those standards would be tied to this mental health transfer to ensure that community mental health gets funded, but also to ensure that there is a standard of care across the country, so that if you live in Newfoundland, you're going to get the same quality of care that you would get in Ontario. That isn't the case right now.

We're very excited to see standards and to see a much higher investment, particularly targeted and [*Technical difficulty—Editor*], if you will, to mental health investment.

Mr. Majid Jowhari: You talked about community mental health organizations. I also noticed that you put a report out in March 2022 that talked about burnout for these community-based health organizations as it relates to mental health. Can you briefly brief us on the findings?

The Chair: If you could briefly brief us, that would be helpful. Thank you.

Ms. Margaret Eaton: When we spoke to our branches across the country, people talked about the fact that the demands for service had gone so high that there were waiting lists in most of the areas we were looking at. At CMHA Toronto, there was a 300% increase in demand for youth programs. At CMHA Edmonton, there was a 200% increase in calls just related to income support and employment needs.

What our CMHA workers found was that they were being asked to do things way beyond mental health. They were asked to help provide food. They were volunteering at vaccine clinics. They were doing everything they could to make sure their communities were healthy and cared for. Because our community mental health organizations are underfunded at the best of times, it just means that this incredible demand, with phones ringing off the hook, has led to burnout for a lot of our workers.

If we look at nurses who work for CMHA, we see that they are underpaid, compared to hospital-based or private nurses working in mental health care. We have underpaid, overworked health care workers in mental health, and we believe that things like investment in community health would go a long way to mitigate that.

The Chair: Thank you, Ms. Eaton.

Thank you, Mr. Jowhari.

[*Translation*]

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

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

Ms. Langlois and Ms. Lelièvre, what is your assessment of the position, if any, or the posture of the Canadian government on the issue that you have shared with us about the WTO? In other words, in the last two years, has the government walked the talk?

You also told us about the problems in relation to the supply chain and that the infrastructure was sometimes non-existent.

What more should the government do to make its contribution match your expectations?

Ms. France-Isabelle Langlois: Canada's position at the WTO is supposedly one of neutrality. However, according to Amnesty International, it is more of a blocking position. In actual fact, it does not help the temporary lifting of patents, which is really needed. There needs to be transparency in terms of revenue and other technologies, whether it's vaccines or any other product, to reach as many people as possible.

Also, as my colleague Ms. Lelièvre mentioned, it is not true that Canada is doing nothing. It is participating in the COVAX mechanism. It could participate more, but above all, it should keep its promises and play a leadership role on the international scene when it comes to deploying logistics. While we talk about lifting patents and almost exclusively about vaccines, the logistics are not being put in place in the countries that need them so that any treatment, including but not limited to vaccines, can be deployed and made accessible to the population. Education is needed to convince the population to use the vaccines or treatments that will be offered to them.

Ms. Lelièvre, would you like to add any comments?

● (1735)

Mrs. Colette Lelièvre: May I add something, Mr. Chair?

The Chair: Yes, but please be brief.

Mrs. Colette Lelièvre: Certainly.

Canada could also support the health systems of countries with which it works on international development. This would allow these countries to prepare for the equitable distribution of vaccines in their own countries. This means providing sufficient support for personnel to ensure that there is adequate delivery within the country. It also means ensuring that the cold chain is maintained.

Substantial support from the Canadian government could certainly help ensure that health systems have the capacity to respond quickly, if need be, when they are going to be able to receive vaccines or access treatments.

Thank you.

The Chair: Thank you.

[*English*]

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

Mr. Don Davies: Thank you.

Dr. Warshawsky, we know that vaccines wane. I've already mentioned European regulators stating that we can't boost our way out ad infinitum and that, potentially, boosting may cause tolerance—I think that's one of the terms they use—long-term. Assuming that the boosters wane over time, what's the long-term game plan after that?

Dr. Bryna Warshawsky: Currently, as you know, the manufacturers are including different variants in their vaccines. In the next few months, we may see different variants included. They're looking at the original strain, the wild-type strain, and potentially the omicron strain. That's the nearest strategy.

As mentioned, we're also looking at other types of vaccines. Mucosal vaccines, which are delivered in the nose or in the mouth, will potentially enhance the vaccine protection that we get from an injectable vaccine and provide more protection against infections.

This research is all ongoing. We need to take each wave as it comes and the epidemiology as it comes to see what products are available. NACI will then make its recommendations, keeping all of that information in mind.

Mr. Don Davies: What's the current state of knowledge about efficacy three months out, say, after a booster? I got my third booster in January. What would you expect my efficacy to be three months after that?

Dr. Bryna Warshawsky: That's a very good question.

With regard to infection, the booster gives you around 60% protection against infection, but over time, so about three months later, it will have fallen. Exactly what it will be, we don't know; it may be 40% or it may be 30%.

Most importantly, it's about severe disease. We are really vaccinating to prevent severe disease. That's the main goal. If you talk about promoting vaccines for people, it's about keeping—

Mr. Don Davies: I know that's why, Doctor, but how long would that last? In June, I'm six months out after being boosted. What is the efficacy of the vaccine to prevent me from serious illness at that point?

● (1740)

Dr. Bryna Warshawsky: We know that once you're boosted, you get into the high nineties in terms of protection against severe disease. We know that, for the most part, it seems to last a number of months, but we don't have data for months and months and months.

With regard to three months out, for the most part the studies are still showing good protection, mostly 70% or higher, and many still in the eighties and nineties, but we need to go out longer to see what the protection for the longer term will be.

Mr. Don Davies: Thanks.

Dr. Kalyan, perhaps I can give you the last word on—

The Chair: Mr. Davies, you're out of time. I'm very sorry.

Mr. Don Davies: That's okay. Thanks, Mr. Chair.

The Chair: We're trying to get a sprint to the finish to get the last two rounds in.

Dr. Ellis, you have the floor for five minutes.

Mr. Stephen Ellis: Thank you, Mr. Chair. I appreciate that.

Ms. Eaton, we did delve a bit into the mental health issues associated with the stress of COVID and the mandates and lockdowns, etc. We talked about the chronic stress that Canadians are under. One of my questions is related.

If the government had a plan going forward with respect to federal mandates, do you think that would go some distance to alleviating the stress that Canadians are feeling chronically at the current time, and leadership?

Ms. Margaret Eaton: Sorry, just to clarify, if the federal government...?

Mr. Stephen Ellis: If they had a plan, or communicated a plan to Canadians with respect to federal mandates, do you think that would go a long way toward alleviating stress? Or am I off base there?

Ms. Margaret Eaton: No, I think most Canadians are concerned about their day-to-day lives: Do they have enough money to make ends meet? Can they see their family and friends? Can their kids go to school? A lot of these issues are provincial, in fact, and not federal. I think there is a little bit of relief of some of that stress now. As we've seen, most provinces are starting to open up. I'm hoping that will alleviate some of the stress.

In terms of chronic stress, I think we're going to have a kind of PTSD response to COVID-19. Some people will not even begin to experience some of the mental health impact until after things go back to normal. Then they'll start to feel the crushing weight. We'll also experience the long COVID impacts on mental health, which we're starting to see.

We believe that over the next two years we'll have to deal with more phone calls, more walk-ins and more concerns expressed by people about their mental health.

Mr. Stephen Ellis: Thank you for that.

You talked a bit previously about virtual care with respect to mental health services. If that was Dr. Cohen—I may have gotten it mixed up—I apologize.

Is it as effective as in-person service?

Ms. Margaret Eaton: There's lots of data now to suggest that virtual is very effective. Our only concern with virtual is that not everybody has access to broadband Internet, and not everyone has access to or can afford the devices that would be needed to actually take advantage of it.

I'll turn to Dr. Cohen, who has a comment.

Dr. Karen R. Cohen: Thank you.

I would agree entirely with Ms. Eaton that there certainly is evidence that for certain problems, care delivered virtually can be as efficacious as person-to-person care, but there are still huge inequities in people having access to not just technology but also the personal and private space to have that kind of care.

I'll make two quick points, if I may. One is around accessibility. I think there were huge inequities in terms of access to mental health services prepandemic. A pandemic that brought about all these mental health concerns only places a further demand on a system where people don't have sufficient access.

The second point is that we tend to treat mental health as if there's one problem and one solution. There is a great range of services. Some are delivered by community programming like the CMHA. Another person might need peer support. Another person might need assessment or psychotherapy. Canadians need better access to a range of solutions to a range of problems.

Mr. Stephen Ellis: Thanks to both of you for that.

I wonder, Dr. Cohen, since we have you on the hot seat, if you might comment on the three-digit suicide prevention hotline and the necessity and urgency to have that in place.

Dr. Karen R. Cohen: I think that any care we can offer people in distress is a good thing, but we have to be able to provide that follow-up care. Emergency response lines are important, but what's more important is the care that's delivered behind them. By and large, there aren't many mental health problems where there's a single session and it's resolved. We need to be able to provide that follow-up care.

● (1745)

Mr. Stephen Ellis: Fair enough, and certainly I would suggest that there are significant inequities in terms of the system with respect to folks who choose to live rurally and often were disadvantaged previously.

Finally, if I might, maybe we should talk a bit about the opioid crisis, which certainly has accelerated during the pandemic and has caused significant problems. I'll leave it open, Dr. Cohen. I'm feeling magnanimous. Could you just give us some words on the opioid crisis?

Dr. Karen R. Cohen: Well, that's not my area of expertise, but I think we've certainly seen increases in the use of substances, particularly for people who may already have had concerns or issues with the use of substances. I would say that this kind of care, those kinds of interventions, both for mental health problems and substance use need more investment, and we need to invest in them with parity, the way we provide care for physical health problems.

Mr. Stephen Ellis: Do I have any more time?

The Chair: No, you do not.

Mr. Stephen Ellis: Thank you, sir.

The Chair: Thank you, Dr. Ellis.

Thank you, Dr. Cohen.

The last round of questions will be posed by Ms. Sidhu, please, for the next five minutes.

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

Thank you to all the panellists for their testimony.

My question is for the CMHA. Thank you very much for the work you are doing for the community. You are reaching one million people with the 318 branches. Thank you to all the frontliners.

On May 3, 2020, a federal investment of more than $240 million was announced, including support for Wellness Together Canada. Health Canada reported that, as of January 2022, the Wellness Together portal had been accessed by over two million Canadians, with many people reporting positive changes in their self-assessment skills. Can you speak to the success of this system? What would you like to see improved, and what do you see that is effective?

Ms. Margaret Eaton: We were really delighted to see Wellness Together and see the federal government make that investment. It was very important. It provides a huge selection of virtual supports, and it even includes in-person support where there are a few hours of free psychotherapy offered to people.

We think it was an absolutely important and necessary response to the pandemic that the federal government could uniquely make to have a national service. We've been very pleased to see that it will be carried on.

The only enhancement I would make is that I think there needs to be more promotion of that service. More people need to know about its availability. I think it can really fill a gap and it will continue to. I know that the government is interested in seeing it carry on, and we are interested in seeing its continuance as well.

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

Dr. Cohen, you can take the next question.

Obviously we know that there's a lot of need and a lot of chronic stress out there, and we should also talk about seniors' mental health. The federal government recently appointed the first federal Minister of Mental Health, with the goal of creating mental health transfer payments, distinct from the existing Canada health transfer, with all of this in mind.

Do you feel that there needs to be more collaboration between mental health providers and the mainstream medical system? Or should there be more focus on community and peer support?

Dr. Karen R. Cohen: That's a great question.

One of the things I mentioned in my opening remarks is that we came together on a paper with our provincial psychological association partners to suggest how a federal mental health transfer could be invested in the provinces.

We strongly support the integration of mental health services and psychological services into primary care. That's the funded door. That's the door where most Canadians first have access to health providers. Integrating mental health services there makes a tremendous amount of sense, and doing it in such a way that there's some kind of parity in funding for services delivered.

Ms. Sonia Sidhu: Thank you.

My next question is for Dr. Eaton.

In terms of virtual care, many physicians offered phone and online virtual appointments. These practices are also referred to as “telemedicine”. What are your observations with respect to the overall uptake and acceptance? Do you think it's helpful? I got lots of positive feedback from my residents.

● (1750)

Ms. Margaret Eaton: Yes, I believe it was very helpful. Many of our CMHAs pivoted to provide virtual services. It was hugely beneficial to people, especially seniors and people who were in lockdown and did not have access to in-person.

In fact, it's been so successful across the country that our branches are going to continue to provide virtual services, even while they're opening up their doors to clients once again on a more regular basis. We hope to continue to be able to provide that and to have funding for that—not just for the actual caregivers, but to actually place the technology into the hands of our clients, for those who need it, and to be able to provide that Internet access.

The Chair: Thank you, Ms. Eaton.

Thank you, Ms. Sidhu.

To our witnesses, that concludes our rounds of questions. I want to thank you for your patience in waiting on us while we exercised our democratic duty. Thank you for your professionalism and for the depth and breadth of the knowledge you contributed to this discussion today. It was a varied and robust panel. It will add greatly to the value of our work. We are extremely grateful for your being with us here today and for answering our questions so comprehensively, professionally and patiently. It's greatly appreciated.

Is it the will of the committee to adjourn?

We're adjourned.