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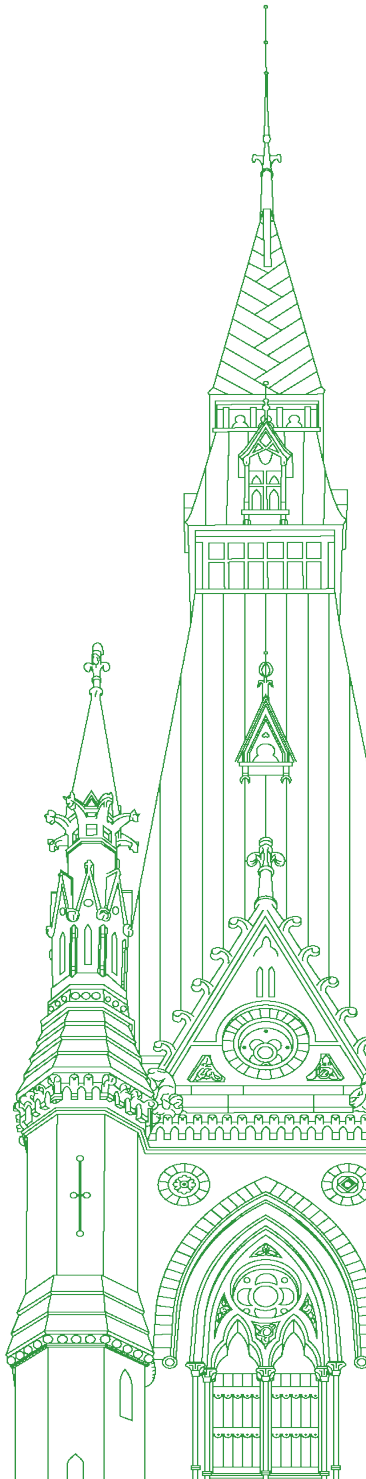

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, June 20, 2022

● (1605)

[*English*]

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

Welcome to meeting number 28 of the House of Commons Standing Committee on Health. Today, we're meeting for a one-hour briefing on labour shortages in the health care sector and the foreign credential recognition program. In the second hour, we'll have a briefing from the Public Health Agency of Canada in relation to the study of the emergency situation facing Canadians in light of the COVID-19 pandemic.

I'll forgo the usual announcement on hybrid proceedings. We're all quite familiar with them at this point, as are the officials who are appearing before us.

I would like it if we could do this right off the top, folks, because I always tend to forget this at the end. I'd like to set a deadline for the submission of witness lists for the children's health study that we will be resuming in September. After discussions with the clerk, I'm going to make a suggestion of July 18. The clerk will send out a reminder a couple of weeks before the deadline.

Is July 18 for witness lists on the children's health study okay?

Some hon. members: Agreed.

The Chair: It's adopted by consensus. Thank you.

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.

I will now welcome our witnesses who are with us for the first hour this afternoon. From the Department of Employment and Social Development, we have Andrew Brown, senior assistant deputy minister of the skills and employment branch, and Erin Connell, director, skilled newcomers, employment integration and partnership, of the skills and employment branch.

We're going to begin with the five-minute opening statement, if one of you has an opening statement to present.

Welcome to the committee. You now have the floor.

Mr. Andrew Brown (Senior Assistant Deputy Minister, Skills and Employment Branch, Department of Employment and Social Development): Thank you, Chair and committee members.

I am joining you from the traditional unceded territory of the Algonquin Anishinabe people.

I'm pleased to join you today to provide an overview of labour shortages in the health care sector. As you may know, labour market pressures are affecting practically all sectors of the economy and most regions of the country.

As of March 2022, there were more than one million job vacancies across Canada, which is significantly higher than prepandemic levels. These vacancies will take longer to fill, given the scarcity of such highly qualified workers among the unemployed and the need for specialized training.

● (1610)

[*Translation*]

Canada's health sector is not immune. This sector was already experiencing a shortage of workers prior to COVID-19, and these shortages have been further exacerbated by the pandemic.

In fact, as of the fourth quarter of 2021, this sector had the second-highest number of job vacancies in Canada, 126,000. Over the medium-term, forecasted job openings over the next 10 years will be particularly acute for key occupations, including registered nurses and licensed practical nurses, physicians and personal support workers.

[*English*]

ESDC has placed a priority on helping to address the health human resource crisis through its skills and training programs.

For example, budget 2021 announced $960 million for the sectoral workforce solutions program to help key sectors of the economy implement solutions to address current and emerging workforce needs. The health sector is a key sector for investment under the SWSP. The program launched a call for proposals in January that closed in March of this year, and these proposals are currently under assessment. Projects are expected to begin as early as summer 2022.

Additionally, as announced in the fall economic statement of 2020, ESDC is funding a $38.5-million pilot project to help address labour shortages in long-term and home care. This pilot will train up to 2,600 supportive care assistants through a microcertificate program and paid work placement. Of these, 1,300 are expected to continue on to pursue full personal support worker certification.

[*Translation*]

There is also the foreign credential recognition program, FCRP, which is a contributions program that supports the labour market integration of skilled newcomers through enhancing foreign credential recognition processes. This includes funding projects to standardize national exams, centralize information portals and provide alternative assessment processes.

The FCRP also provides loans for expenses related to training, licensing exams as well as support services, in order to help skilled newcomers navigate foreign credential recognition processes.

Lastly, the FCRP provides employment supports, including training, work placements, wage subsidies, mentoring and coaching, to help skilled newcomers gain Canadian work experience in their field of study and fully use their talent.

[*English*]

Indeed, internationally educated health professionals play a critical role in the Canadian health care system. These foreign-trained professionals account for a full 25% of Canada's health care and social services workforce, compared with just 10% of working adults for the wider population. However, despite our increasing need for health care workers and reliance upon internationally educated health professionals to fill these roles, these international professionals still face some barriers to licensure and re-entry into their professions, such as costly qualifying exams, limited access to residency training, language barriers and navigating the foreign credential recognition process.

Foreign credential recognition and licencing for regulated occupations, such as nurses, physicians and paramedics, is a provincial or territorial responsibility, and in most cases they further delegate that authority and legislation to regulatory authorities. Within Canada, there are more than 600 regulators overseeing more than 150 regulated occupations.

[*Translation*]

Nonetheless, the Government of Canada recognizes the challenges faced by internationally educated health professionals. This is why addressing their labour market integration has been a key focus of the foreign credential recognition program, particularly since the onset of the pandemic. The program is currently investing $22 million in 20 projects focused on the labour market integration of internationally educated health professionals.

● (1615)

[*English*]

Additionally, since 2018, over $13.5 million in loans have been issued through the program's foreign credential recognition loans to more than 1,500 borrowers, two-thirds of whom work in health care.

Budget 2022 announced an additional $115 million over five years, with $30 million ongoing, to expand the foreign credential recognition program. Along with existing investments in the program, the incremental funding will help up to 11,000 skilled newcomers get their credentials recognized and find work in their field. For example, these investments will support projects to standardize national exams, make it easier to access information, improve timelines and reduce red tape, in order to reduce barriers to foreign credential recognition, starting with a focus on the health care sector.

[*Translation*]

In addition to investments already mentioned, labour market transfer agreements delivered through ESDC provide approximately $3.4 billion in funding for individuals and employers to obtain skills training and employment supports through labour market development agreements and workforce development agreements with provinces and territories. Over a million Canadians benefit from programming and supports under these agreements.

[*English*]

ESDC will continue to work collaboratively with federal partners, counterparts in provincial and territorial governments, and regulatory authorities to help alleviate current and future labour market pressures in the health sector.

Thank you.

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

We're now going to rounds of questions beginning with the Conservatives.

Dr. Ellis, please, you have six minutes.

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

Thank you, Mr. Brown, for appearing here today. As you well know, this is an exceedingly important question that faces all Canadians, with somewhere between 10% to 20% of Canadians not having access to a family physician, which, as we know, is absolutely atrocious.

I have some questions. There are a lot of numbers that you threw around there, and being a physician, I guess I'm really quite curious as to how exactly you work with the medical regulatory authorities to get rid of red tape and do things like standardize national exams and so on.

Mr. Andrew Brown: Certainly one of the things that we are looking to do there is to take a look at ways to really facilitate the process for internationally educated health care professionals.

Ms. Connell may be able to assist in terms of describing a bit how we are working with provinces and territories and their regulatory agencies.

Ms. Erin Connell (Director, Skilled Newcomers, Employment Integration and Partnership, Skills and Employment Branch, Department of Employment and Social Development): Yes, I'd be happy to.

As mentioned, the foreign credential recognition program is a grants and contributions program, project-based funding, and we are currently funding a number of regulatory authorities in this domain, including the Medical Council of Canada.

An example here is updating online licensure tools for international medical graduates and helping them put exams online to increase accessibility for IMGs.

Mr. Stephen Ellis: I certainly have had a lot of international medical graduates reach out to me personally and certainly as a member of Parliament to help them understand the system and help them navigate it.

I guess the fact of the matter is that it's very difficult for them to meet these requirements. Specifically, there was a Ukrainian medical graduate willing—think about this—to take a family medicine spot anywhere in Canada who was able to apply to the CaRMS matching system and, in the second round, there are 99 unfilled family medicine spots in Canada this year for residents in training. There are 99. For some reason, he didn't get one, which is absolutely shocking because he tells me he's willing to go anywhere in Canada to get a residency spot.

It seems like all we're doing is talking and talking, and I guess the question that remains is.... Let's look at what happens in Nova Scotia. You need requirements for licensure, which means you need to be accepted from the World Directory of Medical Schools. It also means that you need to have some part of your LMCC, and you need to have documentation that you are certified with the College of Family Physicians or that you completed a one-year rotating internship in Canada before 1993.

Does this mean that all we're going to do is ask international medical graduates to, again, compete in the CaRMS matching system in round two?

● (1620)

Ms. Erin Connell: It is an unfortunate situation for a number of international medical graduates. They are limited by the CaRMS system that is dictated by CaRMS. As you know, the residency system is very competitive with limited seats. I don't think we as a program have levers to increase the number of seats, but we are happy to work with partners to try to facilitate and expedite the process where possible.

Mr. Stephen Ellis: Through you, Chair, to the witnesses, the primary problem here is really the length of time that it requires for somebody who's trained elsewhere to come to Canada, do all these exams and then get accepted to the resident matching service, which is what Ms. Connell is referring to, the CaRMS system.

The fact of the matter is, if we're not going to change every step of the process, what are we spending all of the money on? I don't have an issue with spending money, even though I'm a Conservative, if we're going to do something. The question is, though, if we're not changing it, what are we spending the money on? I do not understand.

Mr. Andrew Brown: Perhaps I'll jump in there to respond to the question. The federal government has really more of a convening role here with provinces and territories to be identifying exactly some of the challenges that have just been identified.

Notably, one is the time required for an individual coming to Canada who's been trained abroad to have their training and experience recognized, so that they are able to gain experience here and ultimately become recognized as a licensed professional in Canada.

Mr. Stephen Ellis: I don't have an issue with that, but the fact of the matter is that, if we're not going to recognize the training and experience and credentials they bring with them, that means they're still starting so many years behind. They still need to then access the Canadian training system, which we all know is a huge roadblock.

I believe that what Canadians out there are talking about is recognizing the credentials and the experience that international medical graduates bring with them already. To spend more money to say we're going to get people into a system that already exists quite frankly doesn't make any sense to me. That's not what Canadians think you're spending their money on.

Mr. Andrew Brown: We certainly hear that comment. I think that's one thing we can continue to push as we work with provinces and territories. It's really noting the shortages we're facing, particularly in the health sector, and looking at ways that foreign credentials can be recognized more quickly, so when foreign-trained professionals arrive in Canada, they can get to work more quickly in Canada.

The Chair: Thank you, Mr. Brown and Dr. Ellis.

Next we're going to go to Dr. Powlowski, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you both for being here. This is certainly a problem we've been trying to wrestle with. How do we make it easier for foreign-trained graduates to get licensed?

Apparently, we budgeted $150 million, I believe, to help the foreign credential recognition programs. I think that was broken down so some of that money could be used to help with costly exams. Okay, I can see that. There's the cost of navigating the difficult credentialing program. Okay, I can see that.

Then there was some mention of more residency programs, although I think someone here then mentioned that was provincial jurisdiction. I would suggest, with the federal spending power, the federal government could work with the province to help create further residency programs. Could it not?

During this study, I remember asking the dean of Queen's University's medical school, I think, or it may have been the nursing school, if they would or could take more people to train. They said that, yes, they could.

Is some of the money in the $150 million going towards creating more residency programs?

● (1625)

Mr. Andrew Brown: Thanks for the question.

Perhaps I can turn to Ms. Connell to provide a little more clarity with respect to the $115 million that was announced.

Mr. Marcus Powlowski: I'm sorry. Is it $115 million, rather than $150 million?

Ms. Erin Connell: It's $115 million over five years and $30 million per year after that. That's in addition to our base funding.

That funding is a grants and contributions program. We do give funding to provinces and territories, regulatory authorities and other organizations to support the labour market integration of skilled newcomers. We will be continuing to earmark some of these funds towards the health sector, given the crisis and the number of regulated occupations in the health sector.

Increasing the number of residency spots specifically is within provincial-territorial jurisdiction. That said, whether it's FCRP or the new sectoral workforce solutions program, these programs would be willing to work in partnership with our partners to help support efforts that advance the labour market integration of internationally educated health professionals.

Mr. Marcus Powlowski: I take that to mean you would be willing to use some of this money to create further residency programs.

Ms. Erin Connell: We could potentially support provinces and territories that wish to create additional spots in residency programs.

Mr. Marcus Powlowski: As Dr. Ellis has pointed out, there were 99 unfulfilled family doctor residency programs. Perhaps the obstacle isn't so much the residency programs, but the problem is with the licensure. Certainly, the Medical Council of Canada sets up national licensing exams, the LMCCs.

Is some of that money going to go toward helping to perhaps provide education for foreign graduates who want to study and spend some time in order to upgrade their knowledge and skills, so that they can pass the LMCC exams?

Ms. Erin Connell: That could certainly be a project under consideration for the foreign credential recognition program. We already have two project agreements with the Medical Council of Canada, as well as other provinces, territories, regulatory authorities and immigrant-serving organizations. We already have funding agreements with 20 partners in the health space.

We are open to discussing further ideas, whether it is to pilot or test something new, or to ramp up current efforts to expedite the process, put exams online or test new bridging models for international medical graduates.

Mr. Marcus Powlowski: There is also the possibility, it would seem to me, of creating more opportunities for practice-ready assessments, which to my understanding is a way by which foreign graduates can work with a licensed doctor in Canada for 12 weeks, and then the people at the Medical Council of Canada make recommendations as to the further training that's available. That would certainly seem to be an opportunity.

When we asked some of the witnesses earlier on in this study about this, they said that the number of people who went through this process, the practice-ready assessment, was in the order of hundreds, whereas we have far more empty positions than that.

Could some of that money be used in order to make it easier for people to undergo the practice-ready assessments?

● (1630)

Ms. Erin Connell: The practice-ready assessment program is currently being offered in seven jurisdictions. Again, we would certainly be willing to work with the provinces and territories to support their priorities.

Mr. Marcus Powlowski: [*Technical difficulty—Editor*] interested in doing this. In my understanding as to why it is so hard for foreign graduates to get licensed, there are a couple of things. Perhaps it's protectionism within the medical community, although, having recently spoken to the former, present and future presidents of the CMA, they all expressed an interest in making it easier for foreign graduates.

The other thing I've heard as a potential obstacle is that provinces do not want to issue more billing numbers, because more billing numbers equals higher health care costs. Do you think the provinces are really interested in licensing more foreign graduates?

Mr. Andrew Brown: I would like to jump in and respond to that question. We really need the provinces to weigh in on where they are there. Certainly, we are seeing the pressures. We know they are feeling the pressures as well. Responding to the labour market situation and these shortages, both in a broad sense and, specifically, with respect to the health care sector, is something that will take an intervention by the federal government, as well as intervention and collaboration from the provincial and territorial governments, particularly with respect to the health care sector, given provincial-territorial mandates, if you will.

So—

The Chair: Go ahead. Finish your thought, Mr. Brown, and then we'll move to Mr. Garon.

Mr. Andrew Brown: I'll just say that this area is one where we are continuing to work with the provinces and territories. We believe collaboration is part of the solution.

The Chair: Thank you, Mr. Brown and Dr. Powlowski.

[*Translation*]

Mr. Garon, you may go ahead. You have six minutes.

Mr. Jean-Denis Garon (Mirabel, BQ): Thank you, Mr. Chair.

Mr. Brown, I'm curious as to how many projects in Quebec currently receive funding through the FCRP.

Mr. Andrew Brown: Thank you for your question.

I don't know the numbers off the top of my head.

Ms. Connell, do you know the answer?

[*English*]

Ms. Erin Connell: I can. We do have a contribution agreement with the Government of Quebec, the Province of Quebec, for a loans project agreement.

As Mr. Brown mentioned in his opening remarks, we do have loans projects with 11 organizations across the country. With Quebec, we have signed a four-year contribution agreement so that they can administer their loans in the manner they see fit.

[*Translation*]

Mr. Jean-Denis Garon: Thank you.

That ties in with the question I wanted to ask you. Quebec's asymmetrical jurisdiction over labour force training has long been recognized, since the 1990s, in fact. Government workers were even decentralized further to that change. That was when Emploi-Québec was established.

Can you explain the asymmetrical nature of Quebec's agreement with the federal government specifically recognizing Quebec's jurisdiction over labour force training? It is quite an asymmetrical relationship.

Mr. Andrew Brown: As far as the agreements with the provinces and territories are concerned, there are two agreements with the Province of Quebec relating to the labour market and training, and another relating to workforce development. Those agreements go back quite a few years.

In budget 2022, the federal government announced its intention to modernize those agreements with the provinces and territories to give them more flexibility, allowing them to develop their own training and employment support programs.

Mr. Jean-Denis Garon: I'm delighted to hear that the other provinces may take a page from Quebec's book with the recognition of their own jurisdiction in the area.

The idea of using so-called federal spending power is being floated around here. It's often used to sweeten the pill. The government would use its spending power to somewhat force the provinces to change their approach, specifically with respect to immigration and the way in which they deal with foreign candidates in the medical profession such as nurses.

It is well known that Quebec wants even more control over immigration. Quebec is already responsible for its own economic immigration. That, too, is an example of its asymmetrical jurisdiction.

Does the federal government intend to place conditions on health transfers, or other funding, to influence Quebec's economic immigration decisions, particularly when it comes to selecting candidates in the medical profession?

● (1635)

Mr. Andrew Brown: It's hard to answer that question because it pertains to immigration and the agreement with Quebec. I work for a different department, Employment and Social Development Canada. I think the two governments are still in talks to conclude a new agreement, but the federal government certainly intends to fulfill its commitments under the current agreement.

Mr. Jean-Denis Garon: Obviously, like always, we hope those commitments include respecting Quebec's jurisdiction.

Finding people to work in health care is hard because the health system lacks funding, which makes working conditions especially challenging. I'm talking about Quebec's health system, specifically.

Nurses have to work mandatory overtime. Things have only gotten worse with the pandemic, so much so that, in the government's last budget, the Minister of Health was forced to make $2 billion in urgent health care funding available. There were no strings attached to the transfer, which was meant to help the provinces address the backlogs of delayed surgeries.

Do you think inadequate federal funding for health care, coupled with the government's refusal to provide transfers unconditionally and the fact that working conditions are worsening as a result, is a barrier to recruitment?

Who wants to work in an underfunded health care system with poor working conditions? Do you think that hinders recruitment?

Mr. Andrew Brown: Thank you for your question.

Clearly, the working conditions can make it harder to recruit people. That said, you would be much better off talking to Health Canada officials about health care.

What I can say is that establishing a human resources strategy for the health sector is extremely important. That's where our department can play a role. The focus needs to be, first, on people who are in Canada and who can obtain training to find a job in the health field and, then, on people outside the country.

It's important for Canada to find a way to recognize those individuals' credentials as well as their foreign experience so they can help meet Canada's needs.

The Chair: Thank you, Mr. Brown.

[*English*]

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

Mr. Taylor Bachrach (Skeena—Bulkley Valley, NDP): Thank you, Mr. Chair.

Thank you to the committee for allowing me to be here on behalf of my colleague Mr. Davies.

Thank you to our witnesses as well.

I'll start with a pretty general question about the issue of overqualification.

I'm wondering, Mr. Brown, if you can speak to whether your department has the proportion of recent immigrants to Canada who are currently working in jobs at skill levels that are below what their credentials would allow for, and is that a statistic that's easily available?

Mr. Andrew Brown: Again, thank you for that question.

On that, I am not certain of the response.

I wonder, again, Ms. Connell, if you may be able to help out with this, if we have such information.

● (1640)

Ms. Erin Connell: I'm afraid I don't have that statistic handy, but we would be happy to provide it in writing.

Mr. Taylor Bachrach: Maybe on just a general level, would you say that situation of overqualification is more common among recent immigrants to Canada than it is for Canadian-born individuals with comparable educational credentials?

Mr. Andrew Brown: I think that would be a fair statement to make, with the rationale or reason behind that being the need for people who have trained abroad to have their credentials recognized or in fact to pursue some retraining here to then be recognized as a professional in Canada. It does add an additional barrier for someone who is trained abroad as to someone who is trained here in Canada.

Mr. Taylor Bachrach: Thank you, Mr. Brown.

You mentioned that budget 2022 provides $115 million over five years, with $30 million ongoing, to expand the foreign credential recognition program and help up to 11,000 internationally trained health care professionals per year get their credentials and be recognized in their field.

On average, how many professionals have their foreign credentials recognized in Canada each year currently?

Mr. Andrew Brown: Thanks again for the question.

Certainly, of course, provincial and territorial governments and regulatory bodies are responsible for that review and accreditation.

I don't know, Ms. Connell, whether we have figures that have been compiled from those jurisdictions and agencies.

Ms. Erin Connell: I don't have a macro number because, as mentioned, it is a provincial and territorial responsibility. There are 150 regulated occupations.

One figure I could offer is that, through our loans project, which has the goal of helping immigrants through the foreign credential recognition process, to date we've helped 30% of the people who have received loans acquire their credential recognition. An additional 30% found work in their field of study.

Mr. Taylor Bachrach: Thank you, Ms. Connell.

I guess what I'm trying to get at is this 11,000 number. What is it based on if it's not based on a comparison to how many are currently being credentialed? Without knowing how many are currently being credentialed, how did we set this target of 11,000 internationally trained health care professionals per year?

I guess what I'm trying to get a sense of is if that is a reasonable target. Is it ambitious? How does it compare to the current pace? If we're currently credentialing 5,000 per year and we want to get to 11,000, that seems like a pretty achievable thing—I have no idea—but if we're currently credentialing 50, then it's much more ambitious. Do you have any sense, even in ballpark numbers, of how many foreign-trained professionals are being credentialed?

Ms. Erin Connell: Again, I can't give a ballpark figure. We can certainly take that back, but it's very difficult to extract that data. Some provinces are better than others at reporting that.

To achieve our target of 11,000 per year, we intend to do that through our project-based funding. That is through systems improvements that will help skilled newcomers get their credentials recognized, through our loans, where a number of skilled newcomers receive loans and support services, and through the participation of skilled newcomers in our Canadian work experience projects, in mentorship programs, work placements and wage subsidies.

It's a collection of our interventions at a project-based level.

Mr. Taylor Bachrach: Can I assume that the data collection will get better so that you know when you hit the 11,000 target?

Somewhat related to that, is it 11,000 new internationally credentialed professionals or is it 11,000 gross number, including the ones who are currently credentialed under existing programs? This is new money that's being brought to bear. How many new credentials will be recognized through this program?

● (1645)

Ms. Erin Connell: Again, it's not necessarily the number of people whose credentials are recognized. That could be part of it. We do have good reporting results on our projects. It would be a mixture of those who go through the credential recognition process and, thanks to our projects, receive loans and participate in Canadian work experience opportunities.

The Chair: Thank you, Ms. Connell and Mr. Bachrach.

We'll now go back to Dr. Ellis, please, for five minutes.

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

Again, thank you to the witnesses.

I'd like to pick up on that line of questioning. When you're talking about 11,000 individuals being credentialed, do you have a breakdown of what their professions are?

Mr. Andrew Brown: Ms. Connell, are you able to jump in there?

Ms. Erin Connell: We don't have an exact breakdown yet. This is new money. Typically, we do invest heavily in the health sector. Even before the pandemic, the program invested 25% to 30% of its program funding in the health sector. We anticipate ramping that up, as we had started to do when the pandemic hit. We will continue to focus on the health sector as well as reach out to other in-demand sectors in Canada, including, perhaps, the skilled trades and information and communications technology.

In the short term, the health sector is certainly a very big priority for us.

Mr. Stephen Ellis: Thank you very much for that.

When do you anticipate having those numbers from the health sector?

Ms. Erin Connell: It would be after we have a new set of project agreements set up. I would say within the year we would have targets.

Mr. Stephen Ellis: You do understand that 10% of Canadians, at minimum, don't have a family doctor, and we're short 60,000 to 70,000 nurses. That being said, of the 11,000 people, you said 30% of them are in the health sector. Let's be kind and say it's 4,000 people. We're short 60,000 nurses, so that's a drop in the bucket. I'll just leave it at that.

As well, you talked about 20 projects that you're undertaking. I think the committee would be very interested to know two things. One, how many of them are health-related? Two, of those that are health-related, would you please table those projects with the health committee within the next month?

Ms. Erin Connell: Thank you for that. We would be happy to. All 20 of the projects we referenced are indeed in the health sector. We would be happy to table the list of projects with their descriptions.

Mr. Stephen Ellis: That's great. We would also, of course, love the metrics associated with those studies.

That being said, are the studies you're undertaking being driven by your office, or are you asking for proposals from the provincial governments?

Ms. Erin Connell: We have continuous intake for the foreign credential recognition program. We are happy to accept a project concept or a proposal from a provincial or territorial government, a regulatory authority or an immigrant-serving or other organization. The program also regularly launches calls for proposals. We are in the planning stages for that.

Mr. Stephen Ellis: If I could be clear then, it could be from anyone, from an individual to a province, but there's really not a plan here.

We're spending $115 million, plus your regular funding—which I'm not sure what it is, but I'd be interested to hear that—on something that we're asking somebody else to plan for. Even though we already know the scope of the problem in general and the urgency thereof, there's no federal plan on how to address it.

Ms. Erin Connell: I would say that there is a federal plan. As Mr. Brown said, we work collaboratively with our partners at Health Canada and Immigration, Refugees and Citizenship Canada on our piece of the puzzle—

Mr. Stephen Ellis: Can I interrupt you, Ms. Connell? I feel that this could be somewhat disrespectful, and I don't mean it to be.

I would suggest that a plan would be somebody having an idea and outlining it, and then filling in those parts and asking other people to be a part of that, not asking other people to come up with the idea. That's not a plan.

Again, I'm not trying to be controversial, but a plan would be, "I'm telling you what to do. Here's the plan. Here's what we are going to do." What you're doing is convening some meetings with either individuals or provinces.

● (1650)

Ms. Erin Connell: I understand your frustration.

The fact of the matter is that foreign credential recognition, and licensure and certification, is a provincial and territorial responsibility. We convene—

Mr. Stephen Ellis: I'm going to interrupt you again, because you're telling me stuff that I already know, and this committee knows intimately well. I do apologize for sounding rude, but we only have so much time.

With that being said, if it's a provincial jurisdiction, then why are we spending an extra $115 million and your entire budget on something that is not a plan?

Again, I'll be totally honest with you. You do not understand my frustration, because I'm talking here on behalf of up to five million Canadians who can't see a family doctor. You don't have a plan. At least your department does not have a plan. I am exceedingly frustrated.

The Chair: Ms. Connell, we're past time. You can provide a response, without interruption, if you like.

Mr. Stephen Ellis: Mr. Chair, it's fine. It's good.

The Chair: Next we have Mr. Jowhari, please, for five minutes.

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

Thank you to both officials for showing up today.

In both of your responses, Mr. Brown and Ms. Connell, you talked about collaboration. I specifically recall that when you, Mr. Brown, were responding to my colleague Monsieur Garon, you talked about the strategy. You said that the best thing we can do is that we can put a strategy together.

As I'm sure you've followed HESA over the year, we have consistently been hearing about the theme of a pan-Canadian framework or strategy, whether it's for health workforce planning or for licensure for physicians across the country. We also talked about the role that the federal government needs to play to be able to make a difference. We realize that these are provincial and territorial...and also some of these professional organizations.

Mr. Brown, as well as Ms. Connell, can you help us understand what lever the federal government has to be able to play a much more effective role in addressing some of these issues? Whether it's the licensure or the length of time, the residency spaces or making sure of the supply and demand of physicians in the jurisdiction, what lever do we have that we could apply as the federal government?

Mr. Andrew Brown: Thank you for the question. I think there are perhaps a couple of different things that we can think about.

I recognize that there is a lot of focus here on the foreign credential recognition program, and I think that is a piece of it. I think we also need to take a look at our own programs, and for provinces and territories to look at their own skills and employment and training to see what some of the opportunities are to address the shortages. I think it's a number of things.

If we turn to the foreign credential recognition program for a moment, in that case, I might turn to Ms. Connell, to see if there are specific pieces we might point to in that area that would help in terms of a federal lever.

Ms. Erin Connell: We do convene conversations bilaterally and multilaterally with our provincial and territorial partners to better understand their needs and priorities and to talk about partnerships moving forward.

This is a G and C project-based program. We do reach out to regulatory authorities as well. As mentioned earlier, we are currently funding 20 projects in the health sector and continue to do more in that space, so to that—

Mr. Majid Jowhari: Thank you. I apologize for interrupting you. We heard that before, but I'm not sure whether that's a lever or not.

I know that ESDC has recently released a pan-Canadian framework for the assessment and recognition of foreign qualifications, which is more of a guideline to work toward improving the integration of internationally trained workers into the labour market, rather than serving as a legally binding document where the provinces or other organizations have to follow up.

Where is the power of this document going to come from?

● (1655)

Mr. Andrew Brown: All right, Ms. Connell, are you able to help out in terms of the reference there to the pan-Canadian document?

Ms. Erin Connell: Yes, so the pan-Canadian framework was published in 2009 via the Forum of Labour Market Ministers. It is a high-level document with a shared vision, guiding principles and desired outcomes. It has served as a piece that has guided actions both federally and at the provincial and territorial level. It has been a forum to share best practices and do occupational analysis to try to see where the gaps are at pre-arrival, at bridging and at credential recognition. Some of the actions coming out of this have included setting up fairness commissioners and review offices in certain jurisdictions. Others are projects to improve pre-arrival or focus on bridging.

It certainly is—

Mr. Majid Jowhari: Thank you, Ms. Connell. I only have another 15 seconds, if that.

Do you believe that the federal government could use the health transfer fund to be able to really get the provinces at the table to be able to address some of the huge gaps that we have in the delivery of our health care services?

The Chair: Give a brief response, please.

Ms. Erin Connell: I think that would be a question best suited for our Health Canada colleagues.

The Chair: Thank you, Ms. Connell.

[*Translation*]

We now go to Mr. Garon for two and a half minutes.

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

At one time, Quebec was losing doctors and health professionals because they were leaving to work elsewhere. Today, however, the federal government is really doing us a favour, since people aren't leaving anymore because they can't get passports.

Another problem with the federal government is immigration. It's putting the cart before the horse, in my view. This discussion is about making it easier to bring foreign professionals to the country, and yet, the Department of Immigration and Citizenship is the most dysfunctional department in the whole federal government. It can't even manage to get temporary foreign workers into the country on time.

That's why I'd like the witnesses to tell us whether they think a functional federal immigration department would make their job easier as far as the foreign credential recognition program is concerned.

Mr. Andrew Brown: Thank you for your question.

Of course, we have a federal immigration department. As a general rule, there is always room to improve the work of our departments. At ESDC, we work with Immigration, Refugees and Citizenship Canada. Administration of the temporary foreign worker program is an area of shared responsibility, one that involves Quebec's departments as well.

That's one way of addressing the labour shortage impacting the health sector. The other way is really to focus on Canadian workers. It comes down to finding ways to train people, in Canada and in Quebec, so that they can work in the health sector.

Mr. Jean-Denis Garon: Very quickly, I have another question, Mr. Chair.

Mr. Brown, the government allocated $115 million to the program, approximately $30 million per year. If I do the math, Quebec's share is $5.8 million a year.

You just mentioned the training of health care workers. That's an area where Quebec's departments of health and social services and education call for tens of billions of dollars in investment.

Does the government really think that the provinces will be able to solve the huge labour problem without additional health transfers? Quebec's share is just $5.8 million a year.

The Chair: Please keep your answer brief.

Mr. Andrew Brown: I don't know how much exactly is transferred to the Province of Quebec for that program.

Ms. Connell may be able to provide more information on that.

● (1700)

The Chair: Thank you, Mr. Garon.

[*English*]

Next we have Mr. Bachrach for two and a half minutes. We'll then go to the next panel.

Mr. Taylor Bachrach: Thank you, Mr. Chair.

This is a bit of a segue from my last line of questioning on data. I'm sure our witnesses will be familiar with the 2020 evaluation of the foreign credential recognition program that the federal government undertook. In that evaluation, the report states, "a lack of data on labour market outcomes of internationally trained individuals...is an impediment to measure the impact of the Program on the employment outcomes".

In light of this finding from two years ago, what steps is the federal government taking to improve data collection on labour market outcomes of internationally trained individuals?

Mr. Andrew Brown: Ms. Connell, I'll turn to you. Thanks.

Ms. Erin Connell: Yes. Thank you.

Moving forward, we are strengthening our reporting requirements and our resultant outcome measurement of the organizations, provinces and territories that we fund. It's a measure of strengthening the results and reporting regime, so that we can accurately capture how effective the program is.

Mr. Taylor Bachrach: I assume that it will be easier to know when you hit that target of 11,000, because the provinces and the other partners will be reporting to you how many internationally credentialed professionals are making it through the program.

Ms. Erin Connell: Our project proponents will be reporting those results to us. It will be how many loans were disbursed, how many skilled newcomers participated in a Canadian work experience and how many skilled newcomers were helped by projects that support better foreign credential recognition. It's very specific to our projects and our project results.

Mr. Taylor Bachrach: However, that same evaluation stated, "The Program's ability to create systemic changes is limited since the provinces and territories have jurisdiction over credentialing for most regulated professions."

What steps is your department taking to improve coordination with the provinces, territories and regulatory bodies on foreign credential recognition?

Mr. Andrew Brown: Thanks again for the question.

Again, this is one of the areas where it is really focusing on those different aspects of the program. It's looking at opportunities to streamline through consistent national requirements and exams, looking at streamlining the processes for recognition of foreign credentials and sharing best practices.

That is the convening role that the federal government is undertaking. It's meant to facilitate the recognition of foreign credentials.

The Chair: Thank you, Mr. Brown and Mr. Bachrach.

Mr. Brown and Ms. Connell, I want to thank you very much for being with us here today. We've spent a significant amount of time in recent months studying the challenges around the workforce in health care. If there is one thing that we've learned, it's that foreign credentialing is absolutely part of the solution.

Thanks for the work you have been doing in this area. Thanks for the information that you provided to us today, and for your patience with the late start. It's become more of the norm in recent weeks.

With that, colleagues, we will suspend while we have the next panel geared up.

The meeting is suspended.

● (1700)

_____(Pause)_____

● (1705)

The Chair: I call the meeting back to order.

We will now proceed to our briefing from Public Health Agency of Canada officials under our study of the emergency situation facing Canadians in light of the COVID-19 pandemic.

We're pleased to welcome, from the Public Health Agency of Canada, Kathy Thompson, executive vice-president; Cindy Evans, vice-president, emergency management branch; Stephen Bent, vice-president, vaccine rollout task force; Kimby Barton, acting vice-president, health security and regional operations branch; and Dr. Guillaume Poliquin, vice-president, national microbiology laboratory.

Thank you all for taking the time to appear today.

I understand, Ms. Thompson, that you're going to be delivering opening remarks on behalf of the agency, so you have the floor for the next five minutes. Welcome to the committee.

Ms. Kathy Thompson (Executive Vice-President, Public Health Agency of Canada): Thank you very much, Mr. Chair.

Thank you for inviting the Public Health Agency of Canada back to provide an update on the COVID-19 situation in Canada.

We continue to monitor COVID-19 epidemiological indicators, so that we can quickly detect, understand and communicate any emerging issues of concern.

[*Translation*]

As Dr. Tam reported on Friday, COVID-19 disease activity indicators, from daily case counts and lab test positivity to waste water signals, are stabilizing at the national level, with most areas continuing to decline.

Severe illness trends are also declining in most jurisdictions. However, the virus is still circulating in Canada and internationally, and factors such as virus evolution and waning immunity could have an impact on COVID-19 activity moving forward. At this time, we are observing early signals of increased activity in some areas.

As we and Dr. Tam have said on a number of occasions, we are not expecting our progress to be linear. We need to continue to prepare in case there is a resurgence in COVID-19 activity. This means we need to keep up with our personal precautions, including staying up to date with our COVID-19 vaccines and wearing a well-fitted mask. This is especially important as summer approaches, and Canadians get together more and participate in larger events like fairs and festivals.

The steady improvements we have been seeing in epidemiological indicators have allowed us to continue to relax and pause some of our measures.

[*English*]

Last week, the Government of Canada announced it is suspending the vaccine mandate for federally regulated transportation sectors and federal employees. In Canada, we now have better levels of immunity from vaccination and infection, antiviral drugs are more widely available, and our hospitalization rates are lower, relative to when the mandates were first introduced. This means we're now better equipped to effectively manage the COVID-19 pandemic and reduce the pressure on the health care system.

The suspension of vaccine mandates reflects an improved public health situation in Canada at this time. However, the COVID-19 virus continues to evolve and circulate in Canada and globally. COVID-19 remains a public health threat. Our best line of defence against serious illness, hospitalization and death is staying up to date with vaccinations, including booster doses.

Because vaccination rates and virus control in other countries vary significantly, our vaccination requirements remain in effect at the border. This includes an existing vaccination requirement for most foreign nationals entering Canada, and the quarantine and testing requirements for Canadians and some travellers who have not received their primary vaccine series. These requirements will help reduce the potential impact of international travel on our health care system. They will also serve as added protection against any future variants of concern.

The Government of Canada is transitioning to a model in which testing occurs outside of airports for both random testing and testing for unvaccinated travellers. Random testing will continue to occur at land border points of entry across Canada, with no changes.

● (1710)

[*Translation*]

While we continue the fight against this virus, we are taking every opportunity to improve. We continue to learn from both our past actions and our evolving knowledge of the virus.

Although the agency was able to rapidly mobilize, and adapt and respond to the evolving COVID-19 situation, as we move forward, we will look to strengthening our pandemic preparedness by building on the lessons we have learned.

As we look to the future, we are optimistic; however, we also need to prepare for various scenarios. In doing so, we will use science and data to help inform our response to new or evolving situations—just as we have done from the beginning of the pandemic.

We would be happy to answer any questions you have.

Thank you, Mr. Chair.

[*English*]

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

We will now begin with rounds of questioning, starting with Mr. Ellis, for six minutes, please.

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

Thank you to the witnesses for coming, and thank you for your opening remarks, Ms. Thompson.

The data you're talking about, this elusive data we've heard a lot about, can you tell us what metrics you're using?

Ms. Kathy Thompson: There isn't one specific metric. We were really looking at a number of factors. For example, when I looked at the situation when the vaccine mandates were first put in place, there was strong scientific evidence, at the time, that the vaccines were preventing infection. They were working against transmission, against delta and alpha, and protecting against serious illness. There was a rapid acceleration of the delta variant. Hospitalization and ICU rates were very high, and the modelling was showing a strong resurgence at the time.

When we look now, comparatively, we have high immunity, both from vaccinations but also from infection rates. We have significant availability of antivirals. I mentioned the vaccination rates. Over 82% of Canadians are fully vaccinated with a primary series. We have lower hospitalization rates, and we're effectively in a better position now to manage the pandemic. That's why the decision was made to remove the vaccine mandates for public servants but also for the domestic federally regulated transportation sectors.

Mr. Stephen Ellis: The question is, as we've asked multiple times before, would you table that information with those metrics here with this committee? Since you have it at your fingertips, that would be great, within the next two weeks, please.

That being said, we talked about vaccine and vaccine effectiveness. Certainly, we know that the vaccines that are developed are against the original variant. With new variants of concern and vaccine effectiveness waning over six months, the health minister talked briefly about three doses being a fully immunized Canadian.

Does it make sense to continue to use these old vaccines?

Ms. Kathy Thompson: The Minister of Health, Minister Duclos, did indicate last week that the primary series is going to need to include three doses, but we do know, from the vaccine science, that vaccines continue to be very effective, particularly against fighting the severity of the virus. There is also some protection offered in terms of transmission, but we do know that, unlike delta, it does wane over time. The vaccines are still very effective to prevent severe illness and death.

In terms of the vaccines, we continue, along with Dr. Tam, the public health officer, to encourage Canadians to be up to date in terms of their vaccination. It's still the best protection that's available to Canadians.

● (1715)

Mr. Stephen Ellis: I understand that. Since we know that it is really not preventing transmission, and we know that even the Prime Minister has had three doses of vaccine and has had COVID twice.... This is more of a comment than a question. It really befuddles me how you could possibly require Canadians to get a third dose of that particular vaccine. That doesn't seem sensical to me. It seems nonsensical, in fact.

Anyway, that being said, I think that's certainly something that bears looking at.

Mr. Chair, I'd like to give notice of the following motion:

> That the committee undertake a study into the domestic and international roles of the National Microbiology Lab in Winnipeg; that this study include discussions into the research being done at this facility, the safety and security measures in place, and the implications of recent international media stories regarding its scientific integrity; and that the committee report its findings and recommendations to the House.

Thank you, and I'll cede the rest of my time.

The Chair: To Ms. Goodridge or to the next person on the list...?

Mr. Stephen Ellis: To the next person on the list, sir.

The Chair: Thank you, Mr. Ellis.

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

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

Thanks to all of the representatives from the agency for attending today.

I'd like to start with Dr. Poliquin. It's good to see you again. I know you've spoken previously to this committee on updates. One of the subject areas is around genomics.

Could you update the committee on how genomics has helped us respond to the pandemic in its more recent phases, and maybe you could comment on the modelling exercises you are currently undertaking?

Dr. Guillaume Poliquin (Vice-President, National Microbiology Laboratory, Public Health Agency of Canada): Thank you, Mr. Chair.

On the question of genomics, the national microbiology lab continues to work very closely with provinces and territories under the guise of the “variant of concern” strategy. Under this initiative, we have seen a significant acceleration in the capacity to do genomics studies in Canada, going from a capacity of approximately 3,000 sequences per month in December of 2020 to 25,000 to 30,000 sequences per month currently.

Canada has become the fifth-largest contributor of sequences to the global database, with approximately 400,000 sequences coming from Canada. What that translates to in real terms has been the ability, in essence, to monitor viral evolution in close-to-real time here in Canada. Through that, we have been able to look at the arrival of the delta wave. We were able to detect the arrival of omicron within days of its arrival in Canada. We have been able to use that information, in partnership with public health authorities, to help with decision-making.

Moving forward we continue to use this capacity to monitor for the emergence of new variants. We have seen more recently the sublineages of omicron—BA.4 and BA.5, for example—and we are able to track these very closely to inform public health decision-making.

On the issue of modelling, genomics modelling and other monitoring activities work hand in hand. Through our modelling programs we have two main thrusts of work.

The first is on short-term forecasting, for which we use real data from cases, from vaccinations, and we are able to provide an estimate of the trajectory of the pandemic in the coming weeks. We supplement that with dynamic modelling, in which we are able to add new science about how SARS-CoV-2, the virus that causes COVID-19, transmits and evolves. These dynamic models give us a longer-term view of expected changes in the pandemic. Through these models, for example, we continue to look for what may come in the fall, which reinforces the need for Canadians to stay up to date with vaccination and to be mindful of their health choices as we navigate the pandemic.

● (1720)

Mr. Brendan Hanley: Thank you.

I wonder whether, on that note, you can give us any inkling of what you are anticipating. We're always looking towards the next season, whether that's the summer season of travel and gatherings or the fall return to school or the winter of being back inside. There's always another season coming. What are you seeing in terms of patterns for late summer into fall at this point?

Dr. Guillaume Poliquin: Thank you, Mr. Chair.

At this time we are seeing overall in Canada a stabilization in rates of transmission, though as Ms. Thompson indicated, we are seeing some early signs of increased activity in some regions, which we are following closely.

It is notable that we have seen, for example, an atypical flu season with higher than expected transmission rates currently. As a result we are looking forward to a fall with a potential recurrence in activity driven by people moving inside, closer contacts and the return to school, but also due to the interplay of additional viral pathogens, more traditional, making a bit of a return.

Mr. Brendan Hanley: Thanks.

Mr. Chair, do I still have time for one more question?

The Chair: Yes, indeed. You have one full minute.

Mr. Brendan Hanley: I wonder.... I forget what my question was. There are so many questions.

It's for whoever can jump in, but maybe this would be back to Ms. Evans. Just on that note, I wonder about your strategies for getting Canadians to get their doses—we know that we have a lag in third dose uptake—in anticipation of what might be coming at us in the fall.

Ms. Kathy Thompson: Mr. Chair, I'll redirect that question to Mr. Bent.

Mr. Stephen Bent (Vice-President, COVID-19 Vaccine Rollout Task Force, Public Health Agency of Canada): In terms of encouraging Canadians to take the third dose as we continue to work very closely with our provincial and territorial partners in the context of communication to Canadians, Dr. Tam is out frequently reminding Canadians of the importance of keeping their vaccinations up to date, including third doses of the COVID-19 vaccine.

Our intention is to continue to work with our provincial and territorial colleagues over the summer and into the fall, with joint planning and communications strategies and outreach to encourage Canadians to take their third dose.

The Chair: Thank you, Mr. Bent.

[*Translation*]

Mr. Garon, go ahead. You have six minutes.

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

Since the beginning of the pandemic, the Bloc Québécois has argued that decisions about vaccine mandates, restrictions at airports and the lifting of those restrictions should be made by government scientists, not politicians or the House of Commons. After all, the considerations are highly scientific.

The Minister of Transport recently announced that some airport restrictions would be lifted, so I would like to know what the experts at the Public Health Agency of Canada provided in terms of new data prompting the minister's decision.

Are some decisions rooted in science or only politics?

Ms. Kathy Thompson: Good afternoon, Mr. Chair.

As I said a few moments ago, the data and studies were carefully examined. We are also in contact with scientists all over the world and experts in Canada. We work very closely with our provincial and territorial counterparts, indigenous peoples and other partners to ascertain where the situation stands. We examine the data rigorously. We collect data in a number of ways, including waste water analysis and the collection of data at the border, vaccination rates and so forth. We also pay attention to hospitalization rates.

For example, if we look at how many people were hospitalized during the first week of May, we see that they were unvaccinated in many cases. That's why we continue to promote vaccination—

● (1725)

Mr. Jean-Denis Garon: Sorry to cut you off, but I'm quickly running out of time.

My question for you is this. Was last week's decision by the Minister of Transport based on new information or new recommendations provided by the Public Health Agency of Canada?

Did something happen prompting the Minister of Transport to take action when he did?

Ms. Kathy Thompson: The Public Health Agency of Canada regularly provides evidenced-based advice. You asked me whether the data had changed. The data have certainly changed since the vaccine mandate was introduced in the fall of last year. The situation has changed since. That's the type of information we generally provide to the government when we deliver advice. That's what we provide, in consultation with the experts—

Mr. Jean-Denis Garon: Forgive me for cutting you off.

What I gather, then, is that, on the basis of that evidence and expertise provided to the minister, the decision could have been made the week before, two weeks before, three weeks before or what have you.

I'm just trying to understand what role science played in the decision. Clearly, the restrictions were introduced a long time ago. The decision could have been made three weeks ago, four weeks ago or two weeks ago.

The Public Health Agency of Canada did not say that it was time to lift or ease airport restrictions. That's not what happened.

Ms. Kathy Thompson: The information continues to evolve. We always have studies to examine or understand and other experts to consult. The information is constantly changing. I would say that the government's decision is in line with the data we examine and the direction in which the pandemic is headed right now.

Mr. Jean-Denis Garon: Was that same decision in line with what you were seeing three weeks or five weeks earlier, or a week later?

Ms. Kathy Thompson: As I said, the data changes constantly. There are always studies in progress. It is a very dynamic field. On an ongoing basis, we analyze studies, consult experts, and gather advice. The government definitely needs time to assess the information provided to it.

Mr. Jean-Denis Garon: I understand. The minister has been less dynamic than the studies, that is for sure.

Are officials at the Public Health Agency of Canada still very worried that variants that have developed elsewhere, in places where fewer vaccines are available or the vaccination rate is low, could show up in Canada and cause damage, new waves, and new complications?

Ms. Kathy Thompson: We are of course studying the new variants very carefully. We have implemented border measures in part because of that.

I will let Dr. Poliquin speak about the new variants.

Dr. Guillaume Poliquin: Thank you, Mr. Chair.

With regard to the variants, we note that SARS-CoV-2, the virus that causes COVID-19, continues to evolve. It is not really possible to predict how it will evolve in the short and long term.

We have however developed our genomics capacity and, together with our science experts and academics, we have a network to study the variants, to understand their potential impact as quickly as possible and, to advise our public health colleagues on the measures to be taken or planned.

● (1730)

The Chair: Thank you, Dr. Poliquin and Mr. Garon.

[*English*]

We'll have Mr. Bachrach, please, for six minutes.

Mr. Taylor Bachrach: Thank you, Mr. Chair.

I'd like to start by thanking all of our witnesses for their work over the past years in what have been some pretty extraordinary circumstances for our country.

I'd like to pick up where my colleague, Mr. Garon, left off on talking about the travel mandates. This issue has affected a lot of people in the riding I represent. I know that several of those measures have since been lifted, but at the same time, people are frustrated by the lack of explanation as to what the criteria were and how the decision-making process worked.

I'd like to start by going back to earlier in the pandemic when the vaccine became widely available and the government chose to put the vaccine mandate for domestic travel in place. These were rules that prevented unvaccinated people from travelling on airplanes and trains within the country.

Ms. Thompson, could you speak to how those rules were designed to work? I'm trying to get at the heart of this. What is the mechanism or what was the specific risk that was being managed when those rules were first brought in?

Ms. Kathy Thompson: Thank you, Mr. Chairman.

With respect to vaccine mandates, the national and also global epidemiological situation was very different from what we have today. Modelling showed the possibility of strong resurgence. We were in between alpha and delta variants.

While we did have a high vaccination rate even back then, there were pockets and subpopulations that were not vaccinated, including younger individuals. At that time, the government made the decision to increase the uptake of vaccines with the vaccine mandate to offer some additional protection and ensure that there was additional protection through the vaccine mandates at the time, particularly with respect to travel and small conveyances.

Mr. Taylor Bachrach: Can I take it, from your response, Ms. Thompson, that the key objective of the vaccine mandate for domestic travel was to encourage Canadians to get vaccinated, as opposed to preventing transmission in a travel environment?

Ms. Kathy Thompson: It was certainly to encourage vaccination, but at the time we were also looking to protect Canadians from COVID-19, severe illness and hospitalization. There was very strong evidence to show that the vaccines were very effective for all of those risks that we were facing at the time.

Mr. Taylor Bachrach: Can I take from your response that reducing transmission in a travel environment, that is, on an airplane or on a train, was not one of the original objectives of the vaccine mandate for travel?

Ms. Kathy Thompson: The objective of all of the measures that are in place is really to protect Canadians and the health of Canadians, and, in particular, people who are vulnerable and immunocompromised. That is the first objective in all of these measures in addition to promoting vaccines, because we had very good evidence that vaccines were very effective, particularly against alpha and delta, and because we knew that there were some regions of the country and some populations where we didn't have the protection that we were looking for and that was necessary.

Mr. Taylor Bachrach: I have to say, Ms. Thompson, I'm frustrated at the generality of your responses. I think what Canadians are looking for is a very specific explanation of how these rules work, and that is what we've been failing to get for so many months now. It's incredibly frustrating.

I'm a layperson. I'm not an epidemiologist. I'm not a health professional of any kind. I studied glaciers in university, but I feel like I should be able to understand what we're trying to do with these rules, and the explanation is not making sense. Can you try again to tell us how keeping people off of airplanes and off of trains very specifically protected them or protected the people around them?

I'm failing to see it. I thought I understood the mechanism, which was, if you are unvaccinated and carrying the virus, there is less chance of you transmitting it to people around you. I think that's how most Canadians understood those rules to work. In addition, there is this piece around trying to convince people to get vaccinated. However, the piece around transmission is particularly interesting because of what we've been told about how the virus evolved and the changing impact on transmission.

I'm looking for something here, because I'm not clear on how these rules were supposed to work.

● (1735)

Ms. Kathy Thompson: Thank you, Mr. Chair.

Certainly we want to be as clear as we can with Canadians. Dr. Tam always makes sure, during her briefings, that she communicates to Canadians what the situation is in Canada, as well as do other departments that have imposed measures, whether it's Transport Canada for a domestic vaccine for federally regulated sectors, or the Treasury Board for the public service.

With respect to the federally regulated sector, as I indicated, there was strong evidence from international and domestic sources to conclude that vaccines were very effective at preventing infection and, consequently, transmission of the COVID-19 variants that were circulating at the time, namely alpha and delta, and protecting against severe illness and hospitalization and death. That is one of the reasons why we were indicating that the evidence was there to support a vaccine mandate at the time.

The Chair: Thank you, Ms. Thompson.

You're past time, Mr. Bachrach, but you will get another turn.

Ms. Goodridge, go ahead, please, for five minutes.

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

Ms. Thompson, my question is a little bit along the same vein. Earlier in your testimony, you were talking about how, under alpha and delta, in terms of the transmission of the virus, there were studies to show that it was less so with those who were vaccinated, but then you said that things changed with omicron.

As we know, omicron became the variant that was probably dominate in and around December and January. Was the interest in keeping the federal vaccine mandates for travel in place from January onwards mostly about trying to get more people vaccinated?

Ms. Kathy Thompson: We were facing a very strong resurgence. The science was still emerging with respect to omicron. Although it happens very quickly in pandemic time, it still takes a while for the pandemic science to emerge on the effectiveness of vaccines against certain variants and to understand how a particular variant is presenting.

In terms of the omicron surge, there was evidence to support that we were in a surge—it was happening not only in Canada but globally as well—and that we should be maintaining efforts to encourage individuals to be as protected as possible from the vaccination perspective, as well as through personal protection measures—

Mrs. Laila Goodridge: All right. Thanks, Ms. Thompson.

Unfortunately, we don't have much time, so my question becomes.... It's relatively clear.

At a certain point, it became pretty clear to Canadians and to science around the world that the vaccines did not change whether people could get or transmit the omicron variant. Our Prime Minister has now been infected with the omicron variant for the second time in about six months.

Was our keeping vaccine mandates in place in Canada for federal travel done in order to encourage more people to get vaccinated? A simple yes or no would be great.

● (1740)

Ms. Kathy Thompson: It was, as I indicated, to ensure that Canadians had the protection during this latest wave of COVID.

We know that the effectiveness was demonstrated through studies to still be present, even during the omicron wave. Yes, it wanes over time—probably more quickly than with delta—but it still prevents transmission.

I'll see if Mr. Bent wants to add anything.

Mr. Stephen Bent: Thank you.

I would add that, as it was stated earlier, two doses of vaccine still offer considerable protection in terms of severe disease. Fundamentally, in the context of our objective of reducing hospitalizations, severe illness and death, two doses perform well.

We know, as well, that three doses perform better, and that's why we're encouraging Canadians to get their booster.

Mrs. Laila Goodridge: Thank you.

As a follow-up, was keeping federal mandates and restrictions a way of encouraging more Canadians to get vaccinated—yes or no?

Mr. Stephen Bent: I would offer that we've consistently communicated to Canadians that vaccination is one of the most important measures to protect themselves and to protect others.

Mrs. Laila Goodridge: One of the complicated pieces around all of these vaccine mandates is that there has been so much politicization. A lot of Canadians have lost trust. They don't understand what is different today compared with yesterday in terms of being able to get on a plane. What magically changed so that now, today, it is safe, whereas yesterday it was unsafe?

You have a whole amount of fear. There hasn't been a lot of communication with the general public, who perhaps thought that those mandates were in place for some specific reason. We don't have any answers about metrics for why these mandates were kept in place for as long as they were.

We didn't follow any of our G7 partners. While travel and so much is a global phenomenon, Canada stayed on its own, keeping a very different.... We were out of step with our U.S. partners. We were out of step with our European partners. We were out of step with just about everyone in the world. Now, Canadians who believed that Canada was doing this...they're confused as to how, somehow, it's now safe.

What would you tell those Canadians about why there was an overnight change in these mandates and restrictions?

Ms. Kathy Thompson: I would assure Canadians that this is based on the data and the engagement with experts. As I said earlier, we are constantly engaging with experts on the world stage and nationally. We're engaging with provinces and territories—

Mrs. Laila Goodridge: Ms. Thompson, what data and which experts are you referring to?

The Chair: That's your time. Thank you, Ms. Goodridge.

We'll have Ms. Shanahan for five minutes.

Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.): Thank you, Chair.

I too would like to thank the witnesses for being here today.

This is my first appearance at the health committee. I'd like to ask questions that I know are top of mind for residents in my riding.

First of all, there's monkeypox. Over the past couple of weeks, we've seen an increase in cases. I know that it's very concerning in Montreal. As well, in Quebec we've seen some cases on the rise. Can you tell us what the agency is doing to actively work with public health partners to investigate reports of suspect cases of monkeypox in Canada?

Ms. Kathy Thompson: Thank you, Mr. Chair, for the question. I will ask Dr. Poliquin to respond to that.

Dr. Guillaume Poliquin: Thank you, Mr. Chair.

I would like to reassure Canadians that the Public Health Agency of Canada is taking the monkeypox situation extremely seriously. We have had a number of concrete actions with respect to monkeypox.

First, following the international reports from the U.K. on May 17, the national microbiology laboratory relaxed instantly its criteria for testing to remove the need for travel to make sure that all Canadians were able to access the testing they needed. In addition, there was an emergency meeting of the Canadian Public Health Laboratory Network on May 19, prior to the confirmation of the first two Canadian cases, to ensure there was readiness on the laboratory side.

In addition, we have been working hand in glove with our provincial and territorial partners to provide guidance. Within eight days of the first cases being detected in Canada, we issued guidance on the prevention of infection, as well as recommendations to prevent spread. Through the national emergency stockpile, we have made available vaccinations—third-generation vaccines intended for smallpox but also with an indication for monkeypox—for a targeted vaccination campaign to help reach those most at risk.

In addition, ongoing communication has been occurring both through provincial health authorities and through a number of community organizations in order to ensure that messaging is out but respectful, so that we do not enter into an area of engendering unnecessary stigma. The Public Health Agency stands firmly against stigma generation. As such, our communications strategy has been very mindful both to reassure Canadians and to also get the message out to those who need to hear it.

● (1745)

Mrs. Brenda Shanahan: My constituents are also worried about long COVID. I understand that there have been some studies recently about the syndrome's origins, the risk factors and the treatments. Can you tell us, Ms. Thompson or anyone on the team there, what steps the Public Health Agency of Canada is taking to learn more about this post-COVID condition? In terms of the factor of being fully vaccinated, how does that impact subsequent long COVID?

Ms. Kathy Thompson: Thank you, Mr. Chairman. Maybe I'll take those in that order.

We at the agency are working to monitor and build an evidence base to inform public health decision-making with respect to post-COVID or long COVID. We are working closely with a number of partners to make sure that we build that evidence base, starting with Statistics Canada. We are going to be launching a population-based survey on post-COVID conditions to look at and identify some evidence gaps and try to estimate what percentage of the Canadian population is currently experiencing post-COVID conditions. Then we would propose to do a follow-up survey, a second survey with Stats Canada.

We're also working with the Canadian Institutes for Health Research and with the Canadian Paediatric Society to look at some options for studies looking at the impact on children. I think we'll be in a position later this fall to be able to detail the full scope of the work that's under way. We're also monitoring a number of systemic reviews that are happening worldwide.

In terms of the evidence and how it relates to vaccination, the evidence review by the agency found that the prevalence of post-COVID-19 conditions is approximately 30% to 40% in individuals who were not hospitalized for their initial COVID infection. The current evidence suggests that the prevalence is even higher for those who were hospitalized during the acute phase compared to those who weren't. There is a strong indication that vaccination helps to prevent long-term or post-COVID conditions.

The Chair: Thank you, Ms. Thompson and Ms. Shanahan.

[*Translation*]

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

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

I have another question for Ms. Thompson about long COVID-19. We were talking about it earlier.

What is the situation in Quebec. You are somewhat familiar with the epidemiology of long COVID-19 symptoms. At this time, how many people have symptoms that last more than six months and that could be incapacitating? Do you have an answer to that?

● (1750)

Ms. Kathy Thompson: Thank you, Mr. Chair.

That is part of the challenge we are facing. We do not have exact figures, but I will check with Dr. Poliquin for further information. In any case, I know it is difficult to estimate the number of such cases.

Dr. Guillaume Poliquin: We are in the process of refining the definition or defining criteria of the post-COVID-19 syndrome.

We do not have any specific figures right now, but with our partners we are refining the definition and conducting surveys and studies to better determine the prevalence of the syndrome.

Mr. Jean-Denis Garon: From what you said, I understand that we have some information about the symptoms, but the clinical definition for diagnostic purposes has not been finalized. That is consistent with what the experts told us at our meeting last week.

For your part, are you worried about the impact that long COVID-19 could have on the work force in the longer term, specifically in the health care system? We know that workers may have been exposed to the virus before they were vaccinated, and that that is a risk. Many of our health care workers were exposed to the virus early in the pandemic.

Does that worry you?

Ms. Kathy Thompson: Would you like to answer, Dr. Poliquin?

Dr. Guillaume Poliquin: We do of course take the post-COVID syndrome very seriously. We are investing in this area and working with partners to conduct studies on the syndrome. It is too early to say exactly what the long-term effects will be. Yet a study published a few days ago indicates that the risk of developing long COVID-19 is much lower after being infected with the Omicron variant than the Delta variant. So there are a number of processes, and we are studying various permutations of the problem in order to address it.

The Chair: Thank you, Dr. Poliquin and Mr. Garon.

[*English*]

The last round of questions will come from Mr. Bachrach for two and a half minutes, please.

Mr. Taylor Bachrach: Thank you, Mr. Chair.

Ms. Thompson, continuing with questions regarding the vaccination mandate for domestic travel, there are two government decisions that are of particular interest. The first was the decision on June 1 to extend the travel mandate, and the second was the decision two weeks later, on June 14, to lift the travel mandate.

Were both of those government decisions consistent with advice from your department?

Ms. Kathy Thompson: Thank you, Mr. Chair.

Of course, I can't speak specifically to advice provided to the government and to ministers as part of the cabinet process, but I can say, as I've stated before, that the science and the assessment of the Public Health Agency supported the decision to lift the vaccine mandate.

As I said earlier, we appreciate that.... It's also required on the part of the government to be able to appreciate and consider the information that they receive from different sources, so the—

Mr. Taylor Bachrach: Ms. Thompson, did the evidence that your department collects also support the decision on June 1 to extend the mandate?

You spoke of the lifting of the mandate. Did the evidence you were collecting and the science you were reviewing also support extending the mandate on June 1?

Ms. Kathy Thompson: As I said, we are constantly reviewing the studies and the evidence, and the information that was provided to the government is consistent with what we were seeing at the time when the mandates were being lifted. The advice that was provided was constantly evolving—

Mr. Taylor Bachrach: We talked about the lifting already. We're talking about the extension of the mandates now.

I'm just frustrated because I'm asking different questions, but you're giving the same answer to every question. What I want to know is whether the information PHAC was looking at was supportive of extending the travel mandates on June 1.

● (1755)

The Chair: Ms. Thompson, that was the last question.

You won't be interrupted. Take as much time as you need to answer it.

Ms. Kathy Thompson: Thank you, Mr. Chair.

I don't mean to repeat the information, but I can only share with you that the evidence fully supported the decision to implement the mandates. With respect to the timing, as I said, the evidence is constantly evolving. New studies are coming out. Dr. Poliquin was talking a moment ago about a study a few days ago on long COVID.

The information is very fluid in this pandemic that we are all living in, and we are constantly considering and reconsidering the data.

What I can say is that at the time when the government lifted the mandate, the public health evidence supported the lifting of the mandate.

The Chair: Thank you, Ms. Thompson and Mr. Bachrach.

To all of our witnesses from the Public Health Agency of Canada, we appreciate your being with us. We appreciate your patience and your professionalism. I don't know that the work of the Public Health Agency of Canada has ever been more visible than in recent times. We certainly appreciate your being here with us and so patiently and professionally handling the questions that were posed to you today.

I wish you all a good evening.

Colleagues, I have a very pleasant task for you before we wrap. Today is the last meeting for our analyst Sonya Norris. Sonya will be retiring in exactly nine days.

I'll say little bit about Sonya. She earned a master's in biochemistry and spent almost a decade in clinical research. She started with the Library of Parliament 24 years ago, in 1998, and was assigned to this committee. Her first study on this committee was on natural health products. Some of the other studies she has penned include organ donation and transplantation, and assisted human reproduction.

From 2012 to 2019, she worked in the other place—on the social affairs, science and technology committee. She wrote a number of reports, including a series on pharmaceuticals, as well as healthy eating, dementia and robotics. In all, she has drafted about 26 committee reports.

I can tell you that, as the chair, I get to meet weekly with the analysts from the Library of Parliament and the clerk to plan the business of the meetings. Sonya has always been professional, pleasant and good-humoured to deal with. I'm sure that you join me in wishing her a happy and productive retirement.

Some hon. members: Hear, hear!

The Chair: To Sonya's left is Kelly Farrah. Kelly is going to be attempting to fill the large shoes left by Sonya. She certainly has the credentials, including a Master of Science in epidemiology, as well as a Master of Library and Information Science, and 15 years of experience working in the field of health technology assessment. Prior to joining the Library of Parliament, she was a pharmaceutical review manager with Canada's Drug and Health Technology Agency.

As I read it, she sounds very much like a witness as opposed to somebody who will be on our side.

She has worked with PHAC as a research analyst and with the NACI secretariat. Areas of expertise include clinical and economic evaluation of drugs, vaccines and medical devices, and methods for knowledge synthesis in the health sciences. Please join me in welcoming Kelly to our committee as the analyst.

Some hon. members: Hear, hear!

An hon. member: She only has 24 years to go.

Some hon. members: Oh, oh!

The Chair: Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

● (1800)

The Chair: We are adjourned. Thank you.