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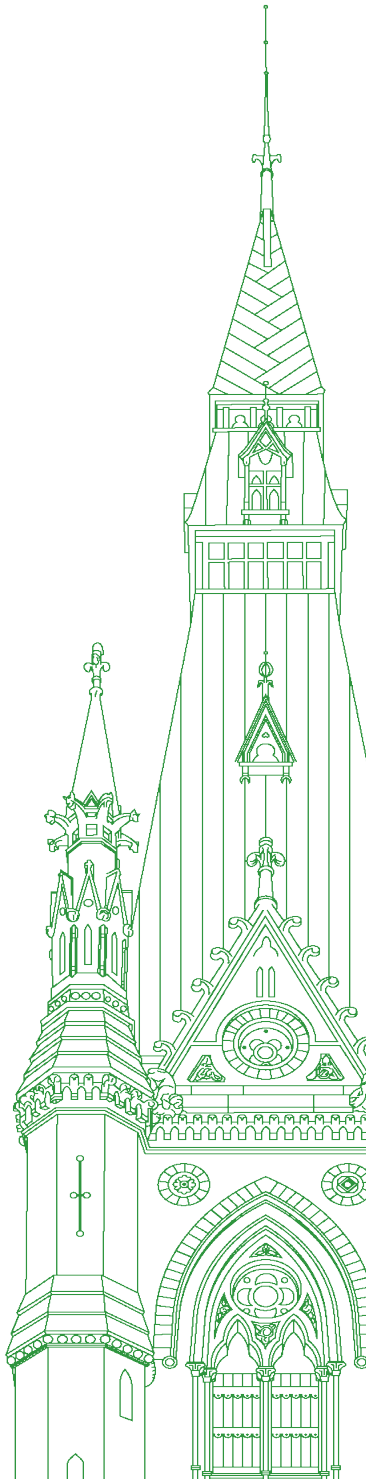

Chair: Mr. Ron McKinnon

Standing Committee on Health

Tuesday, July 7, 2020

● (1100)

[*English*]

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

Welcome, everyone, to meeting number 32 of the House of Commons Standing Committee on Health. Pursuant to the order of reference of May 26, 2020, the committee is resuming its briefing on the Canadian response to the outbreak of the coronavirus.

To ensure an orderly meeting, I would like to outline a few rules to follow. Interpretation in this video conference will work very much like in a regular committee meeting. You have the choice, at the bottom of your screen, of floor, English or French.

As you're speaking, if you plan to alternate from one language to the other, you will also need to switch the interpretation channel so it aligns with the language you're speaking. You may also want to allow for a short pause when switching languages. Before speaking, please wait until you are recognized. When you're ready to speak, you can click on the microphone icon to activate your mike. As a reminder, all comments by members and witnesses should be addressed through the chair. When you're not speaking, your mike should be on mute.

Please note that I will be very strict on time today, given the fact that we have to move in camera later.

I would now like to welcome our first panel of witnesses. Appearing as an individual is Dr. Arjumand Siddiqi, associate professor, Dalla Lana School of Public Health at the University of Toronto. From the Wellesley Institute, we have Dr. Kwame McKenzie, chief executive officer. Welcome to you both.

We'll start with Dr. Siddiqi.

Please go ahead. You have 10 minutes.

Dr. Arjumand Siddiqi (Associate Professor, Dalla Lana School of Public Health, University of Toronto, As an Individual): Thank you very much.

Thanks for the opportunity to speak with you today. I come here with a deep sense of gratitude for my parents and all the others who have made this possible, a strong sense of responsibility that comes with my position as a scientist, and a burning desire for my country, Canada, to do right by all its people.

I am associate professor and division head of epidemiology at the University of Toronto's Dalla Lana School of Public Health, where I hold the Canada research chair in population health equity. I am a social epidemiologist and I study health inequities and the social determinants of health, with a particular emphasis on the social policies and other societal factors that are ultimately responsible for giving everyone a chance at health.

Since the gravity of the COVID-19 pandemic became apparent, Canadian officials have assured us that we are all in this together. Indeed, daily briefings have impressed upon us a sense that the overall number of cases and deaths in our cities and provinces is a good proxy for how worried each of us should be about our risk for COVID-19, or how confident we can feel about returning to some of our pre-COVID activities.

However, in late May came a stunning report—if entirely predictable by those of us who study these things and those of us who live them—which suggested that the city-wide numbers we were receiving in briefings from Toronto Public Health concealed enormous differences in the burden and risk of COVID-19 across Toronto neighbourhoods. A similar phenomenon has also been noted for Montreal. Toronto's northwest neighbourhoods, which are heavily black and working class—areas such as Jane and Finch, Rexdale, and Weston—have been hardest hit. The latest figures suggest case rates in excess of 450 per 100,000 in those neighbourhoods.

Meanwhile the downtown core and central areas, which are heavily white and wealthy, have barely been touched. For example, Yonge and Eglinton has a case rate of 14, and Beaches has 15 cases per 100,000.

This means that the overall figures for Toronto have been obfuscating a more than 40 times greater risk of COVID-19 between Toronto's black working-class neighbourhoods compared to its white rich neighbourhoods. While the coronavirus itself does not discriminate, our society unfortunately does. Canada is structured in a way that has placed the burden of risk for COVID-19 squarely on the shoulders and in the lungs of the black working class and to a lesser extent other non-white working-class people.

The spatial distribution of COVID-19 across Toronto neighbourhoods is less a reflection of neighbourhoods themselves being risky, and more a reflection of the fact that the black people in Toronto tend to live in a small set of neighbourhoods, the ones in which they can afford housing and avoid housing discrimination, while rich whites live in a set of neighbourhoods that offer the most convenience and comfort.

Why are we using neighbourhood data if neighbourhoods aren't really the heart of the matter? Unfortunately, those are the best data we have available for understanding the social characteristics—race, income and so on—that carry risk for ill health, including COVID-19. We are effectively using neighbourhood characteristics as proxy for individual characteristics and because Toronto is so starkly and structurally segregated, and people are so clustered by race and income into various neighbourhoods, for now this is sadly a reasonable proxy to make, even if it's imperfect.

My initial plea to you, then, is to think long and hard about better collection of race and socio-economic data whenever we routinely collect data in Canada on health and other matters in our health care system, our schools, the labour market and so on. This is critical for understanding our country and holding our government to account for racial inequity in the same way gender data is used to tackle gender inequity.

If not the neighbourhood itself, what then is creating greater risk for black working-class people? Because the data is lacking, it's difficult to be unequivocal about the answers to this question; however, there is a very large and robust body of research from other countries on which we can draw, as well as indirect evidence from Canada.

The strongest explanation—though there are others I am happy to discuss—is that essential service jobs that have continued during the stay-at-home orders are largely occupied by black and other non-white working class people.

● (1105)

They are our long-term care and personal support workers. They clean our hospitals and shuttle patients around. They stock our grocery stores, drive our delivery trucks and work in the fields to harvest our produce. Conversely, jobs that afford the opportunity to stay home—along with the peace of mind about one's job security and income—are largely occupied by wealthy white people. They are our bankers and financiers, lawyers, and, yes, our professors.

The obvious consequence is that jobs occupied disproportionately by black and other non-white Canadians force them into environments that carry high risk for exposure to COVID-19, while jobs disproportionately occupied by wealthier whites offer protection from exposure to COVID-19.

At the end of the day, knowing that low-wage black and other non-white workers have little choice, we are sacrificing them so that the rest of us can cocoon in the comfort of our homes and wait this thing out.

This racial job sorting is clearly not a function of chance or choice. It is the outcome of a confluence of Canadian policies and systems in which racial discrimination is so persistent and pervasive that it cannot be regarded as an isolated incident or even as an add-on to understanding our system of institutions and policies. Rather, it is an integral part of the systems themselves. Various scholars have used terms such as systemic racism, structural racism, institutional racism and racial capitalism to refer to this deep embedding of racism in our societal policies and systems.

Beyond jobs, systemic racism is more generally the major factor that determines who has economic security, wealth and income. It can be even more powerful than gender in this respect. In turn, economic security is the main predictor of health because it facilitates the everyday living conditions that are foundational for health: jobs that don't expose us to health risks, plenty of money to pay the bills, comfortable housing, lovely neighbourhoods, good food and low stress.

And this is true whether we're talking about COVID-19 or cardiovascular disease, depression or diabetes. At the end of the day, you need economic security to have a good chance at living a healthy life, and that is precisely why economic security is so crucial and it is precisely why racial and health inequalities are so pervasive and so persistent. Racism limits black working-class people's access to wealth, jobs, income and so on. As horrible as it is that we have racial inequities in COVID-19, this is really just another manifestation of a deeply entrenched system of racial inequity.

So it's the root cause—systemic racism—that we really need to fix in order to address COVID-19 inequities. In what follows I will outline what the science tells us are our best options for doing so.

The first is to deal forcefully with racial wealth inequity, inequity in stocks of money and assets.

Economists such as Miles Corak in Canada and William Darity Junior and Darrick Hamilton in the United States have made a jarring discovery about wealth inequity which, as I will explain, is arguably even more critical than income inequality. It turns out that the largest source of racial wealth inequity is not racial differences in education or even in jobs and income. Those things matter but they are the consequences, not the causes of racial wealth inequity.

The biggest source of wealth inequity is what economists refer to as intergenerational transfers and what the rest of us would call gifts from Mom and Dad and Grandma and Grandpa. That's right: the white wealth advantage is not an earned advantage. Gifts are what allow whites to pay for advancing their education and thus income, and what allow them to put down payments on homes early in life.

This is unfair for many reasons, perhaps the greatest of which is the historic injustices that have allowed whites but not others to accumulate wealth over generations.

So it is these wealth transfers that create opportunity for income, rather than income creating opportunity for wealth. That means that black Canadians have already fallen behind at birth. This is unacceptable, and Canada must consider, as the United States is doing, a system of baby bonds or something similar in which young children from black and other groups that have historically faced disadvantage are provided a sum that matures as the child ages and that in adulthood can be used in the same way that family gifts have been used by rich white families. Economists have even calculated how long such a policy would take to create wealth equality.

In addition to resolving wealth inequity, we do need to address income security for every Canadian. We need to design a labour market in which every job is a high-quality job.

● (1110)

We need to ensure the wages, benefits and working conditions of all jobs meet a high minimum standard and that employment discrimination is more rigorously penalized.

We have strong randomized trial data that tell us a very disheartening tale of racial discrimination in the labour market that cannot be accounted for by differences in foreign degrees or lack of Canadian job experience.

We have to stop taking comfort in the fact that people are somehow managing to survive and create the conditions to let them thrive. There are countless examples we can take of ways to implement this. For example, a universal job guarantee would put an end to involuntary unemployment and create good jobs to do important work sorely needed by Canada. It would also put pressure on the private sector to compete on wages and job conditions.

Finally, we must universalize access to basic services that create high quality of life: child care, education, health and pharmacare more broadly defined, elder care, and so on. We can't limit opportunities based on race and economic position any longer. It's so unjust and so unbecoming of a country with so much to offer.

There you have it. There's no half-hearted way out for resolving COVID-19 inequities. Even if we developed band-aid policies, we'd be right back here talking about this or another racial health inequity soon, because that's how it works. Without resolving the fundamental structural issues of systemic racism and its impact on economic security, nothing ever changes. That's simply not fair for any Canadian to be subjected to.

While the policy solutions I've laid out are bold, they are very doable. Many scholars have highlighted how these policies can be designed and paid for. It's our responsibility—

The Chair: Doctor, pardon me, if you could wrap up, please.

Dr. Arjumand Siddiqi: Sure.

It's our responsibility to do better by all our people, and I certainly hope we do so.

Thank you.

The Chair: Thank you, Doctor.

We go now to Dr. McKenzie for 10 minutes.

Dr. Kwame McKenzie (Chief Executive Officer, Wellesley Institute): Mr. Chair and honourable members, thank you for inviting me to speak to the standing committee.

I am a physician and also the CEO of Wellesley Institute, a think tank that aims to improve health and health equity through research and policy development focused on the social determinants of health. This morning you should have been given the executive summary of the briefing note we submitted to the standing committee. The executive summary gives more detail on the recommendations I am making today. The full briefing note goes into background and gives references for my comments.

I'd especially like to thank Erica Pereira, the procedural clerk, for getting the executive summary translated so quickly.

Survival for those on the *Titanic* over a century ago was directly related to their social status: 60% of those in first class lived, while 42% of those in second class and only 24% of those in third class lived. The *Titanic*'s escape plan was the same for everyone, but third-class passengers were in lower internal berths and had difficulty getting to the lifeboats. The huge death toll was because there was not an adequate plan for them, though they were the passengers most in need.

Fast-forward 108 years to Canada's COVID response. This has actually been very good. We've done really well. But like the *Titanic*, we have not developed an adequate plan for our highest-risk populations, such as people living in congregate settings, those with lower incomes, and of course our racialized populations. Our initial response was focused on flattening the curve, not on who was under the curve. If we'd focused on both, we would have had a better response and we'd have saved thousands of lives.

We now need four groups of actions to ensure that our current and future responses to pandemics are equitable and better. First, we need legislation that ensures that our public health responses, our health response and our social policy responses produce equitable outcomes. Second, we need equity-based federal and provincial COVID-19 health and public health plans. Third, we need equity-based social policy and recovery plans that ensure that the most hard-hit populations are served properly. Last, we need data streams, research and capacity building to ensure that we have good socio-demographic, race and ethnicity information on which to build and monitor public health, health and social policy interventions. I'll go through each of those in a little bit more detail.

Recommendation one is for legislation. We've actually seen racial disparities in infection rates and deaths in previous pandemics. During the H1N1 pandemic in Ontario, the Southeast Asian population was three times more likely to be infected, the South Asian population six times more likely to be infected, and the black population 10 times more likely to be infected than anybody else. Despite this, we did not change our systems to collect socio-demographic data. We did not do research or sit with communities to try to find out why the disparities exist. We went into COVID-19 without the surveillance systems or knowledge that would help us identify and deal with racialized health disparities. Then we set up a *Titanic* response—a one-size-fits-all, colour- and culture-blind pandemic plan that was predictably going to lead to health inequities. Some have argued that this was negligent. I just say that it shouldn't be legal. We have legislation for things we care about. We do not leave them to the largesse of professionals, public servants or politicians. If we want public services to produce equitable responses, we should enshrine this in enforceable law.

Recommendation two is for equity-based federal and provincial COVID-19 health plans. We would have a fairer response if we took a health equity approach to what is left of the first wave, to the second wave and to the recovery. A health equity approach aims to decrease avoidable disparities among groups. It ensures that people with similar needs get the same pandemic response and people with greater needs get a bigger response.

● (1115)

There are lots of evidence-based tools out there such as health equity impact assessments, which could be used to build these sorts of responses, and they have been shown to be effective in public health in Canada. But when we build equitable plans we also have to work with communities to develop strategies that allow them to protect themselves from COVID-19.

Recommendation three is saying let's have those equitable plans, but also let's link to what Dr. Siddiqi was talking about, because health equity recognizes that the risk of illness and the ability to recover are not just linked to health interventions, but also to the social determinants of health.

The Canadian Medical Association has calculated that 85% of our risk of illness is linked to these social determinants such as income, housing, education, racism and access to health care. This offers significant policy opportunities for improving health, because many health disparities are avoidable.

COVID-19 harms health in four ways: through the disease itself, through the side effects of public health response, through health care changes such as cancelled operations, and by the downturn in the economy. These interact with the social determinants of health so that some parts of our population are harder hit than others. As Dr. Siddiqi said, Canada's black populations have been hardest hit by COVID-19.

Our pandemic social policies and recovery plan need to be developed so they decrease inequality and reach the hardest-hit people. Decreasing differential risk linked to social determinants of health is an important intervention here, and probably one of the most important interventions. The idea of a focused recovery plan for the hardest-hit populations would not only improve our response, but would make those populations more resilient to future pandemics and future waves.

The last is numbers and data. I'm a researcher and I'm in a think tank. We think numbers and data are vital, and they have been vital in the fight against COVID. We've relied on the number of cases, the number of deaths, and suddenly everybody understands what an R number is, which I never thought would happen in my lifetime.

Numbers are also useful in indicating whether our interventions are working for everyone, and to do this we need disaggregated data. We desperately need better data streams on race and ethnicity and other social determinants of health for COVID-19, and for health in general. We need similar data, of course, for social policy. These data need to be good quality and there needs to be good data governance and accountability. Communities increasingly want a say in and control of the use of their data.

Wellesley Institute recommends that Canada collect individual-level associated demographic data for COVID-19, including race and ethnicity, and that Canada urgently undertake innovative analysis using existing data to get as accurate a picture of disparities as possible. Also recommended is that Canada develop a strategy for ongoing socio-demographic data collection for health and social policy, including race and ethnicity.

But data is not an end in itself. Data has to be linked to meaningful strategies to decrease disparities. This will mean engagement with communities, research and action to develop equitable public health and social policy interventions.

In conclusion, public health is the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society. Health equity interventions and the concept of social determinants of health are important tools in helping us to organize the best pandemic response. They are also a sound basis for health and social policy.

● (1120)

The one-size-fits-all strategy actually led to a huge death toll on the *Titanic*, and so far it's led to a significantly increased death toll for some parts of the Canadian population during the COVID-19 pandemic.

If we want a COVID-19 response and health systems to be more fitting for the 21st century, we need legislation that ensures equity; we need equity-based COVID-19 pandemic plans; we need social policy and recovery plans focused on decreasing current inequities and we need data streams and research that allow us to properly identify risk groups, build appropriate interventions and monitor their impact.

If we can put all of these in place, we'll move Canada's good response to being a great response, and we'll save lives.

Thank you very much.

● (1125)

The Chair: Thank you, Doctor.

We'll start our questions. We will do two rounds of questions and we will start the first round with Mr. Jeneroux.

Mr. Jeneroux, please go ahead. You have six minutes.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair.

Thank you to the witnesses for being here today. It is fascinating testimony indeed.

Dr. Siddiqi, just to follow up on something you said, have you had success in obtaining some of the demographic information that you've talked about outside of just the greater Toronto area? More specifically, is there data on the location of cases available across Canada?

I know, for instance, that Ontario has a map that highlights COVID clusters, but is there anything being provided at the federal level that would be helpful to you?

Dr. Arjumand Siddiqi: There are two parts to it, and I might defer to Dr. McKenzie to help me out with his understanding of what data are available.

There are actually two issues. The short answer is no, I haven't, but there are two reasons why. One is that it's unclear to me the extent to which the data that are available—which tend to be area-level socio-demographics that we collect from the census, so when the census is done we get a sense of how Canadians are distributed across socio-demographic factors. We don't release that information, at least at all readily, at the individual level, but we do allow people to access area-level information. That needs to be linked right now to COVID cases, which is how we figured out what was happening in Ontario, without understanding what individuals look like. What I'm not sure of is whether other provinces have done that to the same extent, but it would be doable.

The second part of that is that it's worth stating that I, personally, have not accessed any of this data because we have a system in Canada in which agencies and institutions hold the data and they decide who gets to access it. That's very unlike, for example, the situation in the United States where we can download these things off the Internet. There is a lot of research activity that's happened there, a lot of information and analyses that have been generated about that society precisely because independent scientists can readily ask these questions of the data rather than relying on agencies and institutions that have a lot of barriers for doing so.

Mr. Matt Jeneroux: Great. Thank you.

I interpret from that answer that it would be helpful to have some of that national perspective data. Perhaps that's one recommendation we can give to the department.

Mr. Chair, seeing as this might be one of our last meetings, I do want to use my time to proceed with moving four motions. I'm certainly happy to read them. I have the four in front of me here, but I will ask you if you'd like me to read through each one. I know we all have them in front of us, but I would like to move those four motions at this time.

The Chair: Thank you, Mr. Jeneroux.

You have the floor, so you can, in fact, move the motions. If you do move them, you need to move them one at a time, and we can deal with them one at a time.

I should also advise that we are going to an in camera session after our second panel, so perhaps you might wish to choose to move them there instead.

Mr. Matt Jeneroux: I appreciate your advice, Mr. Chair. I'll proceed with moving the first motion. I'll start with the longest motion. If you want me to dispense at any time, please let me know.

I move that:

> Pursuant to Standing Order 108(1)(a), the committee send for the following documents to be provided by the government by Monday, August 3, 2020 and that the documents be published publicly on the committee's website by Monday, August 10, 2020:
>
> All documents, briefing notes, memorandums and emails, regarding the emerging evidence that altered the government's advice on the wearing of masks referenced by Dr. Theresa Tam, Chief Public health Officer, at her appearance before the Standing Committee on Health on Tuesday, May 19, 2020, including all documents, briefing notes, memorandums and emails to/from/between Health Canada, the Public Health Agency of Canada, the Minister of Health's office, The Privy Council and the Prime Ministers office regarding the management of the National Emergency Strategic Stockpile from 2015-2020, including supply inventory broken down by number and all updates sent to the government and the Government of Canada's contracts for PPE since January 2020.

● (1130)

The Chair: Thank you, Mr. Jeneroux.

Is there any discussion? Please signal your wish to speak by raising your hand.

Dr. Jaczek, please go ahead.

Ms. Helena Jaczek (Markham—Stouffville, Lib.): Thank you very much, Chair.

I'm wondering if Mr. Jeneroux would consider possibly amending part of his motion, in particular the reference to emails. As you will no doubt recall, when we did pass a couple of motions previously, I think it was the decision of the committee that it would not in fact be particularly helpful. It would obviously be a huge amount of work in terms of collecting those emails. It would not necessarily substantively assist in what is really the goal of the motion, which is to find substantive documents in relation to government action.

I would like to make what I consider to be a friendly amendment—to delete the requirement that emails be included.

The Chair: Thank you, Dr. Jaczek.

Mr. Jeneroux, I see your hand up.

Mr. Matt Jeneroux: Thank you, Mr. Chair.

I guess I was anticipating something along those lines. I would indicate to the member and to the other members that emails obviously are important in the back-and-forth of this, because we know that's one way in terms of how they communicate. We also want to make sure that [*Technical difficulty—Editor*], because nobody here is in the government. Nobody here knows what those emails say. So it's helpful to the entire committee. Also, with reference to the last minister we had before us, Minister Champagne, he referenced text messages as being important. I know we've ceded on text messages before.

That all being said, I know that these are important witnesses that we all want to get to, so for this particular motion, we'll agree to the friendly amendment, I guess, Chair, if that's what it's called, to replace “all documents, briefing notes, memorandums and emails” with “all documents, briefing notes and memorandums”.

The Chair: Thank you, Mr. Jeneroux.

Do we have unanimous consent for that change? For that, I'll just ask anybody in dissent to please speak up.

Hearing no dissent, I think we shall deem the motion moved as Mr. Jeneroux has just signified....

Mr. Fisher, please go ahead.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Sorry, Mr. Chair, but can you just...?

I was going to agree to the removal of emails, as Ms. Jaczek and Mr. Jeneroux had suggested. Are you suggesting now that we're voting on the motion or that we're voting on that unanimous...and then, if there are other possible amendments to this motion, they would come after that?

The Chair: We're not actually voting. I'm just asking if there is unanimous consent for us to consider that Mr. Jeneroux has moved his motion without the reference to emails.

Any further discussion on the motion is in order.

Mr. Webber, are you dissenting from the unanimous consent?

Mr. Len Webber (Calgary Confederation, CPC): I am, Mr. Chair. I understand a bit more work is involved but I think these emails are important. It will not be unanimous. I will dissent. Thank you.

● (1135)

The Chair: Since there is no unanimous consent, if we wish to make that change it will have to be done by an amendment. Does someone wish to move such an amendment?

Mr. Darren Fisher: I move that we remove the word "emails" from the motion.

The Chair: Very well. Is there any further discussion on the amendment?

Seeing none, Madam Clerk, will you please call a vote on the amendment, which is to remove the reference to emails and, of course, make any appropriate grammatical corrections?

The Clerk of the Committee (Ms. Erica Pereira): Thank you, Mr. Chair.

The vote is on the amendment. If you are in favour, say yea. If you are opposed, say nay.

(Amendment agreed to: yeas 7; nays 4)

The Chair: We will now continue our discussion on the motion as amended.

Mr. Fisher.

Mr. Darren Fisher: Thank you, Mr. Chair.

I'm wondering if Mr. Jeneroux would be willing to remove the PMO and the Minister of Health's office from this as well.

Mr. Matt Jeneroux: No. Nice try.

The Chair: Thank you, Mr. Fisher. Was that a motion or just a comment?

Mr. Darren Fisher: I will move that we remove them.

The Chair: We will discuss Mr. Fisher's amendment, which is to remove the explicit references to the PMO and the Minister of Health's office.

Mr. Jeneroux.

Mr. Matt Jeneroux: Obviously, we believe it's important. I don't know what this particular member is trying to hide between these two. I'm trying to do this quickly because I know we want to get to the witness testimony here. It's obviously crucial to hear the advice that was given to the Minister of Health's office and the Prime Minister's Office, because they were making public statements on masks at the beginning.

The Chair: Thank you, Mr. Jeneroux.

Ms. Jansen.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): It concerns me that we started by being told that to give text messages was too much. Now we're saying that our taking emails is too much. Now we're going to take out the PMO. I find it mind-boggling that everything's too much. Some things are very important. We need to get to the bottom of this.

● (1140)

The Chair: Thank you, Ms. Jansen.

Mr. Davies.

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

I just want to say two things. One is that I support the motions of my colleague to be transparent and to hold the government accountable and to receive information that I think all parliamentarians should be supportive of putting before the health committee, but I am very mindful that we have two excellent witnesses here, who, I think, are giving particularly important testimony today, particularly in light of the global focus on racism in this country.

This is the first time that we've really looked at the impacts of COVID-19 on marginalized populations. I'm just wondering if it wouldn't be better to take these motions.... I, for one, would certainly support holding a separate meeting where we could deal with these motions because I'm concerned that if we continue talking about these motions we will not have a chance to take advantage of this wonderful expertise we have before the panel today and to ask questions.

I wonder if Mr. Jeneroux would consider withdrawing the motions at this point. According to Standing Order 104, if four committee members agree to hold a meeting, then a meeting must be held. I certainly will support that. Then we can deal with these very important matters, but housekeeping matters, in a separate meeting and get to hear from these excellent witnesses here today.

The Chair: Mr. Jeneroux, please go ahead.

Mr. Matt Jeneroux: Thank you, Mr. Chair.

Wholeheartedly, I agree with my colleague, Mr. Davies. I obviously want to get through this as quickly as possible. These motions are very straightforward in my opinion. I attempted to streamline them there at the beginning.

I think this is a bit of an overreach from the government, by a particular member, but if we go to a vote right away, I think that we can get through these quite quickly and we can move this along and get back to the important testimony from the witnesses.

The Chair: Thank you, Mr. Jeneroux.

To the witnesses, I will point out that we are certainly mindful of your testimony and your valuable expertise. However, we do have to take motions when they come.

Dr. Jaczek, please go ahead.

Ms. Helena Jaczek: Thank you, Chair.

Certainly, I do find the testimony that we've heard today extremely important and would certainly like to have my opportunity to question the witnesses as well. However, we are now dealing with this motion.

I was wanting to move yet another potential amendment very much mirroring the wording that we passed a couple of weeks back on a motion proposed by Dr. Kitchen.

The Chair: Pardon me, Doctor. We do have an amendment on the floor. We have to deal with that before we can entertain further amendments.

Ms. Helena Jaczek: Exactly, so what I'm trying to say is that I definitely feel we need to continue this discussion.

The Chair: Okay, thank you.

Mr. Kelloway, go ahead.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thanks, Mr. Chair.

I just want to echo what MP Don Davies said. I absolutely believe we have to have this discussion with respect to the motions on the table and, of course, our response and our suggestions to them.

At the same time, as MP Davies mentioned, this is an important conversation as well, which I think we could look at, whether in a separate meeting or an in camera meeting, and we could address and discuss collegially the motions on the table and at that point be able to provide some feedback into those motions.

The Chair: Please go ahead, Mr. Desilets.

[*Translation*]

Mr. Luc Desilets (Rivière-des-Mille-Îles, BQ): Mr. Chair, I agree with several of my colleagues, including Mr. Davies. This is the second time in two weeks a process like this has happened. I understand that we have to deal with motions, but, in my opinion, we should deal with them separately, outside committee meetings. I feel a little embarrassed dealing with such motions and discussing my differences with my colleagues in front of these experts, who are leaders in their field. I believe that this does not concern them. Even though they are not really inconvenienced by it, I feel that it is not appropriate.

We have two other motions to come and I am afraid that the same process may be repeated. I would like you to take a position on this motion and postpone it. Our rules allow us to deal with the motion in a different time and place. I would actually like us to be able to question these two witnesses, who are bringing us material that is very different from what other guests have provided. It bothers me greatly to miss this opportunity. So I would ask you to postpone the discussions on this motion.

● (1145)

[*English*]

The Chair: Thank you, Monsieur Desilets.

It is the member's prerogative to move the motion when he has the floor. As long as that's the case, we have to deal with it as it comes.

Mr. Van Bynen, please go ahead.

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

I also agree with Mr. Kelloway and Don Davies. We have some very valuable expertise in front of us today, and the opportunity may not present itself to be included in the reports that we will be discussing. Although the process and procedure permit the debate now, I think that out of good conscience, in terms of getting a high-value report in front of the people who will be reading it, we are missing an excellent opportunity to hear and benefit from Dr. Siddiqi and Dr. McKenzie. This is something that should not be waived so quickly.

If any members put forward a motion to adjourn the debate so that we can hear these witnesses, I would be happy to support that, as well. To me, this is an excellent and important opportunity on a very significant issue for our country that can really influence the future that we take, not just for this but also for any future issues whereby we're creating pandemics and we need to decide between equity and equality. This is an opportunity that should not be missed, Mr. Chair. I believe this debate should move forward to another meeting.

The Chair: Thank you, Mr. Van Bynen.

Mr. Davies, please go ahead.

Mr. Don Davies: I don't know, Mr. Chair, if this motion is in order, but I think that I'm detecting majority support. I would move a motion that we table all four of Mr. Jeneroux's motions and schedule a separate meeting in public, because I do believe these should be debated in public, so that we can get back to hearing these witnesses today.

I find it ironic that we have witnesses who are talking about the historic suppression of marginalized groups and not having their voice taken into account in public policy, and here we are in a meeting doing the same thing. I think it's particularly unfortunate and, frankly, worthy of sanction to do so in this meeting. I would move that we table these motions and schedule a separate meeting as early as possible to discuss in public all four of these motions.

The Chair: Thank you, Mr. Davies.

Mr. Matt Jeneroux: Mr. Chair, my hand has been up for a while here. I'm not sure whether you've seen it.

The Chair: Sure. I'll just respond to Mr. Davies, and then I'll give you the floor.

Mr. Davies, the motion you made is not in order at this time. What would be in order is a motion to adjourn the debate on this.

Mr. Don Davies: Then I so move.

The Chair: Okay. We have a motion to adjourn the debate.

Before we entertain that motion, I wonder if Mr. Jeneroux has a comment that would help us in this matter.

Mr. Matt Jeneroux: Yes, Mr. Chair.

Obviously, I want to make sure we get in as many people as possible. At the beginning, I tried to play nice with the government and move this along. Unfortunately, going after the one key aspect of the motion isn't playing nice, at the end of the day. I would respectfully ask, with I guess two motions now on the floor—so I'm not sure whether this would be in order—if perhaps we were to look at....

I don't feel that your original suggestion of being in camera is the right suggestion, Mr. Chair, but I do feel that perhaps we could entertain half an hour or an hour after this particular meeting. I know that there are no meetings after ours. I believe the clerk can confirm whether or not we still have the room. If we could debate these motions in public, I would certainly be happy to do that, to table these now and move to that. However, I'm not sure if that is in order. I will leave it up to you to determine whether I can withdraw a motion or not at this point in time.

● (1150)

The Chair: Thank you, Mr. Jeneroux.

Mr. Davies' motion is in order. However, if we are in unanimous agreement to move to set up a separate meeting for this purpose—

Mr. Darren Fisher: Sorry to interrupt, Mr. Chair, but on a point of order—I don't know the committee stuff like you do—Mr. Davies was talking about moving a motion for a separate meeting, but then he moved a motion to adjourn debate.

I think I would like to ask the clerk, perhaps, what happens when that has been moved. As I understand it, there is no discussion after a member has moved to adjourn debate. I'm just seeking clarity.

The Chair: That is correct; however, for us to execute Mr. Davies' motion to adjourn debate, which we can certainly do, we will then have three other motions to deal with. I am proposing that if we have unanimous consent to withdraw Mr. Davies' motion, if he wishes, and unanimous consent to withdraw Mr. Jeneroux's motion at this time, and to take it up at another time—

Mr. Darren Fisher: Okay. You see? You are smarter than me.

The Chair: We can do things by unanimous consent, but if we have no unanimous consent to act in this way, then we will deal with Mr. Davies' motion and take the other motions as they may come.

Mr. Davies, would you be in agreement with such an approach?

Mr. Don Davies: I would, Mr. Chair.

I mean, it seems to me that we might be able to short-circuit all of this, as I hear Mr. Jeneroux's very generous and reasonable suggestion; I think I heard him say that we can withdraw everything, at this point, and simply deal with these motions after we hear the witnesses in both panels today, which I think gets everybody to the point that we're agreeing on.

Perhaps if you seek unanimous consent we can agree to table all of these motions to the end of this meeting.

The Chair: All right. I will ask if we do have unanimous consent....

I'm sorry; that was after the end of this meeting? We don't have time today to deal with all of this stuff. We will have only 20 minutes for an in camera meeting, if we still have time even for that. I'm proposing that we set up a separate meeting, perhaps next week, to deal with this. I'm asking if we have unanimous consent to do that.

Mr. Matt Jeneroux: Mr. Chair, I have just a quick point of order on that. I do believe there is no meeting after ours. I think that was part of my request, to confirm with the clerk that we could continue on, if we wanted to, for that extra half hour or not.

The Chair: My information is that we have a hard cap at 2:40 eastern time.

In any case, we're getting a little involved here. Do we have unanimous consent to withdraw all the motions now on the floor and to take them up instead at a meeting to be called for this purpose, at a time to be arranged with the clerk but possibly early next week? Is there unanimous consent for that?

In fact, I'll ask the clerk to take a vote on this, just so we're clear.

Mrs. Tamara Jansen: Mr. Chair, I'm wondering if you are going to give a time cap as to when we have to have this extra meeting. You're saying it will possibly be next week, but what if that doesn't happen?

● (1155)

The Chair: I'm just saying that we will ask the clerk to arrange a time for the meeting that is suitable for all of us. I don't know what the schedule is like next week, but we will have a separate meeting for that.

Mrs. Tamara Jansen: I just wonder if we could make sure there's a time limit so that we don't wait a month.

The Chair: We're not going to wait a month. The whole business of unanimous consent is a matter of achieving some consensus. We understand that it's an important matter that we need to deal with. We will deal with it in a proactive way. We just don't want to deal with it now. We want to get back to our witnesses.

We don't have a specific date or time—

Mr. Matt Jeneroux: We put our trust in you, Mr. Chair, to find it sooner than later.

The Chair: Very well. I appreciate that.

That being said, let's find out if we are in agreement.

I'm asking for unanimous consent to deal with these matters in a separate meeting called for that purpose, to be arranged with the chair and the clerk at a suitable time in the near future.

Are we in unanimous agreement on that?

Some hon. members: Agreed.

The Chair: Thank you. We have unanimous consent, and the motions are deemed withdrawn.

We will schedule a meeting for the purposes of dealing with Mr. Jeneroux's motion as originally moved today, as well as the other motions he had wished to move today, and we will carry on with our questioning. Thank you very much, everybody, for your co-operation.

With that, we will return to our questioning.

Mr. Jeneroux, your time is up—

Mr. Matt Jeneroux: Mr. Chair, I do believe I have some time, because the time stops when you call a motion, as you well know, but in the interest of the committee's time and wanting to make sure we give the NDP and the Bloc opportunities to ask questions as well, I will cede the rest of my time back to the chair.

The Chair: Thank you, Mr. Jeneroux. You are correct.

We will go now to Mr. Fisher. Please go ahead. You have six minutes.

Mr. Darren Fisher: Thank you very much, Mr. Chair.

I want to thank the witnesses for being here. I also want to thank Mr. Jeneroux. This is part of the process of committee, and he has every right to move those motions, and we could sit here and talk about those motions and hash them out for the full couple hours of the meeting.

So thank you, MP Jeneroux, for agreeing that we could seek some type of discussion at a later date.

Dr. Siddiqi, first of all, I just want to say that both of you gave so much wonderful testimony that is so valuable. One of the MPs, I think Mr. Van Bynen, commented about the importance of having this testimony in our report. This is our last meeting to get your testimony into this report, so that makes it so important that we get this testimony. If I ask you a question that you feel you've already sort of touched on, feel free to broaden those comments if you wish, because you gave so much stuff and I was trying to scribble things down and it just wasn't possible.

I'll start with you on this question, Dr. Siddiqi. The pandemic, we agree, has disproportionately affected vulnerable communities. How can we do better going forward to address this disproportionate effect?

● (1200)

Dr. Arjumand Siddiqi: Thanks very much for the question. I'm happy to expand.

I think the way to do better is to understand what caused their vulnerability in the first place. There are two approaches that we could generally think about. One is to mitigate the harm done to vulnerable people, but the first is to ask why people are vulnerable in the first place. What makes us sort people into being vulnerable and not? What we've learned from the literature is that this issue of someone's social and economic position, in particular their race and their social class, creates an inherent vulnerability. Without addressing the fact that life, material conditions, stress, opportunity and so on are fundamentally sorted by race and class, we can't possibly hope to do anything about what the eventual outcomes of that vulnerability are, which are things like COVID-19 inequities, cardiovascular inequities, hypertension inequities, educational inequities, employment inequities and so on.

I think what we can do is take a good, long, hard look at how we structure opportunity in our society and say to ourselves, “We want a society in which the policies and the institutions create opportunity for everybody.” I think, as one of the members eloquently said earlier, it's the distinction between equality and equity in the sense that you want to make sure—knowing that we don't have an equitable society and that it's unfair to some—that we start to look at key policies that would get us to equity and would not just unfold opportunities as if they could be equally taken up.

A great example is that of post-secondary education. You could make an argument that anyone can apply and that this creates some equality. We don't stop anybody from applying. If you make the grades and so on, you can get into school. But that's not actually how it works, because you have to be able to pay for school. You have to have teachers who support you in feeling as though you can make it to that point. You have to have an environment around you that doesn't cause you so much stress that you can't focus on your studies and so on. The same is true for COVID. Yes, we could all shelter ourselves, social distance and technically avoid COVID, but that's not actually how things work. Some of us are more exposed than others are by virtue of our vulnerable position.

I think what I'm suggesting is that, as counterintuitive as it may seem, looking at the fundamental injustices of making some people vulnerable in our society is really the way to tackle the outgrowth of that.

Mr. Darren Fisher: Dr. McKenzie, you listed many recommendations. Again, I was scribbling as fast as I could, but would you care to comment on this before my time runs out?

Dr. Kwame McKenzie: Sure, and thanks very much for the question.

I completely agree with Dr. Siddiqi that we need to go fundamentally towards equality and equity, and that there are these fundamental causes that are driving disparities.

The problem is that a lot of the things you are going to do to try to deal with those fundamental causes are not going to happen during this pandemic in the first wave, second wave or recovery. The question is what can we actually do now and what can we actually do that can practically help this group move towards a more equitable response?

I do believe that we will find, if we have the data, that different jurisdictions have had different levels of success in producing equitable responses. I'm completely sure of that. We know that different jurisdictions have had completely different rates of COVID. If you look at B.C. and compare it to Quebec and Ontario, these are very different outcomes. In fact, if both Quebec and Ontario had the same quality of response that B.C. did, there would have been about 2,000 lives saved in Ontario, and there would have probably been about 4,000 lives saved in Quebec.

There are big differences in the ways we've gone about things. If we could even get to the point of equalizing how well the different provinces have dealt with COVID, we would move towards better outcomes for all.

This idea of legislation is to try to promote equity through legislation, to make sure that provinces actually think about equity when they're thinking about their pandemic plans. At the moment, many don't, and that's why we see some of the disparities. Not all of the disparities would be dealt with by thinking about equity in the pandemic plans, but certainly, because, as Dr. Siddiqi said, there are fundamental causes of these disparities, we could make our response better and more equitable and we could certainly save lives by using a health equity lens.

Then going forward, when we're looking at the recovery, we need to use the opportunity of the recovery to try to decrease some of the fundamental drivers of inequities. I think there are things we can do now, directly in our pandemic plans, and then also in our recovery plan, that will actually make us more equitable and will save lives.

I also think that not having the data is criminal. It's 2020, right?

● (1205)

The Chair: Thank you, Mr. Fisher.

[*Translation*]

The floor now goes to Mr. Desilets for six minutes.

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

My thanks to our two guests for their presentations.

Their comments are very interesting and somewhat different from the comments of witnesses we have heard from in the past.

My first question is for Mr. McKenzie.

I really liked the parallel you drew with the *Titanic*. For me, the image was vivid and very real.

You started your remarks by saying that Canada's response had been positive. How was it so positive, in your opinion?

As I listened to the rest of your statement, my impression is that we have completely missed the boat in terms of the black population.

[*English*]

Dr. Kwame McKenzie: Thank you, Mr. Desilets.

I would bring you back to some numbers.

If you look at the death rate per 100,000, in Canada it's been about 23 per 100,000. If you look at somewhere like the United Kingdom, it's been 50 per 100,000. In fact, Canada's rate is pretty good compared to that of many high-income countries, so we've done reasonably well.

Obviously if we compare ourselves to Germany, which has a rate of 11 per 100,000, we haven't done as well as Germany. In fact, if we had had a response that was as good as Germany, one analysis has shown we'd have saved 4,528 lives.

We're in the middle of the pack compared to lots of others. We've done very well; it could have gotten a lot worse.

The problem is that, inside that good response, it's worked better for some people than for other people, so my comments are that we have done well but if we had done equally well for everybody, we'd have all been better off and the death rate would have been significantly lower, and the morbidity would have been significantly lower. We would have been in a better place in order to rebound into recovery.

[*Translation*]

Mr. Luc Desilets: Mr. McKenzie, do we have comparative data for other countries that are part of the G20 and that have about the same black-white population ratio? You mentioned the death rate of 23 per 100,000.

If you analyze the results in a little more detail, are there comparable countries?

How do we in Canada measure up?

[*English*]

Dr. Kwame McKenzie: I think that's a really interesting and important question. It is very difficult to make comparisons between countries. Also, most of the excess deaths, which are linked to ethnic group, are not linked to biology. They are linked to people's social situations, and people's social situations are linked to policy choices. Yes, we could say, “Oh no, we can only compare ourselves with populations that have similar ethnic groups”, but to a certain extent, that makes it sound as if race is the determinant. But race isn't the determinant; social policy and racism are the determinant.

Of course if we look at somewhere like Germany, it has a significant migrant population and significant ethnic diversity, including a very large Turkish population, but it has still managed to have a better response than we have.

● (1210)

[*Translation*]

Mr. Luc Desilets: Thank you very much. That answers my question.

The fourth point you brought up dealt with the importance of obtaining Canada-wide results, so that provinces can be compared with each other and with the national level. A number of speakers have expressed that need and the gap we have. There have been requests for information to be communicated and for collaboration so that we would not have to wait for a year, say, to be able to compile the information and draw conclusions. Some countries have been much quicker than we have. They have been much more advanced and have established systems to centralize that data.

In Canada, in your opinion, whose responsibility is it to ensure this cohesion among organizations, among the provinces, and between the provinces and the federal level? Who should manage it? I feel that we are just passing the buck.

[*English*]

Dr. Kwame McKenzie: I do think there are significant difficulties with regard to data collection that are produced by the federal/provincial and territorial split. But I do think that the federal government itself can make sure it gets its own data house in order.

It is surprising that we have a census and that in our census we do not collect from everybody information on socio-demographic, race and ethnicity. We collect it from only 20% of people, on the long-form census, rather than from 100% of people, including on the short-form census. If we were able to change the short-form census so as to get a full picture of Canada, we would be able, possibly, to link that census data to other data in order to get a good picture of our pandemics, a better picture of our pandemics. It is possible to do these things but at a federal level, and it is also possible for the feds to insist that the provinces produce data.

At the moment, the feds pay a lot to the provinces. Maybe the feds should be thinking about what data the provinces produce in order to demonstrate that their responses are actually equitable. Very few people would give money to a company or a service without being very clear about what they're getting in return. At the moment, sometimes federal transfers are not transparently linked to productivity, especially not to productivity based on equity.

The Chair: Thank you, Mr. Desilets.

I'd like to advise the committee that we have set up a time for our next meeting, to be three o'clock Eastern time next Monday, at which time we can deal with Mr. Jeneroux's motion. We will also move the drafting instructions from today to following that meeting. We are still tight on time today but we will do our best to get both panels in and both rounds, so thank you all.

Mr. Davies, please go ahead. You have six minutes.

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

Thank you, Dr. Siddiqi and Dr. McKenzie, for sharing your expertise with us today. I think both of you have laid out a very clear and powerful case for why the federal government needs to collect comprehensive national data on social, economic and other factors.

Dr. Siddiqi, you recently wrote that the Canadian government has been reluctant to routinely collect race and ethnicity data, and that the consequence is a lack of accountability, according to your writing, in addressing racial disparities in all sectors of society.

In your view, why has the federal government been reluctant to collect race and ethnicity data with respect to COVID-19 and in general?

● (1215)

Dr. Arjumand Siddiqi: I can tell you what we often hear as the primary reason, and then I can speculate about what might be going on.

We're often told that the reason for withholding this data, for not making it publicly accessible, not collecting it more widely, etc. is really to protect the privacy of Canadians, since there may be some issues particularly with a general release of the data that would compromise the safety and privacy of Canadians were those data able to identify particular Canadians. We have very little reason to believe that is enough of a concern to suppress really valuable information. Is it somehow, through de-identified data, still possible to identify particular Canadians? It almost never is. Maybe there is a slight outside possibility, the way there is with census data for that matter, but not enough for me to believe it's actually a legitimate reason for not collecting this data and not allowing it to be freely, publicly accessible to be analyzed by people like me, Dr. McKenzie and others in order to inform our country about what's happening to us.

That brings me to what I think might be going on. It's unfortunate, but I do think that when we don't collect data, that's at least one way in which we can ignore the evidence. We can equate our own opinions with a claim that those opinions are facts, because the facts simply aren't available to us.

My sense is, as you've pointed out and I've pointed out before, that with data and the ability for independent scientists to analyze that data comes a groundswell of evidence that in one way forces us to at least admit to the facts, to at least have to contend with and confront and recognize the fact that there are empirical evidence sources being put before us, rather than having a situation in which anyone can say virtually anything and we don't really have a good way to contend with or refute what people are saying.

I think that part of the hesitation may be that this actually creates some serious empirical demonstrations of what's happening in our society and that then, as Dr. McKenzie said, that's not the end; it's just the beginning, and that will make us have to move forward with action.

Mr. Don Davies: Thank you.

Dr. McKenzie, I want to focus on mental health for a moment.

A June 29 article from Global News noted that before moving to Toronto you ran a mental health service in north London, U.K. When someone with psychosis or another serious form of mental illness was in crisis, your team of medical professionals showed up first rather than the police. You noted in that article that this was possible because the U.K. funds mental health care in ways that Canada does not.

Could you please provide the committee with further detail on the effectiveness of this program, and maybe outline the key differences between the U.K.'s and Canada's approaches to funding mental health care?

Dr. Kwame McKenzie: Thank you very much for the question. I didn't know quite where it was going; I thought you were going to be talking about the echo epidemic of mental health that was going to come through COVID.

The situation that we find in Canada in general is that about 7% of health care spending is spent on mental health. In the U.K., it's between 9% and 11%, depending on where you are. A lot more money is spent on mental health in the U.K.

Mental health, obviously, as you know, is about people. There's not amazing surgery to be done and all of those other things. There aren't loads of equipment. It's about people. If you're not spending the money, you don't have the people, and if you don't have the people, you don't have the service.

The difference I've seen in Canada compared to the U.K. is that there is not a comprehensive enough mental health service, and there's not a comprehensive community mental health service. Because of that, there are more crises. There are many more mental health crises and, as you know, these can end up tragically.

The actual breadth and depth of mental health services in Canada are not sufficient, I believe, to meet the needs of the population. If we are to get an echo epidemic of mental health problems due to COVID, I believe we are going to have real problems unless we significantly start investing in building capacity to deal with the mental health impacts in the community and elsewhere.

● (1220)

Mr. Don Davies: You spoke of the legislative—

The Chair: Thank you, Mr. Davies.

That ends round one. We'll start round two with Mr. Webber.

Mr. Webber, please go ahead. You have five minutes.

Mr. Len Webber: Thank you, Mr. Chair, and thank you to our two doctors who are here today for their testimony. It is incredibly interesting, for sure.

Mr. Chair, I certainly hate going behind Mr. Davies in questioning, because once again he has brought up some points that I wanted to bring up.

It's about that same article, Dr. McKenzie, that article in Global News regarding your experience in the U.K., in north London. It was about the team of the medical professionals who showed up first—not the police—when there was a mental health crisis in the community. You talked a bit about it. Can you explain to us how this came about, how it worked and how you dealt with violent or armed non-cooperative people?

I know that this wasn't a part of your testimony today, but I think it is very relevant in the mental health side of it. Can you elaborate a little more on how you began this?

Dr. Kwame McKenzie: One of the things we found, and one of the things that we've always thought, is that if you can intervene early, you decrease the need for crisis intervention, so our team was very straightforward. It was community based. For every person who we saw, they and their family were given a telephone number that they could call any time, and we would go to see them. Yes, we did all the crisis calls. Yes, they called us first, rather than the police, and, yes, we went out to see them. Over the three to four years I was there, none of our staff were injured and none of our clients were injured. That didn't happen.

Some of that is because we are experts in de-escalation, and we are experts in dealing with mental health crises, and some of it is because people knew who we were, and that makes a difference. But a lot of it was because we saw people earlier in their diseases and earlier in their problems. Rather than waiting until things got so acute that people were ringing the police, families were ringing us early and we were going to see people, and we were decreasing the problem.

Community mental health services properly deployed are very important and they work. Yes, we did have problems when people were very disturbed, and we needed to have the police as backup, though we led the response. The police would be in the car outside, and if we needed them, we called them in. We had them there, but we never had anybody put in handcuffs and taken away. Part of the reason for this is that it is traumatic, and even if it's done and the person doesn't get hurt, you then have to deal with the trauma.

That's what we did. It worked well. It expanded across London. It's the way things were done at that time.

● (1225)

Mr. Len Webber: I think that is brilliant, Dr. McKenzie. I think that we should certainly be looking at implementing something like that here across our country as well. Thank you for sharing that.

I have a quick question for Dr. Siddiqi.

Again, thank you for your presentation and for sharing your experience on your studies of relationships between race and health outcomes. In an article in The Globe and Mail on June 1, you said that the United States was “night and day” different from Canada in race-based data collection. Can you better explain those differences, Dr. Siddiqi?

Dr. Arjumand Siddiqi: I have a lot of experience with the U.S. because I trained there and lived there for a long time. I still do a lot of research there. That's the foundation of my comments.

In the United States, they have routinized the collection of data on race the way we have routinized it on age and gender. In the United States, you answer a question about your race nearly every time you would answer any questions about your demographics or where you live. That means you answer it when you access the health care system or the education system, when you apply for a job and when you actually get a job and your address and information are collected. Then the United States makes that information, that data, publicly accessible. You and I could, right now, go to the Internet and access datasets that are either administrative, meaning they're the collection of this routine data, or they are government surveys the way we have the Canadian community health survey and so on. We could just go to the Internet, download that data with really good documentation about how to use it, and create analyses right now of what racial inequalities and socio-economic inequalities look like.

To give you another example, we're conducting some work on inequalities in birth outcomes in the U.S. We can do that because birth certificates have information on race and we can do it because that information is downloadable off the Internet with ease. I don't have to apply to request the data, go into a StatsCan data centre to analyze it between nine and five, get certified to do that, tell them exactly what I'm going to ask and then—

The Chair: Dr. Siddiqi, could you wrap up, please?

Dr. Arjumand Siddiqi: Sure.

In Canada what happens is that there are all of these barriers, first, to collecting the data and therefore having data, and second, to accessing the data that we already have.

Mr. Len Webber: Interesting. Thank you very much.

The Chair: We will go now to Mr. Van Bynen.

Please, go ahead. You have five minutes.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

I want to thank both of our witnesses for the very powerful information they've given us. I was particularly interested in the recognition that intergenerational wealth transfer was a root cause of systemic racism, so I thank you for that.

My first question is for Dr. Siddiqi. It's my understanding that the Dalla Lana School of Public Health has a self-directed, student-led organization called the Infectious Disease Working Group that has created a community resource navigation tool. I'm hoping you can share with the committee a little more about the tool. What does the group hope to achieve with it, how was it developed and what has the group discovered from the information it's obtained in the development of the tool?

Dr. Arjumand Siddiqi: Yes, I'm very proud to say that the tool has been developed by a couple of our doctoral students. Taking the lead were Isha Berry and Jean-Paul Soucy. As well, David Fisman, Ashleigh Tuite and others of our faculty have been integrally involved in developing that tool.

Essentially, the backdrop of that tool was to make up for the fact that there was not routinely available data on COVID, and we were in a crisis in which we desperately wanted information and needed desperately to get information out to the public. With the ingenuity of this team and their colleagues, they took the media reports that were coming down the pike of who was dying from COVID, what their characteristics were and where they lived, and they essentially assembled their own database. You can imagine that it is painstaking work to put together a database that's not in any way automated but really requires the blood, sweat and tears of people extracting information from wherever they can find it.

In terms of what they found, there was a variety of things, really, that came from that data. They were able to tell us how the pandemic was proceeding, where we were seeing hot spots and whether things were getting better or worse as days went on. What they weren't able to tell us is something about the inequities in terms of socio-demographics, so they tried to collect information on things like occupation and so on, when it was available from a media report. Because they weren't relying on a source that has a standard information collection set-up, they really were at the mercy of whatever they could find. Usually, that involved where people lived, what age they were and, of course, their COVID-19 outcomes.

This was really able to tell us a lot, but what's sort of remarkable is the fact that they did this in such short order and with their own ingenuity and initiative, but also that they had to do this because we didn't have a government system of routine data collection that was publicly accessible.

● (1230)

Mr. Tony Van Bynen: Thank you. Would the outcome of that information be made available to this committee?

Dr. Arjumand Siddiqi: Yes, sure.

Mr. Tony Van Bynen: That's great. Thank you.

My next question is for you, Dr. McKenzie. First of all, I really found enlightening your comment that it is important for us to understand what's “under the curve” as opposed to bending the curve, and a lot of that reflects some of the social disparities that we've heard about. What changes would you like to see in the minimum wage, income supplements and social assistance and supports to start putting some equity into the system?

Dr. Kwame McKenzie: As you know, I was the research and evaluation chair for the Ontario basic income study. I like the idea of a basic income. I like the outcomes of a basic income. I like the fact that it does improve equity, and I like the fact that there are health and mental health outcomes as well as dignity. Dignity and social inclusion are very important.

When thinking about these things, I also like the idea of us trying to think of how.... When we're thinking of income supports, we tend to think about a level of money that we're giving people, but we never link that necessarily to the level that's needed for health. When we're thinking about how much EI people get and how much CERB people get, I'm very interested in whether that package actually allows people to be healthy, because that will help to decrease disparities.

I also think that the accessibility of the packages like the CERB and others is important. I have noticed a number of studies coming forward now and showing, for instance, that in the black population about 40% have lost income or their jobs over the pandemic, but a lower proportion of the black community than others have come forward for social assistance and have the CERB. I think there are equity problems in the accessibility of things like the CERB. Some of it is due to people not knowing their rights and some of it is due to the digital divide between people, but it's definitely there.

The big things, I would say, are the following: When when we're thinking about social assistance, can we link it to health and work out what people need to be healthy? Can we think of how we make sure it reaches the right populations and that they actually get it?

There are other things that I would suggest.

The Chair: Thank you.

Dr. Kitchen, please go ahead for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair, and thank you, Dr. Siddiqi and Dr. McKenzie for your presentations.

I greatly appreciate hearing that from you. A lot of what you talked about is that data is lacking, and the fact that we need to have ongoing data. We've heard that throughout this committee. There is a big challenge in collecting and disseminating data, whether it's because of provincial barriers, federal barriers, etc.

You did talk about social inequality when you touched on the issue of income, you talked about housing and you talked about race, etc. I've noticed, in doing a little bit of research on you beforehand, that both of you have mentioned issues of persons with disabilities.

I'm wondering if you both could comment on that in this particular demographic. I'll start with Dr. McKenzie, and then Dr. Siddiqi you might be able to throw in some input on how this is having a big impact on dealing with that. You talked about how we need to hit the hardest hit group.

● (1235)

Dr. Kwame McKenzie: I think it's really important to be thinking about disability.

I think I've mentioned before the analysis of comparing Germany to Canada. The big difference between Germany and Canada with regards to lives lost has been that 80% of people who've lost their lives in Canada are from long-term care, and only 34% of people who lost their lives in Germany are from long-term care. They sorted out long-term care and that made a difference.

In the end of this wave, and in the next wave, I believe it's going to be vulnerable populations such as people in congregate living situations, people with disabilities, who are going to be the next frontier for producing a quality and equitable response along with the racialized populations.

I think focusing on their needs, sitting down and working out what they need to be able to protect themselves is going to be important. As I said before, I agree with Dr. Siddiqi about the fundamental causes. I also think that we need to sit down and say to people with disabilities, "What do you need in order to be able to use the tools we've got? We have the tools of testing, physical distancing and tracing. How can you do this? What stops you from doing this?"

If we could start working those things out and finding innovative interventions, we might be able to protect a whole bunch of people in those groups because that's what happened in long-term care in different countries. Those countries had really good policies on prevention of infection in long-term care and they launched them at the same time as their lockdown, they protected their elderly—we didn't do that.

Mr. Robert Kitchen: Dr. Siddiqi.

Dr. Arjumand Siddiqi: I'll just add one which is from a data perspective.

I think, as Dr. McKenzie said, it would be important to understand what people with disabilities face and to engage with them about their needs.

It's also important to understand how this is an axis of vulnerability at the population level, and what the kinds of patterns are of things people are facing.

I'll just add that in relation to the earlier question about the infectious disease working group, there is a group.... I misspoke because there are two groups at our school. One group led by Kahiye Warsame, Yulika Yoshida-Montezuma, and others is looking into socio-economic issues and they may also be able to look at disability.

Mr. Robert Kitchen: Thank you.

The precautionary principle is the idea that there is "a social responsibility to protect the public from exposure to harm, especially when scientific investigation has found a plausible risk." This means starting with the highest level of protections for society and whittling that down as new information about the risk posed, or lack thereof, comes forward.

Both of you indicated that certain demographics in communities within Canada face greater risk with respect to COVID-19, yet the Public Health Agency of Canada chose not to utilize the precautionary principle in dealing with the virus.

Do you feel that if we'd used the precautionary principle, we could have helped to quell the spread of COVID-19 amongst some specific demographics in Canada?

● (1240)

Dr. Kwame McKenzie: For me, that's the simplest question I've had all day. Yes, most definitely, Dr. Kitchen; I completely agree with you.

Mr. Robert Kitchen: Thank you.

Dr. Siddiqi?

The Chair: Thank you, Dr. Kitchen.

Please give a very quick response, Dr. Siddiqi.

Dr. Arjumand Siddiqi: [*Technical difficulty—Editor*] in some ways, yes, but in some ways, the fundamental issue is the increased risk for exposure, for being out there. That's an issue as well.

The Chair: Thank you.

We go now to Dr. Jaczek.

Please go ahead. You have five minutes.

Ms. Helena Jaczek: Thank you very much, Chair.

As a public health practitioner for so many years, it's been so refreshing for me to hear the emphasis from both of you on the social determinants of health. This is vital, and you've brought it to the fore. Both of you have dug so much deeper within what were originally considered the social determinants of health, digging into the data to certainly analyze much further, with Dr. Siddiqi emphasizing racialized problems in that community in terms of susceptibility and so on.

My first question is for you, Dr. McKenzie. It's great to see you again, if only virtually. I'm wondering if you could tell us a little bit more about the basic income pilot in Ontario. I note that the Wellesley Institute on May 6 conducted a survey with a number of stakeholders to look at vulnerable people in particular. One of the most common responses to that survey, in terms of the recovery from COVID-19, was potentially the need for a universal basic income.

For the benefit of the committee, could you tell us a little bit more about your role on the basic income pilot in Ontario, which of course was terminated after only one year, and whether there were some learnings in that one-year time period that were collated and that we could think about going forward?

Dr. Kwame McKenzie: I was lucky to be part of the basic income pilot project as the research and evaluation advisory group chair. I advised directly the running of the basic income pilot and the link between the basic income pilot and the third party evaluators, who were a consortium of academics. In some ways, as you probably remember, I was a translator between the academic language and the bureaucratic language in order to make it work.

The basic income project had two different bits. It had a randomized control trial in two areas, Hamilton and also in Thunder Bay in the north of Ontario, where people were randomized through either the basic income or not the basic income. It then had a saturation study in a different place, Lindsay, with 22,000 people in a predominantly farming area to see whether there would be a change in the economy in that area if all low-income people were offered the basic income. The basic income or essentially the amount of money you got was based on a tax rebate, which worked very well.

We learned loads of things. One, you can do it. Two, people love it. They find it a much more dignified way of getting their social assistance. Three, entrepreneurs take risks and build businesses if they have backing and they know they have at least a basic income. Four, people change their lives and go back to college. They get into better housing and give themselves a fundamental chance in order to move forward if they have a basic income. People move themselves out of poverty if they have a basic income.

It was a travesty, in my mind, that it was stopped. You can't start a research project, say to people that they have three years in order to revolutionize their lives and then take the money away. It's bad for their health. It's bad, obviously, for the country not to have that information. It made us look bad on the world stage, because people all over the world were looking for these results. When there were follow-ups of some of those people, such as in Hamilton, people who'd gotten even one year of basic income had done better than people who hadn't.

For people, I think it's about time that.... There are rights and responsibilities from being a citizen. Maybe there has to be a deal with the citizens that they have rights, and those rights are for a basic level of income that befits a high-income country.

● (1245)

The Chair: Thank you, Dr. Jaczek.

[*Translation*]

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

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

Good afternoon, Ms. Siddiqi.

[*English*]

The Chair: Pardon me, Mr. Desilets. Your microphone seems to have been disconnected.

[*Translation*]

Mr. Luc Desilets: My apologies, Mr. Chair.

Ms. Siddiqi, you quite rightly alluded to the wealth inequities and gaps between black people and white people, and to a kind of baby bond that might exist elsewhere. Can you quickly tell us what that is?

[*English*]

Dr. Arjumand Siddiqi: Yes. Thank you very much.

As I mentioned, one of the most unfortunate aspects of inequity is that it starts at birth before anyone has a chance to do anything, and that is a result of prior generations having more socio-economic resources among whites and fewer among blacks. In the United States, the disparity in family wealth is tenfold, so if a median white family has $170,000 in wealth, a median black family has more in the order of $17,000.

In order to combat that, they have talked a lot about strategies that would reduce wealth inequality. One of those strategies is what they refer to as “baby bonds”. The idea is that you provide children, when they are born, with a sum of cash that is actually something that can mature over time, so it's not intended as cash to be spent right away. There are many needs that do need immediate attention, but this particular proposal is the idea that you provide a sum that can mature over time and that in adulthood can be used to buy the kinds of things that rich families buy for their kids when they become adults. They often pay for education. They often provide them with down payments for homes. This kind of a baby bond would function in that same way. There are economists who have made estimates that suggest that a proposal like this may be able to close the wealth gap in a couple of generations if it were big enough and done well enough.

● (1250)

The Chair: Thank you, Mr. Desilets.

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

Mr. Don Davies: Thank you.

Both of you have commented on the profound and corrosive impact of entrenched racial wealth inequality and structural racism. I'm curious what the trend is. Is it staying flat? Are we getting better? Is it getting worse?

Second, in my limited time, I'd like to ask each of you this: If you were Prime Minister, Dr. Siddiqi, and if you were Minister of Finance, Dr. McKenzie, what would be your top two priorities for the federal government to start addressing this?

Dr. Kwame McKenzie: We start with the Prime Minister, don't we?

Voices: Oh, oh!

Dr. Arjumand Siddiqi: Thanks very much, both of you.

In terms of wealth inequity, it's very difficult to say, because we don't have good data. In the U.S., I could answer that question for you. In Canada, it's very difficult to say.

Generally speaking, on economic inequity, I can tell you, for example, that income inequality is rising. It's getting worse, and we think that for wealth inequality, only more so.... In fact, we have some evidence that it's the case. The racial divide is very difficult to calculate, because we don't have a lot of data.

If I were to suggest the top two things that we could do in our society, the first would be that we do something to close this wealth gap and to figure out ways in which families can have the economic security and the economic means to generate education, income, etc. To me, wealth inequality would be paramount. The second would be a tie between income inequality and the universalization of many of the services and the programs that we know help, such as access to education, including post-secondary education, and access at the other end to early childhood education and child care and so on.

Let me just say one thing about the basic—

Mr. Don Davies: Dr. Siddiqi, I'm sorry. I want Dr. McKenzie to have a crack at his two priorities.

Dr. Arjumand Siddiqi: Sure. I'm sorry.

Dr. Kwame McKenzie: To start off with, it's just to say if you look from the first generation to the second generation to the third generation, the rate of poverty for the black population of Canada increases. It's the only part of Canada where the poverty rate increases from people who are immigrants to their grandchildren, and that is a problem.

I believe that there are a lot of things we can do, but one of the things we have to do is that we have to raise the floor. One of the reasons why I was interested in social assistance and the basic income and other things like that is to raise the floor so that the gaps between rich and poor are decreased, and that will help racialized populations significantly.

I also think that we probably do need to start looking to a sort of more enforceable legislation, a sort of legislation with more teeth, that starts looking at racial equity. If you look in the Toronto area, the truth is, from studies from the United Way, that the racialized population has not had a pay increase in real terms in the last 30 years, and the gaps between them and other groups have increased over that time.

The Chair: Doctor, could you wrap up, please?

Dr. Kwame McKenzie: Oh, yes. It's good to say that. I could have gone on forever.

The gaps increased over that time, so we have to decide what we need to put in place to stop that from happening.

The Chair: Thank you, Mr. Davies, and thanks to all of you.

In particular, thank you to the witnesses, who have given us such great information. Thank you for sharing your time with us today.

With that, we will suspend and bring in a second panel. Thank you very much.

● (1255)

(Pause)

● (1300)

The Chair: The meeting is now resumed.

Welcome back to meeting number 32 of the House of Commons Standing Committee on Health. We're operating pursuant to the order of reference of March 26, 2020. The committee is resuming its briefing on the Canadian response to the outbreak of the coronavirus.

I would like to make a few comments for the benefit of the new witnesses. Before speaking, please wait until recognized. When you are ready to speak you can click on the microphone icon to activate your mike. I remind you that all comments should be addressed through the chair. Interpretation in this video conference will work very much like in a regular committee meeting. You have the choice at the bottom of your screen of either floor, English or French. If you plan to alternate from one language to the other, you will need to switch the interpretation channel so that it aligns with the language you are speaking. You may want to allow for a very short pause when switching languages. When you are not speaking, your mike should be on mute.

I would like to welcome our witnesses.

We have, from the Canadian Institute for Health Information, CIHI, Ms. Kathleen Morris, vice-president, research and analysis, and Ms. Mélanie Josée Davidson, director, health system performance. From the Department of Public Safety and Emergency Preparedness, we have Ms. Colleen Merchant, director general of national cybersecurity, national and cybersecurity branch. We have Mr. Scott Jones from CSE, head of the Canadian Centre for Cyber Security. We have Chief Superintendent Mark Flynn from the RCMP, director general of financial crime and cybercrime, federal policing criminal operations. From Statistics Canada, we have Ms. Karen Mihorean, director general, social data insights, integration and innovation; Mr. Marc Lachance, acting director general, diversity and populations; and Mr. Jeff Latimer, director general and strategic adviser for health data.

Thank you all for being here. We will start with our statements from witnesses. We will start with the Canadian Institute for Health Information.

Please go ahead. You have 10 minutes.

● (1305)

Ms. Kathleen Morris (Vice-President, Research and Analysis, Canadian Institute for Health Information): Thank you, Mr. Chair.

On behalf of the Canadian Institute for Health Information, thank you for the opportunity to appear before the standing committee.

I am speaking to you today from the traditional territory of the Wendat, the Anishinabek first nation, the Haudenosaunee Confederacy and the Mississaugas of the New Credit. I recognize that this land is now the home of many first nations, Inuit and Métis people.

Since 1994, CIHI, as we're usually called, has been a leader in health data and information. CIHI is a not-for-profit independent body funded by the federal government and all provinces and territories. Our board of directors is made up of deputy ministers of health and other health system leaders, representing all regions of the country. CIHI has signed data-sharing agreements with every province and territory and several federal organizations.

Pan-Canadian health data is a shared responsibility between us and our partners at Statistics Canada, Health Canada and the Public Health Agency. Each organization has a defined role within the health ecosystem, with CIHI's focus on health care systems and their functioning.

For example, CIHI oversees data on hospitals and long-term care, health spending and workforce, and information on health system performance. Data is provided to us voluntarily by the provinces and territories. This allows the data to be aggregated and compared and for health systems to learn from each other. We also work closely with organizations that are international, such as the OECD and the Commonwealth Fund, which enables us to learn from other countries.

CIHI makes the data and information available to policy-makers, health system leaders, researchers and the public. Although we play an integral role in providing relevant and reliable data and analysis to policy-makers, we are neutral and objective in fulfilling our mandate. We neither create policy nor take positions on it. Ultimately, we work to help improve the health care system and the health of Canadians. Maintaining public trust is critical to our success. We're committed to protecting the privacy of Canadians and ensuring the security of their personal health information.

During COVID-19, CIHI's work has focused on three main priorities: first, maintaining the current data supply and looking for opportunities to improve; second, developing analytical products or services that assist with the COVID response; and third, to provide data and information quickly to those who need it.

Let me share one or two examples in each of those three priority areas.

In terms of maintaining and enhancing the data supply, we work closely with our data suppliers to mitigate disruptions to the data. We are pleased to report that hospitals and the majority of long-term care homes were able to complete data collection for the 2019-20 fiscal year within the normal deadlines. We also shared new standards to capture confirmed and suspected COVID cases in care facilities. This information will be critical as we look back at how our hospitals responded to the pandemic. We also created guidelines for race-based data collection in health in an effort to facilitate the collection of high-quality data, which I know was a focus of your earlier discussions.

The second goal is around providing analysis to support decision-making. During the early phases of the pandemic, we received many requests from those who were trying to project the need for hospital beds, for staff and for supplies such as ventilators and personal protective equipment. In response, we developed a tool to help those who are modelling to be able to deliver results at a local level. We also provided advice and facilitated the exchange of information among modelling teams working in different parts of the country. Most recently, we released a report that looked at Canada's pandemic experience in long-term care compared to that of other countries. The report found that early adoption of strict public health measures in long-term care was associated with fewer cases of COVID-19 and lower death rates.

Finally, our third initiative was around responding to requests. In addition, over the past few months CIHI has responded to more than 500 requests for information and data. The topics of these requests have changed over the weeks. Initially, they were very focused on describing the situation: how many cases, how many patients and how many hospitalizations. As time went on, we had more questions around long-term care. Most recently, the questions have focused on the reopening of the health system and ensuring that's done safely, and on the potential consequences of the shutdown on issues such as mental health, substance use and planned surgeries.

● (1310)

As we navigated the pandemic, working closely with our federal partners, it became apparent that there were several gaps in important data flows within and among health care systems in Canada. COVID-19 has highlighted some of these gaps, and we see them falling into one or more of three categories.

The first is gaps in data availability. These are real gaps. The data simply doesn't exist, as the panellists in the first half of this session may have highlighted. The gaps here could include information on supplies and equipment available in the system, or they could be gaps around the characteristics of long-term care homes, such as the number of patients to a room, the ownership models and the staffing ratios. We also saw significant gaps when we tried to examine some parts of the health workforce, such as the number of personal support workers and where they worked.

The second gap involves data that exists but that can't be accessed quickly enough to support decision-making. For example, we needed more timely hospital and emergency room data. This data is collected from hospitals across the country but does not flow in quickly enough to support pandemic-type decisions. To temporarily fill this gap and help the federal government understand whether hospitals were becoming overwhelmed with COVID cases, we created a dashboard report on the supply and use of hospital beds, ICU beds and ventilators. This report is updated manually on a daily basis by key contacts in the provinces and territories as well as CIHI staff.

Finally, some gaps exist because we can't integrate data. Information systems often can't speak to each other, sometimes because they use different standards, but sometimes the data doesn't include personal identifiers that allow this connection. For example, right now we can't follow a patient's full COVID experience from testing through to treatment and, hopefully, to recovery, because public health electronic medical records and health system records are fragmented.

CIHI is always working to enhance the scope and availability of Canada's health system data for analysis and decision-making. While there are many gaps, we recommend focusing on three.

First is comprehensive, timely and integrated health workforce data to support planning and policy.

The collection and analysis of health workforce data is fragmented and incomplete today. We need to capture additional professions in our current systems, such as respiratory technicians and personal support workers, to better understand both the mix of staff who provide front-line care and where they work. We also need to make sure that this data is linkable to data on the use of health services and to financial data systems. This could help identify infection rates in the health workforce, the use of overtime and the longer-term effects of COVID-19 on front-line workers.

The second gap is in the need for more complete and timely data on long-term care homes: the residents, the workforce and the facilities.

While there's excellent information on the clinical profiles of long-term care residents in most parts of the country, there are some significant gaps. We have little information about the residents' quality of life and care experiences before COVID, or how these might have changed during the pandemic. We also have limited information about the facilities themselves, the mix of staff who provide care, and the way infectious outbreaks are dealt with. It's important to recognize that while long-term care treats our most vulnerable seniors, many older Canadians live in a variety of different group care settings for which we have very little information.

The final area is a need for more timely and comprehensive data on hospital-based care and clinic services, both for COVID patients and for patients with other health conditions.

CIHI's hospital data provides deep insight into the number of Canadians treated and the type of care they receive, but this high-quality data is assembled by health information specialists after a patient is discharged from the hospital. To better manage our systems when they're facing emerging issues like COVID-19, but also the seasonal flu or the opioid crisis, we need to automate the flow of hospital data in real or near real time and have more information on patients when they're admitted.

Discussions around these actionable solutions are under way. The groundwork is there, but these solutions require the engagement of health system managers and health care providers, leadership from policy-makers and funding for the development and implementation of information systems.

● (1315)

Today we ask for your commitment and support. Better data allows for better decisions and, ultimately, healthier Canadians.

Thank you for the opportunity to present. I'd be pleased to answer any questions.

The Chair: Thank you.

We go now to the Department of Public Safety and Emergency Preparedness, the RCMP and the Communications Security Establishment.

I believe Mr. Jones is going to start. Please go ahead for a 10-minute statement.

Mr. Scott Jones (Head, Canadian Centre for Cyber Security, Communications Security Establishment): Good afternoon and thank you, Mr. Chair and committee members, for the invitation to appear today to discuss cybersecurity during the COVID-19 pandemic.

As mentioned, I'm Scott Jones and I am the head of the Canadian Centre for Cyber Security at the Communications Security Establishment. I'm very pleased to be joined by my colleagues: Chief Superintendent Mark Flynn, director general of financial crime and cybercrime from the RCMP, and Colleen Merchant, director general of national cyber security from the Department of Public Safety.

Our departments have distinct but complementary mandates as they relate to cybersecurity.

The CSE, reporting to the Minister of National Defence, is one of Canada's key intelligence agencies and the country's lead technical authority for cybersecurity. The Canadian Centre for Cyber Security, or as I will refer to it from now on, the cyber centre, is a branch within the CSE. We defend the Government of Canada, we share best practices to prevent compromises, we manage and coordinate incidents of national importance and we work to secure a digital Canada.

Public Safety leads the Government of Canada's cybersecurity policy work. This involves the implementation of the 2018 national cybersecurity strategy and the coordination of government-wide efforts to help secure digital and cyber-assets through strategic-level initiatives. Public Safety also supports critical infrastructure protection and offers assessment tools to provide expert advice to owners and operators on how to improve their cybersecurity and cyber-resilience posture.

RCMP federal policing is responsible for the investigation of attacks against Canada's critical infrastructure—which includes the health care sector—in collaboration with the police of local jurisdiction. Additionally, the RCMP has its national cybercrime coordination unit, which is a national police service that coordinates the response of Canadian police agencies to cybercrime incidents. Together our three departments work with the greater Canadian cybersecurity community to protect Canada and Canadians from potential cyber-threats.

Today I would like to provide an update on what the current cyber-threat environment looks like in the COVID-19 pandemic and also highlight the important work that the CSE, the RCMP and Public Safety are doing to protect the Government of Canada and Canadians specifically in the context of the health sector.

Cyber-threat actors are attempting to take advantage of Canadians' heightened levels of concerns around COVID-19. Prior to, and amplified by, the pandemic, our lives are becoming increasingly reliant on digital communication. Cybercriminals are aware of this digital reliance and are seeking to take advantage of the current situation. More than ever, collaboration for cybersecurity is critical, whether it is for the cyber-infrastructure underlying the Internet of things, connected devices or for the applications supporting digital exposure notification. Designing solutions with cybersecurity in mind is a condition for long-term success.

From a government perspective, the underlying objective must be to protect Canadians online. These efforts are under way and they are significant, with the cyber centre as the lead for the federal government. Among these efforts, cybersecurity and cybercrime remain interconnected and remind us of the importance of pursuing those responsible through the criminal justice system.

Law enforcement remains a critical element of cybersecurity. As such, the RCMP federal policing program investigates the most significant threats to Canada's political, economic and social integrity, including cybercrime that targets the federal government, threatens Canada's critical infrastructure and the health care sector, involves the use of cyber-systems to facilitate or support terrorist activities and threatens key business assets with high economic impact.

The RCMP works with domestic and international law enforcement partners and with other Government of Canada agencies to ensure that the wide array of cyber-threats is not treated in isolation. Appropriate and timely information sharing is essential for investigation, which in turn contributes to improved cybersecurity for Canadians. For example, the cyber centre and the RCMP work together by sharing information about scams to warn Canadians and share indicators of compromise so they can be blocked and prevented. From a public safety perspective, they tackle these questions by engaging with stakeholders and fostering good discussions to identify problems and propose policy solutions.

The cyber centre is working tirelessly to raise public awareness of cyber-threats to health organizations by proactively issuing cyber-threat alerts and providing tailored advice to the health sector, government partners and industry stakeholders. Throughout COVID-19, the cyber centre has worked closely with industry and commercial partners to facilitate the removal of malicious websites, including those that have spoofed Canadian government departments and agencies. The cyber centre has also helped monitor and protect important Government of Canada programs against cyber-threats, including the Canada emergency response benefit web application. We have continued to evaluate cloud applications, including for the Public Health Agency, and enabled cybersecurity monitoring and defence for cloud usage across the government.

Individual Canadians, however, are also at risk. As people and organizations shift to working and learning from home, personal devices and home networks have become attractive targets. In response, the cyber centre has partnered with the Canadian Internet Registration Authority, CIRA, to create and launch the CIRA Canadian shield, a free DNS firewall service, which provides online privacy and security to all Canadians for free.

● (1320)

The cyber centre has also collaborated with the Canadian Anti-Fraud Centre. It is operated by the RCMP, the Ontario Provincial Police and the Competition Bureau, which are are Canada's trusted sources for reporting and mitigating mass-marketing fraud.

The Anti-Fraud Centre's primary goals are prevention through education awareness, the disruption of criminal activities and the dissemination of intelligence that enables law enforcement to identify organized crime involvement in fraud schemes.

Through targeted advice and guidance, the cyber centre is helping to protect Canadians' cybersecurity interests. I encourage all Canadians to visit getcybersafe.gc.ca and all businesses to visit cyber.gc.ca to learn more about our best practices that can be applied to protect you and all Canadians from cyber-threats.

Finally, the cyber centre has assessed that the COVID-19 pandemic presents an elevated level of risk to the cybersecurity of Canadian health organizations involved in the response to the pandemic. Cyber-threat actors know that the health sector is under intense pressure to slow the spread of COVID-19 and to produce medical treatments to prevent new infections and their spread. Hospitals and other front-line medical services are often vulnerable to malicious cyber-threat activity due to limited cybersecurity capacity.

We continue to recommend that Canadian health organizations remain extra vigilant and take the time to ensure they are applying cyber-defence best practices, including increased monitoring of network logs, reminding employees to be alert to suspicious emails and to use secure teleworking practices where applicable, and ensuring that servers in critical systems are patched for all known security vulnerabilities.

To further protect the health sector, Public Safety, in close collaboration with the cyber centre, is developing a Canadian cyber-survey tool to provide health sector organizations such as hospitals, doctors' offices and long-term care facilities, among others, with an easy-to-use tool to assess the cybersecurity of their organization. The survey can be completed in less than an hour and is completely voluntary. It will be used for two main purposes.

The first is to provide the organization with a report detailing any technical and cybersecurity program-related findings that could and should be addressed to enhance their cybersecurity. The second is to identify cybersecurity trends and common challenges in the health sector to help tailor cybersecurity engagements by the Government of Canada to strengthen the cybersecurity posture of the health sector as a whole. Public Safety is aiming to launch this survey tool in the coming weeks and will broaden the application of this tool to all 10 critical infrastructure sectors to examine the cybersecurity of all aspects of supply chains.

It should also be noted that the RCMP's national critical infrastructure team has worked with the Public Health Agency of Canada to share awareness material within the health sector. In addition, they have divisions across the country to continue to develop new partnerships within the health sector, increasing those organizations' situational awareness of the potential threat landscape.

Together, our three departments would like to note that even when all of the possible precautions are taken, if a compromise occurs, it is critical that organizations inform us of any cyber-incident they experience. Cybersecurity is everyone's responsibility, and it will take all of our expertise and collaboration to protect Canada and Canadians. The more we share, the better protected we will all be. If we don't share, then the next person who gets hit will be the next victim.

Thank you for the invitation to appear before you today. We will be happy to answer any questions you may have.

The Chair: StatsCan, please go ahead. You have 10 minutes for an opening statement.

Mr. Jeff Latimer (Director General and Strategic Advisor for Health Data, Statistics Canada): Thank you very much, Mr. Chair.

I'd like to thank you for the opportunity to appear before your committee as a representative of Statistics Canada. As a public servant, I am always grateful for these opportunities. I'm here with my colleagues Karen Mihorean and Marc Lachance. They will answer questions within their areas of expertise if required.

It's clear to us that the pandemic has raised significant concerns about the disproportionate impacts across Canada based upon socio-economic differences. Not all groups have been equally affected, and we have observed such impacts within our data, particularly among seniors living in long-term care facilities, health care workers, racialized communities, indigenous communities and those living in low-income households.

Before presenting a few key examples, it's important to highlight the data collection accountabilities related to COVID-19.

As you probably know, the provincial and territorial public health authorities are responsible for collecting and reporting within their jurisdictions on COVID-19 cases. The Public Health Agency of Canada is responsible for receiving this data from the provinces and territories and reporting at the national level. While Statistics Canada does not collect COVID-19 data directly, we do provide expertise and advice on gaps in existing data and on potential strategies to address such gaps, as well as data collection and data exchange standards.

I'd like to make one last point related to data collection before I provide examples. There are generally two methods: survey data, from a sample the population, and administrative data, typically from a census of all cases. COVID-19 data is collected through administrative data, which often has a number of limitations. In Canada, it is clear these data limitations are creating significant challenges.

First, there is a lack of common data standards and data exchange standards across the country, along with inefficient data processing and data quality concerns. Second, the lack of granularity in the data that is collected related to COVID-19 makes it difficult to answer key policy questions. For example, there is no data collected on such demographic characteristics as race, ethnicity or income, and no data on an individual's underlying health status. In addition, detailed geospatial data is not available to better understand the spread of COVID-19. Finally, and I think most importantly, the data submitted to the federal government does not include identifiers that could facilitate safe and appropriate record linkage with existing Statistics Canada datasets that could potentially fill these gaps.

That said, we have been actively collecting new survey data and analyzing our existing data to shed some light on the potential indirect impacts of COVID-19. During this time of social distancing, for example, 64% of youth are reporting substantial declines in their mental health status, compared with only 35% of seniors. The unemployment rate for students in May of this year was 40%, which is triple the rate reported last year in the same month. A similar pattern was evident among non-student youth as well. More than 70% of seniors in Canada over the age of 80 report at least one pre-existing chronic condition related to severe symptoms of COVID-19, which is more than double the rate among adults under 60.

If we look at the immigrant population, we see that employment losses during COVID-19 have been more than double compared with the Canadian-born population. We also know that before COVID-19, black Canadians were already experiencing unemployment rates twice that of the general population. The wage gap between these groups has been widening in recent years. Among black youth, almost twice as many report experiencing food insecurity as compared with other young Canadians. Visible minority populations, such as Chinese and Korean Canadians, have reported increases in race-based negative incidents over the last few months. One in ten women have reported being concerned about violence in their home during the pandemic.

If we examine the socio-demographic characteristics of long-term care workers, who are currently facing some of the most difficult challenges, we see that they are more likely to be immigrants, they are less likely to work full time, and they are more likely to earn less than the average Canadian. Indigenous men are two and a half times more likely to be unemployed. They earn, on average, 23% less than their non-indigenous counterparts. In almost all indicators, including health status and life expectancy, the indigenous population lags well behind Canadian averages.

The pandemic has shone a glaring light on many of these pre-existing social inequities that Statistics Canada has been tracking for decades. In order to respond to the need for more data, we have launched a number of rapid data collection vehicles, such as web panels and crowdsourcing surveys. The topics have included the impacts of COVID-19 on labour, food insecurity, mental health, perceptions of safety, trust in others and parenting concerns. Statistics Canada finished collection just yesterday, using our crowdsourcing surveys, to better understand the impact on persons with long-term disabilities. This data will be available in early August. It will include information on visible minority status as well as such other demographic markers as gender, immigrant status and indigenous identity. More data on mental health issues will also be made available in the coming weeks. It will provide breakdowns by gender diversity, immigrant status and ethnocultural groups.

In partnership with the provinces and territories, we have also significantly increased the timeliness of death data in Canada so that a clear picture of excess deaths during the pandemic can be estimated. We will be releasing this data publicly next month.

We are also partnering with the Canadian Institute for Health Information to examine in greater detail the issues among health care workers and long-term care facilities.

● (1330)

Finally, we are working with the Public Health Agency of Canada to make detailed preliminary data on the number of confirmed COVID-19 cases available to Canadians and researchers.

I'd like to thank you very much for your time. My colleagues and I are available to answer any questions you may have.

Thank you, Mr. Chair.

The Chair: Thank you. Thank you to all the witnesses for their statements.

We will start our rounds of questioning and we will undertake to do two rounds. However, we are going to be short on time, so we're going to cut it down. In the first round, we're going to do five-minute time slots instead of six, and we'll start with Ms. Jansen.

Ms. Jansen, please go ahead for five minutes.

Mrs. Tamara Jansen: Thank you very much.

I wonder if I might be able to begin my questions with Ms. Merchant. I have a question in regard to an issue that has had a bit of news.

On March 31, 2019, Canada's National Microbiology Lab sent 15 strains of Ebola and henipavirus to the Wuhan Institute of Virology for the purpose of gain-of-function experiments. In gain-of-function experiments, a pathogen is intentionally mutated for the purpose of seeing if it's more deadly or infectious. An ATIP was recently released that gave us some of the details of that transfer of those viruses to the Wuhan lab, but most of the important information was missing.

Since the government has stated repeatedly how it is committed to a whole-of-government approach to pathogen security, can you explain what part your department played in the investigation of this breach?

Ms. Colleen Merchant (Director General, National Cyber Security, National and Cyber Security Branch, Department of Public Safety and Emergency Preparedness): Was that question directed to me?

Mrs. Tamara Jansen: Yes, Ms. Merchant. I'm wondering about the whole-of-government approach to pathogen security. Can you explain what part your department would have played in investigating this breach?

Ms. Colleen Merchant: That's something that I would not be able to answer. It sounds like it was not a cybersecurity issue. I would be happy to go back and see if someone else in the department would be able to answer that question.

Mrs. Tamara Jansen: Is there possibly anybody else on the panel who might have some information in regard to that breach?

Ms. Colleen Merchant: I don't think so. Scott and Mark from the RCMP would not have information on that either.

Mrs. Tamara Jansen: Okay.

We know that in 2014 China conducted a significant cyber-attack against the NRC and, despite this history, the NRC has partnered with a company connected to the Chinese regime, CanSino, to produce a vaccine in Canada. Are you concerned about this at all?

Ms. Colleen Merchant: From a cybersecurity standpoint, we're very concerned whenever there's an issue with the vulnerabilities in any of the information that may be transferred between organizations. From a telecommunications or a computer security aspect, we're always concerned, whether it's from here to another country or even within Canada.

To secure the infrastructure is where Scott Jones and his organization, the cyber centre, come in to provide the best advice and guidance to organizations such as the NRC.

● (1335)

Mrs. Tamara Jansen: Is your department monitoring the situation right now in regard to the work that's being done with CanSino?

Ms. Colleen Merchant: Public Safety would not be monitoring that. That would more likely be monitored, I would say, from a cybersecurity perspective, by the cyber centre or some of our security and intelligence colleagues, but from a strategic policy point of view, which is where Public Safety fits in, it's not something that we're monitoring closely.

Mrs. Tamara Jansen: It would not be your department that would discover whether inappropriate cyber interactions were happening between, say, that doctor—Dr. Qiu—and the team at the Wuhan Institute of Virology?

Ms. Colleen Merchant: No, it would not be. That's more in the security and intelligence area.

Mrs. Tamara Jansen: Okay. Then I think I'll move on to Statistics Canada.

Mr. Latimer, following the SARS break in early 2003, IBM produced an IT system for the Public Health Agency of Canada called Panorama. It was meant to ensure we had a comprehensive national communicable disease outbreak management system. This program was developed by IBM, the creator of our infamous Phoenix pay system, and in August 2015 the Auditor General of B.C., where I'm from, found that the program was prone to errors, slow to function and susceptible to unsuspected system outages. It was basically a complete disaster that cost B.C. taxpayers alone the ridiculous sum of $113 million, which was 420% more than originally quoted.

Are you familiar with this program and how it functioned?

Mr. Jeff Latimer: Thank you for the question.

I am not familiar with this program, as it's a Public Health Agency accountability, so I would not be able to comment on it. I can comment on the current data situation in Canada, but not on that system.

Mrs. Tamara Jansen: Okay.

The Chair: You have 18 seconds, please.

Mrs. Tamara Jansen: I was wondering about the problem of getting national data collection programs together. Is it because we're unable to get provincial buy-in? I was told that in two weeks, StatsCan could come up with a live system that could be used for this purpose.

Mr. Jeff Latimer: I'm not convinced that two weeks would be appropriate, but I do think that we have the expertise and the experience to help the country develop national data standards and data exchange standards, yes.

Mrs. Tamara Jansen: So you could come up with something like that—

The Chair: Thank you, Ms. Jansen. We'll go now to Mr. Fisher.

Mr. Fisher, please go ahead. You have five minutes.

Mr. Darren Fisher: Thank you very much, Mr. Chair.

Thanks to all of you for being here today. My first question would be for the Communications Security Establishment folks.

We're hearing about coronavirus scams and phishing. Just this week, we're hearing about seniors who are getting calls about the top-up to COVID-19 assistance from the government on OAS and GIS, calls that are asking for information to access their bank accounts in order to deposit this money, when of course they don't have to apply for this money.

How does your organization work with the local RCMP or with local police forces, I guess, to investigate something like this? Also, how do you work to ensure that the public is aware of these scams? We put it on our Facebook today, and it's been shared over 300 times.

Mr. Scott Jones: Thank you for the question, Mr. Chair.

There are actually many different ways we're working on to deal with this. Maybe Chief Superintendent Flynn would like to jump in as well, from the RCMP perspective.

The first thing is that for anything that looks like it's impersonating the Government of Canada, we've been very active in trying to make sure that we are protecting both the brand and the integrity, so we're taking those offline very quickly, to the point where a lot of times that's happening before Canadians can fall victim to it. The second thing, though, is that we also are sharing a lot of information so that these are blocked. For email-based scams that you click on and it gets you to do something, the CIRA Canadian Shield actually has those blocked. Canadians would be protected if they were to use this free service that has been stood up.

In the third way, we are working with the RCMP's Canadian Anti-Fraud Centre, as I mentioned in my opening remarks, to also get information out there so that Canadians are aware. Unfortunately, COVID-19 is a particularly good lure to get people to click and to share information. That's why we've been putting out a lot of information and threat assessments and threat bulletins, etc., as well.

Mr. Darren Fisher: Thank you for that.

For the folks at CIHI, we were all shocked at this committee—we have heard a lot about this, and Nova Scotia has been hit just as hard—to find out that four of every five deaths from coronavirus were those of residents in long-term care.

What kinds of measures do you believe the provinces and territories should implement in long-term care? I know that you folks touched on this a bit during your opening remarks, but how are other countries tackling this problem?

● (1340)

Ms. Kathleen Morris: Thank you very much for the question, Mr. Chair.

You're correct. CIHI did actually share some information quite recently about how the long-term care sector in the country had been quite hard hit.

Overall, looking across all age groups, Canada's death rate from COVID has actually been lower than an international average, but the incidents in long-term care have definitely stood out as one of the highest. One of the things we learned from this was that countries that implemented some specific measures targeted at the long-term care sector at the same time as they put in their broader shutdown measures really had many fewer COVID infections and deaths in long-term care. Some of the things that might be included in specific long-term care measures would be around broad testing for residents of long-term care facilities, and repeated testing. There would be isolation wards, potentially, to make sure that if one of the residents becomes ill, there's a way to separate that resident from others to reduce infection.

As well, one of the important parts is is to have the right kinds of supports for long-term care workers, such as being able to use surge staffing, for example, when the caseload became greater. In Canada's case, the army was involved in some provinces. Others were having specialized trained teams and were making personal protective equipment freely available so that all of the long-term care workers felt secure.

Those are some of the measures we've seen in other countries that had lower death rates in long-term care.

Mr. Darren Fisher: They had higher death rates possibly across the board, but they were lower in long-term care.

Ms. Kathleen Morris: That's correct.

Mr. Darren Fisher: To the StatsCan folks, thank you for being here.

Tell me a little bit about how StatsCan is changing from what they normally would do and going above and beyond because of this new normal and the impacts we're facing with COVID-19.

Mr. Jeff Latimer: I think in my opening remarks I highlighted a few things. I'll repeat them and add a few that I think are important.

First and foremost, we have been implementing significantly new data collection methods that are quite rapid. For example, our web panels and our crowdsourcing surveys, while they're not the same as our full representative surveys across the country, are providing significant and new information in a very rapid time frame. I think that's a critical step forward. We're still relying, and we need to rely, on our national statistics program, but these are interesting and important additions.

We've also been working with the provinces to speed up the collection and reporting of death data in Canada. That's a critical piece. It used to be two years, almost, between the fact of the death and the reporting, and we are now planning on releasing monthly reports. We are working with the provinces and territories and we are hoping to have as much coverage as we can on a monthly basis. Those reports will be starting next month. It's a massive increase, and I think an important one for Canada, to start to see the death data and to move forward with that data. Those are two that I think are really important.

We are working in a number of other areas. Disaggregation of data is a critical piece. We're really working hard to try to make the data available at the level that's required to make significant policy decisions.

Those are three that I would highlight.

The Chair: Thank you, Mr. Fisher.

[*Translation*]

It is now Mr. Desilets' turn.

Mr. Desilets, you have the floor for five minutes.

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

My thanks to all the witnesses for joining us. I also thank them for agreeing to provide us with their expertise and their knowledge.

My first question goes to Mr. Latimer.

Here on the Standing Committee on Health, we have heard, on several occasions, a good number of participants talk to us about all the major difficulties, that happen everywhere and in different ways, in circulating information and data, in collecting those data, and in exchanging data between the provinces and the federal level.

Today, just now, we heard the representative from the Canadian Institute for Health Information tell us about those same concerns. An hour earlier, it was Dr. McKenzie. In short, a number of witnesses have brought up the matter.

Mr. Latimer, do you agree with the statement I am making?

● (1345)

Mr. Jeff Latimer: Thank you very much for your question, Mr. Desilets.

[*English*]

I would agree that there are significant issues in the way in which COVID-19 data is collected in the jurisdictions and reported federally. I highlighted a couple in my opening remarks.

There really are no common data standards and data exchange standards across the country. I think that is a significant issue. The level of detail that is collected does not provide the important demographic breakdowns that would be required. As well, personal identifiers at the federal level are also not available. That linkage would be a significant savings and a way in which we can fill in data gaps through record linkage with our existing data holdings.

Therefore yes, I would agree with that statement.

[*Translation*]

Mr. Luc Desilets: In a developed country like ours, how do you explain the fact that we do not have a master plan, an integrated plan, although we are well aware that, in the case of a pandemic such as the one we are experiencing, information is critical?

South Korea managed to establish a system that gave very precise guidelines in 24 hours. This is your area: perhaps you can understand it. Frankly, I cannot.

How is it that we have no integrated plan to transmit critical information?

Mr. Jeff Latimer: Thank you for the question.

[*English*]

I do not want to speak on behalf of my colleagues at the Public Health Agency of Canada, but I will say that they are working on a strategy. We are collaborating with them every single day and working closely to help develop a national strategy that would address all of the issues I've highlighted.

[*Translation*]

Mr. Luc Desilets: Mr. Latimer, am I to understand that the responsibility should fall to the Public Health Agency of Canada? Should the agency manage, supervise and control this compilation of extremely essential information?

[*English*]

Mr. Jeff Latimer: I would not be comfortable. I think it's well above my decision-making authority to decide who in Canada should be collecting this data.

I will say that both organizations have the expertise, and we are working collaboratively to fill in the gaps.

[*Translation*]

Mr. Luc Desilets: I am talking about the Public Health Agency of Canada. What is the other organization you mention?

[*English*]

Mr. Jeff Latimer: I was talking about the Public Health Agency of Canada and Statistics Canada, and we are working collaboratively with Health Canada as well. We are working with all three.

[*Translation*]

Mr. Luc Desilets: Thank you very much, Mr. Latimer.

Do I have any time left, Mr. Chair?

[*English*]

The Chair: You have about 40 seconds.

[*Translation*]

Mr. Luc Desilets: I will be quick.

Mr. Jones, two weeks ago, the Standing Committee on Health asked the government to establish a way for security to be built into digital products and services from their design stage.

Does that seem realistic to you?

[*English*]

Mr. Scott Jones: I think it's very important, as I mentioned in my opening statements, to have cybersecurity designed from the start to understand what threats can be faced. Unfortunately, when we look at an application, typically we look at the benefits. We also need to look at how it can be misused from a cybersecurity perspective. I think we've made a lot of strides, certainly in the exposure notification system. Part of the team that's working on this is making sure that it is ready from the start and designed with cybersecurity in mind.

It's important that we continue to reinforce that it's not just the benefits of the technology. We also have to look at how it can be misused.

[*Translation*]

Mr. Luc Desilets: Thank you, Mr. Jones.

The Chair: Thank you, Mr. Desilets,

[*English*]

We will go to Mr. Davies.

Mr. Davies, please go ahead for five minutes.

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

Thank you to the witnesses for being here.

Ms. Morris, my first question is to you.

Does CIHI currently collect national information regarding the availability of health care system resources such as ventilators, intensive care units and hospital beds?

Ms. Kathleen Morris: We do collect that information and we have quite detailed information on the patients who would be using these services. One of the challenges is that it flows a little more slowly because it's based on discharge data, so it's not available as quickly as we might like during a pandemic situation.

One of the things that we've done to address this issue is pull together data very quickly, working with the provinces and territories, to create a dashboard that looks at the supply of ICU beds and ventilators, the number of COVID patients who are using these resources and the number of people with other health concerns who need that type of care. We put that together and update it daily.

● (1350)

Mr. Don Davies: Thank you.

Do all provincial and territorial governments now provide CIHI with that information?

Ms. Kathleen Morris: Yes. There are a few small gaps, but in general we're getting good data flows from the provinces and territories.

Mr. Don Davies: Could you undertake to provide this committee with a list of that information? I'm curious, for instance, to know how many ventilators we have available in Canada, particularly if we face a second wave in the fall. Is that something you could provide to the committee?

Ms. Kathleen Morris: I believe that would be possible, and I will take a look at the.... The numbers change daily, but we will endeavour to bring you some of that information after the meeting.

Mr. Don Davies: Thank you.

In response to calls for better demographic data to understand health inequities and COVID-19, in May CIHI released an interim race data standard, intended for use by any jurisdictional organization that decides to collect this kind of data. However, as you probably heard in the first panel and after that, many advocates have criticized this approach because it's voluntary. They say the federal government has a leadership role to play to ensure there's consistent pan-Canadian data, regardless of jurisdiction.

Since the current gap in information makes it impossible to target resources and care where they're most needed, should the federal government impose mandatory national standards with respect to the collection and sharing of socio-demographic data related to COVID-19?

Ms. Kathleen Morris: We believe that having as much detailed data available as possible is critical to understanding, planning and managing health services. We've worked for quite a long time with affected communities to develop what we call our equity standards. Those talk about income, sex, gender—a number of things—and they include race and indigenous status. They are important to really understand the situation and to plan services.

One thing we've learned through this is that while collecting the data is important, it's also very important that the communities that generate the data or are the subject of the data are comfortable with collaborating in the data collection. In many cases there are racialized groups in particular who believe that data collection has been used for purposes that have created difficulties for them. We believe that attitude is changing and that the benefit of data is clear. Our role is to provide the standards so that it's collected in comparable and clear ways and can be aggregated for good use.

Mr. Don Davies: Mr. Latimer, you've identified that one of the gaps is a lack of common data standards nationally. Do you also think there should be national mandatory reporting with respect to demographic information, such as race and ethnicity? I would note that we do know, and we heard in the previous panel, that in our census StatsCan does give a sample of 100,000 people who are typically asked those questions. Is it time to make that apply to everybody?

Mr. Jeff Latimer: I'm going to turn to my colleague Marc Lachance, who has the expertise to answer that question for you.

Mr. Marc Lachance (Acting Director General, Diversity and Populations, Statistics Canada): Good afternoon.

This is a very good question. Similar to our colleague from CIHI, Statistics Canada produces national standards. As you mentioned, the census is one of the major data collection activities in which we apply those standards. As a national statistical organization, Statistics Canada makes all those standards available. We develop them with communities and with experts. We also test them with the respondents to ensure that they understand those standards. As a result, we have standards that we can make available to other organizations. They're all available publicly. As mentioned, they are all trusted and used.

We are also working closely with our—

● (1355)

Mr. Don Davies: With respect, Mr. Lachance, the question is whether or not you would make it mandatory for all Canadians to be asked about race and ethnicity instead of only 100,000.

Mr. Marc Lachance: I don't think I understand the question about the 100,000.

As you know, in the census we do ask those questions to a certain ratio of the population. There are standards relating to ethnicity and ethnic origins. We also have visible minority questions. Those are the questions that we ask through the census, and also through other surveys.

Statistics Canada doesn't have the mandate to force those standards. We apply those standards to our surveys to ensure that the interoperability among our surveys is as good as the census and other population surveys we are administering, including the health surveys.

Mr. Don Davies: Thank you.

The Chair: That ends round one. We will start round two now. We're going to cut back time on this round as well. The five-minute slots will go to four minutes. The two-and-a-half-minute slots, unfortunately, will have to go to two minutes.

Mr. Webber, please go ahead for four minutes.

Mr. Len Webber: Thank you, Mr. Chair.

Mr. Latimer, you brought up StatsCan's collection of data on COVID-19 deaths. I want to know whether you are collecting data on non-COVID deaths due to cancellations of elective surgeries, such as heart procedures or cancer treatments, because of the response to this pandemic.

Mr. Jeff Latimer: We collect data on all deaths in Canada, not just COVID-19. The monthly death reporting that we're planning on starting next month will include all deaths that are reported to us from the provinces and territories. We would not be able to make a determination as to whether those deaths were the result of something, but other analysts may be able to look at those questions.

Mr. Len Webber: Thank you for that.

This question is directed to Mr. Jones at the cyber centre.

Almost overnight and without warning, industry and government went home to work during this pandemic, adopting things like Zoom overnight, as we did here. There is much talk about government employees working from home in the future as well. Many of these employees have access to state secrets, military information and personal information.

How would you recommend that we balance the risks between personal safety and security and national safety and security?

Mr. Scott Jones: I think there are a lot of important elements. First, we do have advice and guidance for Canadians who are working from home with regard to the things they can do. In using Zoom, for example, as we are right now, you can be a lot more secure by using lobbies, waiting rooms, word passcodes and things like that, so that you can't be "Zoom-bombed"—the tool of the time—or something like that. In working from home, a lot of things can be done to make yourself more secure. Canadian Shield is one of those for every Canadian.

From a government-specific aspect, though, we work with our colleagues at Shared Services Canada and Treasury Board. For example, I use a government-furnished device that is managed very carefully. I do not have administrative privileges. We do have defensive monitoring, and it works through the government network. Even though I'm using my home Wi-Fi, I am not connected directly to the Internet. I connect back into the government through a secure network.

With regard to the national security side of things, which is also one of our responsibilities, I have people who are still working inside secure facilities because the nature of the work requires it.

Mr. Len Webber: Thank you.

Do you have any concerns, Mr. Jones, about Huawei technology in home Internet networks?

Mr. Scott Jones: I think one aspect we really look at is how to layer in multiple levels of cybersecurity. From my perspective, every piece of technology has some level of vulnerability. We really look to offset that. If one product doesn't work the way you expect, how do you layer it in?

I'll use the example of my work device here, which is connected over VPN. We use encryption to protect the confidentiality of the work that's being done. We've done operating system hardening, so we've turned off a lot of features. I can't install different software. I can't bypass our security controls. Even if, for example, somebody manages to put the alligator clips, to use an old term, on the lines, they can't read anything I'm doing. The encryption is protecting it.

It's about layering security so that you're not dependent on just one thing to protect yourself.

● (1400)

Mr. Len Webber: Thank you for that.

This is a question for Chief Superintendent Mark Flynn of the RCMP. This issue wasn't discussed here today, but I am certainly curious about it.

The RCMP is responsible for enforcing quarantines. We understand that compliance rates have left much to be desired, as many have thumbed their nose at the requirement to isolate for 14 days. Can you explain how you enforce the quarantines and, more importantly, how you deal with non-compliant travellers, such as U.S. travellers claiming they are going to Alaska through Canada and taking other alternate routes in Canada?

Chief Superintendent Mark Flynn (Director General, Financial Crime and Cybercrime, Federal Policing Criminal Operations, Royal Canadian Mounted Police): I am from the RCMP. Unfortunately, that is not an area of my responsibility. I can say, however, that the RCMP, being both federal police and provincial police for many of the provinces across the country, have been actively involved in significant efforts to enforce the Quarantine Act.

I'd be happy to go back to my colleagues to get some additional information for the committee.

Mr. Len Webber: That would be fantastic. Thank you.

Mr. Chair, can I just ask that the information be provided through you to the committee?

The Chair: Yes, absolutely. Thank you, Mr. Webber.

Witnesses, please take note that if you have any information that you want to send to the committee, send it to the clerk. It will be translated as appropriate and distributed.

Mr. Kelloway, please go ahead. You have four minutes.

Mr. Mike Kelloway: Thanks, Mr. Chair.

Colleagues, staff and witnesses, thanks for being here today.

My questions are for StatsCan. I'd like to start by talking about Canadians and mental health during this pandemic. We know that many factors related to the COVID-19 pandemic—job loss, isolation, uncertainty, anxiety—can impact the mental health of individuals.

Can you describe the impact that COVID-19 has had on the self-perceived mental health of Canadians?

Mr. Jeff Latimer: I'll start with one short answer and then turn to my colleague Karen Mihorean for more details, if she has some.

One point we are making is that we have seen a significant decline in self-reported mental health during the pandemic. I highlighted in my remarks that 64% of youth, which is a significant number, have reported declines in their mental health status, and 35% of seniors. It is obviously an important issue.

Karen, do you have any additional information that you'd like to provide?

Ms. Karen Mihorean (Director General, Social Data Insights, Integration and Innovation, Statistics Canada): Yes, thank you.

What we've found is that not just youth have experienced a significant impact on their mental health. We've been able to compare the data from our crowdsourcing and our web panel surveys to the Canadian community health survey, looking at overall rates and general perceptions of mental health in what people were reporting in 2018-19 and then how it compares now. It's not just in youth that we are seeing a decline; we're also seeing it among the indigenous population and in immigrants. These are also populations that have been particularly hit with job loss, for example, and the ability to remain financially stable. We are seeing rather significant declines in self-perceived mental health among those three groups especially.

Mr. Mike Kelloway: The numbers on any one of those groups are staggering to me. The 60% with respect to youth is quite striking.

With respect to the report on self-perceived mental health, are there any policy recommendations that come from it? I know you've just mentioned some key findings, but are there any policy recommendations that you can share with the committee and the rest of us?

Ms. Karen Mihorean: Statistics Canada doesn't make policy recommendations. We provide the information for our colleagues—for instance, PHAC, Health Canada and associations across the country—so that they see the data and, given the more severe impact of COVID on the mental health of certain groups, come up with the policies that are best placed to address that issue.

Mr. Mike Kelloway: Wonderful.

Mr. Chair, how much time do I have?

The Chair: You have one minute.

Mr. Mike Kelloway: Oh, wonderful.

Mr. Jones, we know that cyber-attacks on health and research organizations can come from many different actors throughout the globe, as in the case of a state-sponsored attack, for example. What plan is in place at Public Safety Canada or the RCMP, or both, to put an end to the attack, find the guilty party and prevent further attacks?

● (1405)

Mr. Scott Jones: Typically, if there is an attempt to compromise a health organization, we would respond from the cyber centre.

We've done a few different things. The first is alerts. When we see anything that a health organization needs to take action on, we issue those alerts, and they're timely. It's either alerts or flashes, etc. Those are things that need to be acted on immediately. Unfortunately, what we've seen is that some of them aren't acted upon, leaving vulnerabilities open and essentially making it free to compromise organizations.

The second thing is that multiple times a week, we have a call with all of the health sectors around Canada to continue to provide advice on what they're seeing and what we're seeing in terms of targeting, so they can also share information back to us. It's very important that it be in two directions, and that when they see something suspicious, they report it to both us and to the RCMP, in the event of criminal matters, although we do share, and it's important that we continue to share.

The third thing is that we published a threat assessment specific to the health sector, a threat bulletin to tell them that they can expect to see increased state-sponsored targeting as states look to gain more information on, for example, vaccine production and research, and to warn them what it would look like and then to continue to try to build awareness, because at the end of the day, prevention is far cheaper than responding to any incident.

The Chair: Thank you, Mr. Kelloway.

We go now to Mr. Jeneroux.

Mr. Jeneroux, please go ahead for four minutes.

Mr. Matt Jeneroux: Thank you Mr. Chair.

Thank you to the witnesses for being here today on a busy July day.

I want to follow up with Ms. Morris. With regard to a question from my colleague Mr. Davies, I asked about the information on ventilators and hospital beds. I'm curious as to when you started collecting that information. Was that, say, before January?

Ms. Kathleen Morris: We have some baseline data, particularly on hospital beds and ICU beds, and more recently, I would say over the last few months, we have been collecting information from provinces and territories on that, so we have both historical baseline data and more up-to-date information.

Mr. Matt Jeneroux: On the up-to-date stuff, approximately when did that change so that you started collecting more of that?

Ms. Kathleen Morris: That's in the last several weeks.

Mr. Matt Jeneroux: Okay. Thank you.

To Statistics Canada, it's my understanding that you guys are developing a national household survey on COVID-19. Is that correct?

Mr. Jeff Latimer: No, we don't have a national household survey, but I will let Karen speak to you about the surveys we are launching, if you like.

Ms. Karen Mihorean: Thank you for that question.

As we've already mentioned, and as Jeff mentioned in the opening remarks, we did develop a web panel that we use to follow about 7,000 Canadians. These are labour force rotate-outs, so they participate in our labour force survey. This is what we call our probabilistic sample, which we can generalize to the general population. We launch a new topic through our web panel. It is a household survey, done through an electronic questionnaire, and they are provided with the link to respond to the questions. About every four to five weeks we send a different theme, and all of these themes have been specifically related to various things related to COVID: job loss, behaviours they've taken to protect themselves or, as we mentioned before, mental health. We've asked questions around recovery and those sorts of things.

Then we also have our crowdsourcing, which is not a household survey. We are currently working with the Public Health Agency of Canada on a survey of about 25 to 30 questions to look at the unintended consequences of COVID. We're hoping to launch that survey sometime later in August. That survey will be, again, a probabilistic survey that we will be able to generalize to the population. We will have at least national, provincial and territorial estimates, and hopefully we will have them for the larger CMAs as well. I'm sorry I don't have the exact sample size for that survey.

Mr. Matt Jeneroux: It would be great if we could have you back to explain some of the data that you get. I think that would be interesting.

My last question goes back to CIHI.

We saw that data was obviously lacking in the lead-up to COVID-19. What recommendations do you have to improve our data sharing regarding COVID-19, but also in any future pandemic or a second wave?

● (1410)

Ms. Kathleen Morris: I think creating the infrastructure to have more timely hospital data would be a critical piece to support public health surveillance. The hospital data is very rich, and it's a fabulous resource for both health system managers and researchers to follow patients over a long course of time. The piece that is missing in it is the quick and timely information on admission so that public health has that information as soon as a patient is hospitalized.

It's been challenging with COVID because people very often have very long lengths of stay, and getting the information only when the patient has left the hospital delays things for up to a month.

The Chair: Thank you, Mr. Jeneroux.

We go now to Dr. Jaczek. Dr. Jaczek, please go ahead for four minutes.

Ms. Helena Jaczek: Thank you very much. My questions will be directed to CIHI and StatsCan. As a number of my colleagues on this committee have said, the testimony from witnesses overall has been extremely critical of our existing datasets, the timeliness and so on. I am sure you are very aware of that.

Ms. Morris, you have obviously told us that the Public Health Agency of Canada, StatsCan and CIHI have very clearly articulated areas of responsibility for which they collect data. Mr. Latimer has made the comment that in fact there is really no identifier that links across these organizations so that a researcher can follow the data on a particular individual, although obviously with non-nominal data. They cannot link across easily. You have made a reference to data-sharing agreements.

Can you explain how a researcher might use those data-sharing agreements to facilitate an inquiry? Our witnesses earlier today made it very clear that in the United States there was a very easy way of following datasets and linking them. What do you see going forward? What exists now, and how could we improve?

Ms. Kathleen Morris: Thank you very much for the question.

Researchers are a big customer of CIHI. I spoke of 500 data requests. Many of those were from researchers looking for information to do modelling work to help predict the impacts of the pandemic on the health system as well as to model restarts in terms of beginning elective surgery and other procedures as things started to improve.

One of the things that's particularly helpful with the CIHI data is that it does come with an identifier, so we can follow patients across datasets in terms of the prescription drugs they've been prescribed, whether they are in long-term care, in hospital settings or, in some cases, in primary care. We can follow them across.

That's particularly helpful in looking at health system performance measures such as readmissions or repeat emergency department visits, and it's very helpful at following the complications that might happen over time. For example, with COVID, it would be very interesting to know whether there are any long-term health consequences for patients who test positive that we could follow over the course of their lifetimes.

However, you're correct that there are data gaps. Some of them relate to the timeliness of the data. The data that CIHI collects has been built to facilitate benchmarking across long-term care facilities, hospitals and health regions, and the benchmarking supports improved health system performance. The data is complete, it's comparable, it uses common standards, and it provides very good information on care, but things like readmissions or pain levels in long-term care or worsening pressure ulcers are all things that don't change from day to day, typically, and the improvement efforts are okay if you can provide that information on a quarterly basis or an annual basis.

● (1415)

Ms. Helena Jaczek: Ms. Morris, can PHAC use that identifier to link with their dataset?

The Chair: I'm sorry, Dr. Jaczek, but your time is up.

Ms. Helena Jaczek: Could I have a yes or a no?

Ms. Kathleen Morris: CIHI data could be linked to testing data, because I believe both of them have a unique identifier.

[*Translation*]

The Chair: The floor now goes to Mr. Desilets.

Mr. Desilets, you have the floor for two minutes.

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

My first question goes to Mr. Flynn.

We have heard about the situation where Dr. Xiangguo Qiu, her husband, and a group of students were expelled from the National Microbiology Laboratory in Winnipeg.

How was the Royal Canadian Mounted Police called on to play a role in that situation?

[*English*]

C/Supt Mark Flynn: Thank you, Mr. Chair.

The RCMP can confirm they've had referrals with respect to activity at the Winnipeg lab. However, it would be inappropriate and could potentially impact an investigation if I were to speak to it with any detail here this afternoon.

[*Translation*]

Mr. Luc Desilets: I can understand the situation perfectly.

Can you tell us whether Canada considers that the situation has anything to do with an espionage activity?

[*English*]

C/Supt Mark Flynn: As I stated, for me to speak at any level with respect to the investigation could jeopardize that situation.

[*Translation*]

Mr. Luc Desilets: Okay, I understand. No problem.

What lesson should we take from the incident?

Is Canada too open to receiving foreign researchers and including them in our teams?

Can it be a simple screening error?

[*English*]

C/Supt Mark Flynn: In a general sense, without speaking about this incident, if you look at the history of crime, we have all types of individuals—Canadians, immigrants and foreign individuals—who are involved in significant crime in Canada. It's difficult to speak in generalities around this type of situation.

[*Translation*]

The Chair: Thank you, Mr. Desilets.

[*English*]

Thank you.

[*Translation*]

Mr. Luc Desilets: Thank you.

[*English*]

The Chair: We now go to Mr. Davies.

Mr. Davies, please go ahead for two minutes.

Mr. Don Davies: Thank you.

Mr. Latimer, at his appearance before this committee on April 14, Dr. Amir Attaran said the following:

> Scientists need transparent data on the disease from every province to make mathematically and medically accurate disease models and forecasts. We're not there, because the provinces hold the data, and sharing it with the Public Health Agency of Canada is optional. They have no legal obligation to share. Then, even more foolishly, the Public Health Agency of Canada censors the data before it's disclosed to scientists, probably to avoid embarrassing certain provinces.

Can you confirm if PHAC has engaged in the practice of removing information from the provincial and territorial COVID-19 data disclosed to scientists through Statistics Canada?

Mr. Jeff Latimer: I cannot confirm, explain or comment on that. I have no idea what the Public Health Agency of Canada is doing. What I can tell you is that it's highly unlikely in the data they're sharing with us. The only thing we're doing is cleaning it for accuracy. We're not removing or hiding any of the data we put on our website.

Mr. Don Davies: Okay, thank you.

Mr. Jones, I just want to be clear on this: Can you confirm if there have been any successful cyber-breaches at Canadian research institutions working on COVID-19?

Mr. Scott Jones: Yes, we have had successful breaches. We've been looking to continue to reinforce other research institutions, including through proactive advice and guidance. One of the challenges, I think, that's mostly unknown is that research institutions tend to be what we would call more of a small or medium-sized organization, so we'd also refer them to not only the specific health sector guidance but also the pragmatic steps and advice on guidance that we've given for small and medium-sized organizations to look at.

● (1420)

Mr. Don Davies: Can you confirm whether any of those were state sponsored?

The Chair: Thank you, Mr. Davies, your two minutes are up.

We are running short of time. We're up against a hard cap.

I'd like to thank all the witnesses once again for being here and for sharing with us your time and your expertise. We appreciate it. It will help our study a great deal.

Thank you to the members.

With that, we will adjourn.