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Official Report of Debates (Hansard)

P-7

Standing Committee on Public Accounts

2021 Annual Report, Auditor General:

Value-for-money audit, COVID-19 personal protective equipment supply

2nd Session
42nd Parliament

Wednesday 30 March 2022

Chair: Taras Natyshak
Clerk: Christopher Tyrell

Journal des débats (Hansard)

P-7

Comité permanent des comptes publics

Rapport annuel 2021, vérificatrice générale :

Audit de l'optimisation des ressources, Approvisionnement en équipement de protection individuelle lié à la COVID-19

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Mercredi 30 mars 2022

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 30 March 2022

Mercredi 30 mars 2022

The committee met at 1231 in room 151, following a closed session.

2021 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH

MINISTRY OF GOVERNMENT AND CONSUMER SERVICES

MINISTRY OF ECONOMIC DEVELOPMENT, JOB CREATION AND TRADE

MINISTRY OF LABOUR, TRAINING AND SKILLS DEVELOPMENT

Consideration of value-for-money audit: COVID-19 personal protective equipment supply.

The Chair (Mr. Taras Natyshak): Good afternoon, colleagues and guests. I would like to call this meeting of the Standing Committee on Public Accounts to order. We're here to begin consideration of the value-for-money audit on personal protective equipment supply from the 2021 annual report from the Office of the Auditor General.

Today joining us are officials from the Ministry of Health, the Ministry of Government and Consumer Services, the Ministry of Economic Development, Job Creation and Trade, and the Ministry of Labour, Training and Skills Development. Welcome. You will have 20 minutes, collectively, for an opening presentation to the committee. We'll then move on to the question-and-answer portion of the meeting, where we'll rotate back and forth between government and official opposition caucuses with 20-minute intervals, with some time allocated for the independent member.

So now, without any further interjections, I would invite each of you to introduce yourselves for Hansard before you begin speaking, and you can begin when you're ready. Thank you.

Dr. Catherine Zahn: I'm Dr. Catherine Zahn, Deputy Minister of Health.

Ms. Renu Kulendran: Hi, I'm Renu Kulendran. I'm the Deputy Minister of Government and Consumer Services.

Ms. Alison Blair: Hi, there. I'm Alison Blair. I'm the associate deputy minister for pandemic response and recovery.

Mr. Doug Kent: Hi. I'm the assistant deputy minister for Supply Chain Ontario, and my name is Doug Kent.

The Chair (Mr. Taras Natyshak): The floor is yours. You have 20 minutes.

Dr. Catherine Zahn: Thank you very much, Mr. Chair. Good afternoon, everyone. As I mentioned, I'm Dr. Catherine Zahn, and I'm the Deputy Minister of Health. Thank you to all the members of the Standing Committee on Public Accounts for having me here to speak today.

Thank you very much to my Ministry of Health colleagues, all of whom have dedicated countless hours to lead and support the province's pandemic response. Please welcome Alison Blair, associate deputy minister responsible for pandemic response and recovery. With me, I also have Melanie Fraser, associate deputy minister of health services, and Kyle MacIntyre, assistant deputy minister of the health transformation division.

I'd like to thank the Auditor General for her recommendations through the value-for-money audit on the COVID-19 personal protective equipment supply.

I'd like to start by stating the principles that drove our decision-making at the onset of, during and as we begin to emerge from the pandemic. These included, first of all, optimizing continuity of patient care; secondly, supporting the health and safety of health care and other front-line workers; and third, collaborating across government and the health sector to get the job done.

The work under discussion today was driven by the need to secure a sustainable supply chain for personal protective equipment, or PPE, and other critical products in support of these goals. As a ministry, we've learned and will continue to learn from the experience of the COVID-19 pandemic to ensure Ontario is prepared for and able to respond expediently to future emergencies of all types.

When I joined the Ministry of Health in September 2021, I engaged my team in an exercise designed to focus our work on strategic priorities. It should be no surprise to you that managing the pandemic response and recovery was at the top of that list, and we recognize that the sine qua non for that response and recovery was urgent action to protect and support health care workers.

Throughout the pandemic, Ontario's health care workers have been incredibly courageous. They're skilled, they're flexible and they're resilient. The ministry, our government partners and the health sector worked together to get PPE, other critical supplies and infection prevention

and control practices in place and up to speed at the interface of patient care.

As we look back on these two years, we're asking ourselves so many questions: What did we start to do that we plan to continue to do—the positive learnings from the experience—and what did we start to do that will stop, as well, as the inverse of that? What were we doing before that we had to stop, and which of those things should we revive? We're examining every inch of our work and will continue to walk through this challenging time with the health and safety of health care workers and patients as our very top priority.

To set the stage, at the onset of the pandemic, COVID-19 put pressure on the end-to-end global supply chain as countries around the world struggled to obtain pandemic supplies of all types. This was particularly difficult in health care for smaller organizations, particularly those that had limited administrative capacity. Ontario's health sector faced an urgent need for PPE, and Ontario responded with rapid action, mobilizing across government and the health sector to respond.

Over these two years, it's been quite amazing to participate in this coming together to support a global effort against the COVID-19 pandemic. The Ministry of Health worked across government to mobilize our incident response structures and establish a pandemic supply chain task force. The pandemic supply chain task force is a collaboration that brought together the Ministry of Health, the Ministry of Government and Consumer Services, Ontario Health and the shared services organizations that provide supply chain services to hospitals. This task force consolidated the planning, sourcing, tracking and distribution of PPE, as well as other critical supplies, across Ontario. It allowed health organizations of all sizes to leverage Ontario's buying power and capabilities, including sourcing, procurement, management and distribution solutions. Ontario Health, which had been in existence for only a year, inherited a leadership role and shouldered the burden of pandemic operations throughout the successive waves of the pandemic. I think that the results speak for themselves. Ontario has demonstrated some of the best outcomes in the world during the pandemic. This would not have been possible without the rapid pivot of the ministry and Ontario Health to a laser focus on COVID-19.

Continuing with the partnership theme, through collaboration with community agencies and organizations, the Ministry of Long-Term Care and the Ministry for Seniors and Accessibility, we established targeted programs, proactively deploying PPE and, indeed, IPAC capabilities as well as supplies of other sorts to the spots where they were most needed. Early efforts to source PPE for the province's stockpile at a time when the global supply chains were disrupted helped to quickly get Ontario on its feet. This process has now matured into an integrated pandemic supply chain operation, involving partners across government, agencies and the sector.

In the first few months of the pandemic, the ministry responded to literally tens of thousands of requests for masks, gloves, gowns, face shields, respirators and other equipment to protect health care professionals and other front-line workers. Government staff worked seven days a week, sometimes 24 hours a day, to deliver PPE within 24 hours to sites in urgent need, and we sent proactive shipments of PPE to vulnerable sectors.

As of February 2022, the government has invested over $2.5 billion to purchase over 1.35 billion masks, one billion gloves, over 42 million gowns, 17.5 million face shields, 218 million N95 respirators and other critical pandemic supplies. We track PPE levels through a weekly virtual inventory of PPE, giving us a deeper understanding of the sector's needs and the ability to respond preemptively. Now, even in the face of increased demand, we have a robust, stable and closely managed supply of PPE in the province that can meet our current and future needs.

As we look forward, recovering from the COVID-19 pandemic will take time. Supporting our front-line workers is, as I've already mentioned, a top priority for the ministry. We'll continue to work with our government and agency partners to perfect a secure, resilient and sustainable PPE supply chain that we can rely on for generations to come. We've gratefully received the Auditor General's recommendations and are committed to addressing them, working towards a reliable health system that includes a strong PPE supply chain.

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Thank you very much for your time today. I look forward to continuing the conversation.

The Chair (Mr. Taras Natyshak): Thank you very much.

Ms. Renu Kulendran: Thank you to the Chair, to the committee and to my colleague Dr. Zahn. My name is Renu Kulendran. I'm the Deputy Minister of Government and Consumer Services.

It's a privilege today to address the Standing Committee on Public Accounts and to provide an update on my ministry's progress on the Auditor General's value-for-money audit of the government's COVID-19 personal protective equipment supply.

I'd like to take a moment to introduce the officials joining me. To my left is Doug Kent, who is the assistant deputy minister of our ministry's supply chain, Ontario division. Just behind him are Chris Gonsalves, who is the assistant deputy minister of the Ministry of Government and Consumer Services supply chain transformation office, working very closely with Supply Ontario as it gets established; and then finally Jackie Korecki, who is the director of the change management branch, also representing the Ministry of Government and Consumer Services, Supply Chain Ontario. All have been very much involved in pandemic response, supply chain and working with various sectors.

We would like to thank the Auditor General and her staff and acknowledge their work over the course of this audit. Collectively, we're reviewing all the recommendations and continue to work to implement them. We also recognize that the role of the Auditor General is vital in ensuring democratic transparency and accountability. As

a ministry, we take the recommendations in the report very seriously, and we are committed to examining areas where we can improve.

My ministry is aligned with the recommendations made in this report, and we are committed to building on them and the lessons learned from the COVID-19 pandemic to ensure that Ontario is better prepared and able to respond to future emergencies by ensuring access to personal protective equipment and critical supplies to keep Ontarians safe. MGCS is continuing to take strides to centralize and strengthen purchasing practices to address these recommendations.

To lay the groundwork, the government passed the Supply Chain Management Act in March 2019, which established an enabling legislative framework to support supply chain centralization. This jump-started our journey of transforming and centralizing supply chain across government.

Supply chain centralization will transform how the public sector delivers programs and services and achieve better results for the public and for the people of Ontario. It will create a more streamlined supply chain system, deliver better value for taxpayers, reduce red tape for businesses, foster innovation and make it easier for companies of all sizes to do business with the government.

This act also designated the Ministry of Government and Consumer Services and the Ministry of Health as supply chain management entities to centrally manage public sector supply chains, including the ability to collect procurement data from public sector organizations.

Then, in March 2020, when the World Health Organization declared COVID-19 to be a pandemic, the province's fragmented procurement system was brought to light. COVID-19 put significant pressure on the government's decentralized supply chain model for personal protective equipment and critical supplies and equipment. This experience validated our commitment to centralize the Ontario public service, the broader public sector and the health sector procurement process through a single integrated supply chain, allowing the government to leverage its buying power as one and provide the oversight necessary to align supply with demand.

With that in mind, the government established Supply Ontario, a new provincial agency established to address challenges in the public sector supply chain system. Supply Ontario is laying the foundation to be a customer-centred responsive organization that benefits from modern supply chain practices and data-driven decisions.

The COVID-19 pandemic also made it so that Ontario's public sector supply chain had to pivot quickly to address the urgent needs around PPE and critical supplies and equipment as the province faced shortages of these supplies for front-line workers and individuals. In response to this, the ministry, in collaboration with the Ministry of Health and the Ministry of Economic Development, Job Creation and Trade, established the supply chain management initiative to ensure that first responders, essential services and front-line staff had the critical supplies and equipment they needed. This included creating task force teams to source PPE in a globally constrained market; launching the Ontario Together Fund to help establish stable, reliable, Ontario-made sources of PPE; and building capacity in systems to understand the need for PPE and distribute it across the province.

The province took immediate steps to manage the public sector supply chain, including rapidly proclaiming the Supply Chain Management Act; deploying the provincial virtual inventory, which provided supply chain visibility to inform decision-making; and pursuing Ontario-made solutions for the supply of PPE and other critical supplies. As part of that, we were also able to develop more Ontario-based production capacity.

That's why on July 10, 2020, the province issued an open and competitive request for bids for surgical-grade masks produced in Ontario. From this request for bids, the government secured contracts with PRIMED Medical Products, Canada Masq Corp., Viva Healthcare Packaging Canada and JY Care to manufacture level 1 and level 2 surgical protective masks right here in Ontario. These companies are contracted to produce 50 million masks annually over the next five years, not only bringing much-needed PPE but also adding jobs to their local communities. This will provide health care and essential service providers across the province with a secure local supply they can rely on. It will also help Ontario's public health officials to plan ahead and reduce the province's reliance on strained global supply chains.

Moving forward, the province is committed to leveraging its collective buying power to create a consistent, reliable source of supplies to prepare for Ontario's recovery. In order to strengthen the security of our supply chain and reduce risks, the government is continuing to support procurement from domestic sources where possible. Our continued commitment to build our province's domestic supply capacity has been supported by Ontario companies that have retooled their operations to support our COVID-19 response.

This is further underscored by the recent Building Ontario Business Initiative announced on March 9. BOBI, as it's affectionately known, will reduce barriers and provide companies in Ontario with greater access to public procurement opportunities, helping them to sell more goods and services, creating jobs in local communities, and recovering from the economic effects of the COVID-19 pandemic.

To further support the Buy Local principle, the government passed the Building Ontario Businesses Initiative Act, which mandates public sector entities to give Ontario businesses preference when conducting procurement for goods and services under a specified threshold amount.

MGCS has also introduced the Personal Protective Equipment Supply and Production Act, legislation that seeks to ensure that Ontario's public services, and especially its critical front-line workers providing essential services, have access to a robust and ongoing centralized supply chain for personal protective equipment, critical supplies and critical products to be maintained and kept current on behalf of the whole public sector.

MGCS has taken immediate action already, partially implementing all the recommendations made by the Auditor General. Actions our ministry has taken include a virtual inventory tool that collects data on inventory and short-term consumption from health and non-health entities on a weekly basis, processes that are sustaining a healthy stockpile based on current operational demands and methods for engaging with ministries and their entities to understand their demand and fulfill requests for PPE from the stockpile—

The Chair (Mr. Taras Natyshak): You have two minutes remaining.

Ms. Renu Kulendran: MGCS continues to work with partner ministries to fully address all recommendations. We have a good plan in place and are working diligently to address and apply the Auditor General's recommendations. We look forward to reporting back with more information as implementation is under way.

Once again, committee members, thank you for the opportunity to address you today. We are happy to answer any questions you may have. Thank you for your time.

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The Chair (Mr. Taras Natyshak): Thank you very much. With that, we will move to the government side with their first 20-minute rotation. I recognize MPP Hogarth.

Ms. Christine Hogarth: Thank you all for being here today, but also, thank you for your work over the past two years. It's been tough on all of us. It's been tough on politicians, but it's been extremely tough on you and your teams as well. So thank you, on behalf of the people of Ontario, for all the work you've done—24 hours, weekends. It's amazing how people came together to help in such a terrible time.

It's actually interesting to have this conversation. It's two years, but it's been a tough two years, thinking of where this all started, when everybody was fighting to get masks and find this PPE and the situation. I know you talked a lot about moving forward and how changes are going to be made, but I guess my first question is: Can you tell us a little bit about how Ontario's stockpile was established and its status prior to the 2020 pandemic?

Dr. Catherine Zahn: Perhaps I'll start by giving a little bit of history and background. Thank you very much for the question. Again, for Hansard, I'm Dr. Catherine Zahn, Deputy Minister of Health. I'll give a short overview and then perhaps ask associate deputy Blair to fill in some of the details and then pass it on to Deputy Kulendran to comment as well.

The history is an 18-year history, which ends in a very-good-news story. Many of you will remember the SARS epidemic that occurred 18 years ago in 2003-04. As a bit of background, prior to—actually, even more recently than that, personal protective equipment was used, by and large, in the health care system and primarily in the hospital system. At that time, for SARS, the stocks of PPE belonged basically in the hospitals. After that pandemic, there was a review and an opportunity to provide a more reliable, more systemic level of top-up for when the health care system became short during emergencies such as SARS.

In the subsequent years, facing H1N1, Ebola and then, more recently, COVID, there were a number of activities prior to COVID to increase the stocks, as you know. Interestingly during that time, even though there was H1N1 and the Ebola pandemic, the requirements for PPE were much lower. There was much smaller demand than we had anticipated. Thus, a review was beginning to be undertaken after, I believe, an Auditor General report in 2017 about the supplies that were either past their expiry date or about to expire. An initiative was put in place to destroy those stockpiles and replace them appropriately when this pandemic came on the scene. So that initiative was halted, and we went into the current situation, in a state of global shortage of PPE.

With that, I will turn it over to associate Blair to fill in the blanks that I might have neglected.

Ms. Alison Blair: Great. Thanks very much, Deputy. I'm Alison Blair, the associate deputy minister for pandemic response and recovery. I'll be happy to add on to Dr. Zahn's answer. First of all, about stockpiling and the role the stockpile plays, as you know, before COVID-19 and during, health care providers who have been involved in working with health care and who have dealt with previous outbreaks of different kinds are responsible for gathering their own PPE. But we do recognize that having a provincial pandemic stockpile is very important when things don't work as one might expect them to. A global supply shortage is the experience that we had in terms of COVID-19. Stockpiling has been an important part of pandemic management and preparedness throughout the history of the Ministry of Health and in the development of the partnership between the Ministry of Health and the Ministry of Government and Consumer Services.

Prior to 2020, the ministry had stocked up on various pieces within the stockpile for SARS, as deputy Zahn mentioned, Ebola, and through H1N1. We've been consistently in compliance with all of the mandatory emergency management program guidelines that have been in place and requirements under the Emergency Management and Civil Protection Act—which isn't to say that we don't have lots to learn, as the deputy talked about.

It's important to note the health organizations and their role in maintaining their own stockpiles, and I'll talk a little bit about that in terms of the influenza pandemic as well. Together, the local and provincial stockpiles were intended to support health system readiness for any type of infectious disease emergency, including an influenza pandemic.

In 2003, following the SARS pandemic, the government responded decisively to address the weaknesses in the public health system that the virus had exposed. Valuable lessons were learned that led to significant improvements in the system at that time. In collaboration with health sector partners, the Ministry of Health made many changes to address the gaps related especially to prevention and control of communicable diseases and their outbreaks.

In 2004, we created and began to maintain a stockpile as part of the 2004 Ontario Health Plan for an Influenza Pandemic, which we call OHPIP. I hope you'll let me say that rather than the whole thing. OHPIP is intended to plan for influenza pandemics of various shapes and sizes. Since then, the ministry has maintained the provincial inventory of supplies and equipment to make sure that front-line health service providers are protected from those infectious diseases and also the occupational health and safety threats that come around during that time. The plan identifies the roles and responsibilities of the provincial health system partners and provides a range of strategies to respond to different scenarios based on the severity of the pandemic and other factors in the plan. It also serves as a planning resource for Ontario's health system to respond in the event of an influenza pandemic, in particular. It informs broader pandemic planning in the province and is intended to support a balance between timely decision-making and accountability for decisions made in a continuously changing environment.

In 2006, Ontario developed its first supply and equipment stockpile to ensure that health organizations had rapid access to critical supplies and equipment when their own resources were not sufficient to address the emergency. The stockpile was designed to be a stopgap when local stockpiling activities were unable to meet demand. A good example of that is when there's a sudden surge in demand for PPE and medical supplies during a pandemic and global competition may not be easily accommodated by suppliers. We now know a thing or two about that. The original stockpile of protective equipment and mass immunization supplies and equipment was meant to act as an emergency supply that complements local stockpiling activities.

The stocking guidelines in 2006 from OHPIP: Although it's impossible to predict precisely how a pandemic may play out with transmission and infection outcomes and understanding how much supply is needed—all the volumes in the development of a stockpile are, therefore, educated estimates—OHPIP sets out the guidelines for the provincial stockpile. Our assumptions in this were based on a 35% impact of an influenza pandemic for the general population, and 50% for long-term-care homes with vulnerable residents. The guideline recommends that health service providers have a four-week supply and that the provincial stockpiles have a four-week supply to cover an eight-week pandemic. This number came from Canadian Pandemic Influenza Preparedness, CPIP, which references the World Health Organization, which says that each pandemic wave could last from a few weeks to a few months.

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Assumptions were then made for each type of health organization or location of care to determine the expected volume of PPE that was needed. Risk to health care workers in the workplace is considered highest in settings where people first present with their symptoms, in settings providing care for vulnerable people and in settings where staff are performing the highest-risk procedures that create sprays and splashes.

In 2013, Ontario updated the OHPIP to incorporate lessons learned after the H1N1 pandemic and the ministry's review of the province's response to the 2009 H1N1 influenza pandemic. During that time, during that pandemic, the ministry provided over 28 million PPE items to health care providers and organizations. You'll note that Dr. Zahn referred to distributing over a billion during COVID-19.

OHPIP continues to serve as a planning resource for Ontario's health system to respond in the event of an influenza pandemic. Consistently, with the 2013 scalable plan, the ministry is able to deploy supplies and equipment from the provincial stockpile to health workers and health sector employers in need.

Stockpiling was also identified as a supporting tool referenced in the 2016 Ebola step-down plan to enhance health system capacity. The availability of a stockpile by health partners was identified as a tool to help enhance health system capacity and retain readiness, obtained through preparedness for Ebola during the 2014 West Africa outbreak. Health care organizations at that point in time were also told to maintain their PPE stockpile and always ensure its availability in clinical and other appropriate settings. The province further enhanced the availability of PPE through the procurement of biohazard suits and N95 respirators to further protect health care workers who treated Ebola patients.

In addition to procuring for Ontario's health care workers, the ministry also donated PPE to the World Health Organization for West Africa to support the local health system's readiness and response to the Ebola outbreak at that time.

As the province experienced different emerging infectious disease threats and recognized that OHPIP 2013 did not apply to all of those threats, the ministry adapted its response and undertook new planning tailored to those threats to address aspects not covered by the OHPIP. This process allowed the ministry to expand overall readiness for infectious disease emergencies.

The ministry's health system emergency management branch, which manages the ministry's emergency management program, including the stockpile for the health sector, maintained awareness of the content of existing plans and balanced updating those plans with the creation and expansion of new planning in response to actual events. The health system emergency management branch underwent continual annual planning for seasonal influenza surges and concurrent planning for non-infectious disease threats as well.

In 2018, we created the ready and resilient health system framework, which was intended to move readiness forward to be able to respond to all types of threats, including pandemics such as COVID-19. A stockpile modernization review was one part of the ready and resilient health system. The modernization review was aimed at ensuring that any stockpile replenishment was sustainable, and that proper equipment was procured to prepare for diverse infectious disease threats.

Before the COVID-19 pandemic, the ministry was adapting its infectious disease planning to apply more broadly than to an influenza pandemic only. This was informed by impacts of seasonal influenza and other highly infectious viruses on the provincial health system, like Ebola virus disease and MERS. Supplemental to this shift, the ministry established a ready and resilient health system approach to ensure readiness, regardless of the virus or health system impacts from other hazards, such as drug and medical shortages, floods or forest fire evacuations.

Moving forward, based on this ready and resilient plan, the ministry will incorporate COVID-19 pandemic lessons learned into all applicable emergency response plans to support a ready and resilient health system.

I hope that gives you a good summary.

Ms. Christine Hogarth: Yes, thank you very much for that. It is something we'll always remember when we go back in time, so I thank you for your comments about the past and some changes that are made moving forward.

My second question, actually, is over to the Ministry of Government and Consumer Services. Talking about PPE, we look at an optimal mix of manufacturing and importing. My question to you is, what percentage of Ontario's PPE is still imported? Because as we've said, we don't want to rely on other countries in times of need. I'm just wondering if you could give me an answer to that. Thank you.

Then I'm going to pass it over to my colleague MPP Crawford.

Ms. Renu Kulendran: Thank you for the question. I'm happy to add that, along with our colleagues at the Ministry of Health, we've been on this journey together in terms of establishing a robust stockpile and using a variety of strategies, including open procurement practices and competitive procurement practices, that are designed to spur Ontario production, as I mentioned. It's really gratifying to see how far we've come since 2020, when we sourced most of our PPE and CSE internationally. They were sourced through companies, but came from international sources.

To be here today and to be able to say that 46% of the PPE purchased in Ontario is manufactured in Ontario and that we're well on a path, over the next 18 months, to get to 93%—there are some products that, because of the nature of the parts that are used to manufacture them, we still have to rely on international sources for. In this case, when we look at our category management and what is in our stockpile and some of our demand analyses for sectors—because we supply not only collectively to health, but also to non-health sectors in the broader public sector, including sectors like education. We have demand scenarios that model out what could be utilized against public health guidance and Ministry of Labour, Training and Skills Development occupational health guidance so that all of this is domestic. Having a supply chain that is domestic is really a critical piece of this because it ensures that we will never again be in the situation that we were in, in March 2020, when we had to all collectively scramble and, working with our different partners in the system, try to access that critical PPE.

Ms. Christine Hogarth: Thank you for that.

The Chair (Mr. Taras Natyshak): Three minutes.

Mr. Stephen Crawford: I'll ask one question to government and consumer services, and then when we come back I'll go to health. I just wanted to follow up, actually, on my colleague's question on the PPE manufacturing here. You mentioned that the goal was to get to 90%. Is that correct?

Ms. Renu Kulendran: We will be at 93% within the next 18 months. The goal is 100%, always. We are looking at, in terms of those key categories of critical supplies and equipment and personal protective equipment, how we can actually have a fully domestic supply chain. But—

Mr. Stephen Crawford: Right. When we say domestic, we don't necessarily mean it's made in Ontario, but it's made in Canada. Just for clarification, is that correct?

Ms. Renu Kulendran: As part of our Building Ontario Business Initiative, in terms of using government procurement as a lever, we do want to support Ontario production.

Mr. Stephen Crawford: So when you say domestic, with these numbers, is that Canada or Ontario or predominantly Ontario?

Ms. Renu Kulendran: It's predominantly Ontario. I'll ask my colleague Doug Kent to clarify.

Mr. Doug Kent: Thank you. Doug Kent, assistant deputy minister for Supply Chain Ontario. The last time I looked at the numbers, it was about 7% Canadian and the rest was Ontario.

Mr. Stephen Crawford: That's good. That's great.

Just with the remaining time: I know that the government has been, obviously, at the forefront of wanting to have this made in Ontario, invest in Ontario. Put through the supply chain, could you comment on how the government of Ontario has furthered this initiative through businesses and whatnot?

Ms. Renu Kulendran: Absolutely. A lot of this began with the Ontario Together Fund, which was designed to incent and really leverage the creativity of Ontario companies in terms of coming up and providing a retooling to supply PPE. As I mentioned, that engendered quite a good response. As a result, for surgical masks we have long-term arrangements with four Ontario companies that are manufacturing those surgical masks. We also, working with our partners in the federal government, made a significant commitment and worked with 3M to establish production in Brockville for N95 masks. That long-term deal, which is a five-year deal, will actually supply the province's N95 masks for the next decade.

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The Chair (Mr. Taras Natyshak): Thank you very much. We will now move on to the opposition side. Madame Gélinas.

M^me^ France Gélinas: My questions were going in a different direction, but I want to continue on what you were just talking about: that 46% of PPE that we have stockpiled right now comes from Ontario—7% from Canada and the rest from Ontario. Congratulations. I'm

really happy. But that's not what we hear on the ground. Dent-X in Vaughan had 900 contracts with dentists throughout Ontario. They have had the contracts forever. They've supplied surgical masks forever for dentists. Then came the government, through their partnership with Medbuy and the shared services organization, and Dent-X now has zero contracts and zero sales. It has been trying to get in touch with Medbuy to say, "Hey, guys, we exist. We have been supplying medical masks through 900 dental contracts forever and now we are out of business." How do you reconcile the two?

Ms. Renu Kulendran: Thank you for the question, MPP Gélinas. I can't speak to the specifics of any particular company. I'm happy to have the details off-line and follow up. But I would say that we competitively procure against demand, as well as have a rigorous quality assurance process. All the products that we procure have to meet these quality assurance standards, as well as Health Canada guidelines. I can't speak to the specifics of the particular company. I'm happy to take the details and follow up off-line.

I don't know, Doug, if you want to speak any more about the QA/QC process or add anything.

Mr. Doug Kent: Sure. Why don't I talk about the QA/QC process? For the QA/QC process, we have two stages. One is quantitative, where we actually ask the lead proponents in a competitive process, once they are identified as lead proponents, to provide us their paper certifications. That would include their test data that supported their Health Canada approval. As well, we look to things like NIOSH as well as CSA standards, which are required by the infection control committees across the province.

Once they provide us with that paper evidence that they are certified and qualified, we then ask them to provide samples of their product. We then provide those samples of products to clinicians and to a clinical team to make sure that it meets the qualitative aspects of what PPE should meet in a clinical setting. Once it has passed that, we also send it out to independent labs. The independent lab will then verify that the certifications that have been provided are equivalent for the sample products that are provided.

M^me^ France Gélinas: I can assure you that the people that come to us still sell to other provinces. They cannot sell to Ontario. They meet all the Canadian guidelines. They have been in business in Ontario, and now, through this centralized procurement process, they are losing business. Small businesses in Sagamok First Nation and the Wiikwemkoong First Nation: same thing. They were helped by the province to start to make surgical masks and they haven't sold a single mask to Ontario.

I'm bringing this forward to complement what Mr. Crawford was talking about. I'm all for what you're trying to do. I'm all for supporting Ontario businesses. I applaud you for being at 46% and aiming for 93%. I'm all good with this. But I want you to know that some of the partners, the group purchasing organizations, the shared services organizations—some of their practices on the ground are hurting Ontario businesses. So, I would really like the Ontario government to have more oversight as to how you get to bid. Because they don't make it to the point where they can show that they are recognized by Health Canada or anything; they don't get to bid at all.

And they all point in the same direction. They point to the group purchasing organization that puts them aside, and when they come to talk to me they always say the same thing: It's because their kickback is not big enough and that Medbuy would prefer to do business, to purchase with a company that gives them a bigger—in my office, they use "kickback;" outside of the office, they use "rebate."

I am putting it out there because it is hurting businesses right now. The finger is not pointed at you, at the ministry. It is pointed at the group purchasing organization and the shared services organization. But as long as you don't ask for the transparency and the oversight to make sure that your aims are actually achieved on the ground, Ontario businesses are being hurt.

Ms. Renu Kulendran: If I can just add: To the honourable member, I think it's so very helpful, that context, and we're happy to take that away. I would say that, through the Building Ontario Business Initiative and the oversight and the levers that we have in terms of not only the OPS procurement directives but also the broader public sector procurement directives, there are complementary initiatives under way that are really meant to support domestic production, and that includes all domestic production. So I'm happy to take your comments away and follow up. Thank you.

M^me^ France Gélinas: Thank you. That was not my first question, but I just wanted to continue on that line of thought.

When the Auditor General's report came out, the front line was really that we had known, since her report in 2017, that Ontario was paying $3 million a year to rent warehouses to hold expired PPE. We all knew this in 2017. It made the front line of all the papers and everything else. From 2017 to 2020, I heard that there had been some turnover, but we were still in a position where we had all this stockpile of expired N95, of expired PPE, and we were in a pandemic. We all know that it was difficult to bring in new stock.

What can we give the Ontario public, who saw this as a failure of their government, a failure at many, many levels? Three million dollars a year to rent warehouses full of stuff that you can't use—it's pretty hard to justify this as a good use of taxpayers' money. The fact that we needed those stockpiles and we were entering into a pandemic and we did not have the stockpiles—anyway, you all know the story; I don't have to go there. What would you tell the Ontario public now to reassure them that it's not going to happen again, that there will be measures in place to make sure that the warehouses that we pay for have stockpiles that are usable and that are being renewed, and that we don't discard the old ones but make sure that our health care system can use them? I don't know. I'll let you answer it. How do you give confidence to people that this will not happen again?

Dr. Catherine Zahn: Thanks very much for the question, MPP Gélinas. The first thing that I would say is

that at this point in time we're in a really strong position and it is as a result of cross-government partnerships and a multi-stakeholder effort.

I think I mentioned, to one of the earlier questions, the fact that, after the Auditor General's report about the excess stockpiles that were expired and that were costing the taxpayer money was released, there was an initiative under way to begin to destroy, in a systematic way, the stockpile.

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I will, in one minute, refer the details to associate deputy minister Blair, but as the pandemic emerged, there would have been concern about destroying large amounts of PPE in the face of the possibility of being unable to receive anything.

Perhaps, associate deputy Blair, you could fill in the details there.

Ms. Alison Blair: Great. I'll be happy—sorry.

M^me^ France Gélinas: And really focusing on how we reassure the public that it will not happen again.

Ms. Alison Blair: Great. I will probably quickly offer this up to my colleagues at MGCS, but I'll quickly say that we had entered into contracts for the destruction and were in progress at the time that the pandemic came along. So there were certainly steps being taken, and, as Dr. Zahn reported, we paused that to make sure that we had even expired stock in the stockpile in case it was needed. But also, as Deputy Zahn said, we are in a very different position now, in terms of how we monitor and how we make sure that there's rotation and the distribution of the PPE and critical supplies and equipment that are in the stockpile.

I think I'll turn that over to Deputy Kulendran to provide—

Ms. Renu Kulendran: Thanks, Alison. Just to add to what Alison has already indicated, we have inventory data now. We work with logistics companies to ensure that the way in which we store our product includes and incorporates rotational practices and has a first-out approach in terms of stock that is approaching a critical timeline date around expiry, and to also match that against demand in sectors. So I would say we have a much better sense now of what the burn rates are in different sectors. We work with 74 sectors now that we did not work with before, pre-pandemic, to support their needs. We have really good data on about 6,000-plus organizations that we work collectively with health to serve. Using these rotational practices and with this inventory management, we have a much better ability to distribute the stock in a timely way.

I'll turn it over to Doug to talk a little bit more about that process.

M^me^ France Gélinas: If you could clarify for me. You say that you have better inventory data for 74 sectors. How is that done and how frequently is it done? How do you assess the burn rate and that kind of stuff? How many warehouses do we have now?

Mr. Doug Kent: Sure—why don't I take that. Across those 74 sectors, I believe Dr. Zahn in her opening remarks noted that all of those entities within those sectors report weekly into a system that we've built called the virtual inventory tool. It was literally to try and get an understanding of what the whole public sector inventory is. As part of that, the individual entities report not only what their inventory position is at the end of the week, but also what they have consumed over that week.

It's all fed into an inventory system. We have a group called our supply and demand planning group which monitors that, and they monitor that against what they were expecting to be consumed in that sector and overall. That allows us to understand what's the draw, both within those sectors and specifically against our stockpile. If we see there's a draw in a particular sector, then we can make sure that our stockpile is positioned to support them. That's kind of the mechanics of how we support the sector.

With regard to the overall supply and demand planning, that's the beginning, but we are also looking at the draw from the different warehouses. Right now, there are three main warehouses that support our pandemic stock. One, kind of our epicentre, is what we call MEOC, and that's where the health emergency stockpile has been. Then what we've done is to make sure that that's our epicentre. We have what we call distribution centres. So we have two distribution centres: One distribution centre largely supports health and the other distribution centre largely supports what we call the non-health sector, which is kind of everybody else other than those who are within the health sector.

The reason we did that was because of the significant volumes of orders. I think that Deputy Kulendran noted that we do over 4,000 orders a week. To move trucks and ship that often, you really do need two distribution centres, one that is supporting health demand and the other the non-health.

Again, we look at that draw, we plan the draw and we plan the replenishment from either our contracted suppliers that Deputy Kulendran talked about or, if we have to, we'll draw from the open market through a competitive procurement.

M^me^ France Gélinas: Do you expect this weekly monitoring of stockpiles and how much they have used and all of this to continue post-pandemic?

Mr. Doug Kent: Two things: First of all, what we've done in the PPE Supply and Production Act is we've made it a requirement that we have to maintain a tracking of inventory. In addition, the Auditor General recommendation was that we had to maintain the inventory tracking, and so, right now, as Supply Ontario is starting up, we're working with them on transferring the lessons learned and we're looking to turn this infrastructure over to Supply Ontario.

M^me^ France Gélinas: How long before Supply Ontario will take over?

Mr. Doug Kent: Maybe what I can do is turn it over to my colleague Chris Gonsalves, and he can speak to that.

The Chair (Mr. Taras Natyshak): Please just introduce yourself before you begin.

Mr. Chris Gonsalves: Chris Gonsalves, assistant deputy minister for supply chain transformation.

I thank the member for the question. Regarding Supply Ontario, their scaling up, becoming operational and taking on this business—just going back to comments that the deputy made, Supply Ontario was established during the pandemic as a brand new agency, and so, right now, they are focusing on their initial foundational activities to build capability and capacity so that they are able to deliver on their mandate, which includes, more broadly, supporting the supply chain for the province, delivering best value, focusing on supporting the province's objectives around enabling economic growth and also objectives around a resilient supply chain so that we are prepared for emergencies in the future.

Mme France Gélinas: But is the goal to continue to use shared services organizations and group purchasing organizations that would go through Supply Ontario, or would Supply Ontario take over the signing of the contracts that are now signed by group purchasing organizations and shared services organizations?

The Chair (Mr. Taras Natyshak): You have just two minutes left.

Ms. Renu Kulendran: Maybe I can answer that question. We're still working through a lot of transitional activities and we are also still working through a pandemic, so some of those—in terms of the broader implementation, we want to make sure that the path that we started on with respect to supply chain centralization is stable.

What we have done in terms of work with the agencies is worked a lot on, as Chris indicated, the sharing of that experience, sharing data on sectors, and Supply Ontario is going to be a data-centred organization and take a full view of the province's public-sector supply chain in that regard.

It is early days in terms of its establishment, and so there are certainly things that we will be happy to report on as we continue to progress with this transition in terms of what that operating model looks like and what that means for Ontario in the longer term.

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The Chair (Mr. Taras Natyshak): Thirty seconds left.

Mme France Gélinas: So in answer to my question: The group purchasing organizations will continue to exist until such time as decisions are made regarding the models that Supply Ontario will go with.

To answer my previous question as to how we reassure the public that what happened in 2017 and on won't happen again, we can say that you have weekly monitoring in place of stock as well as burn rates, as well as distribution to 74 sectors within the broader public sector.

The Chair (Mr. Taras Natyshak): Merci, madame Gélinas.

That concludes the 20—

Mme France Gélinas: I got some yeses, so I'm happy with that.

The Chair (Mr. Taras Natyshak): Thank you very much. I'm just going to give the Auditor General a moment to provide us with some information.

Ms. Bonnie Lysyk: Yes, I just wanted to clarify. The member had a question with respect to how many warehouses there is PPE in. We're involved in the inventory counts on that, and our understanding is that there are eight provincial plus four regional warehouses. I think the contract with one of the warehouse providers was extended to get eight warehouse locations.

I think the distinction here is the Ministry of Government and Consumer Services handles about 40% of the PPE, and 60% of the PPE is warehoused and purchased by the Ministry of Health. So it's two separate groups that are managing the PPE right now. With respect to Supply Ontario, my understanding—and correct me if I'm wrong—is that that will eventually become part of Supply Ontario's buying. But I think it's bought in two separate ministries right now.

Mme France Gélinas: Expect a question.

The Chair (Mr. Taras Natyshak): We're going to move to the government side for the next rotation of 20 minutes. I recognize MPP Crawford.

Mr. Stephen Crawford: I just wanted to finish up very quickly with a very quick question, and then I'd like to take it over to health. To consumer services: The Ontario Together Fund obviously had the goal of getting more Ontario-made PPE. Would you define it, as you see it to date, as a success?

Ms. Renu Kulendran: Thank you to the member for the question. Certainly, it has yielded significant volume with respect to PPE from Ontario companies. When you think about the fact that we have four significant contracts with Ontario manufacturers to manufacture those surgical masks, as well as the work that has been done to create a decade-long supply of N95s through the 3M plant—and there are additional contracts and goods and services—I think it's been a success in terms of not only being able to help the province develop a strong domestic supply chain and stockpile, but also with respect to impacts on communities in terms of job creation and businesses that retooled. It's been certainly remarkable on a number of fronts in terms of the work that it's done.

Mr. Stephen Crawford: Okay. That's great. So it's having the intended consequence. There are always going to be bumps along the road, but I think we want to be in a better spot should a situation like this occur again. So that's good to hear.

My next question is for the Ministry of Health. I just want to get a sense of, in the early days of the response, how did the ministry mobilize the stockpile and distribute its PPE? Going back in time to the early stages of COVID.

Dr. Catherine Zahn: Thank you very much for the question, member. I haven't spoken for a while so I'll repeat my name: Dr. Catherine Zahn, Deputy Minister of Health.

In the early stages, as I mentioned before, the majority of supplies were held by individual organizations, and so especially some of the larger organizations had the capacity to fulfill their own needs. When it was recognized fairly early in the environment that areas—for example, the obvious one being long-term care, but also shelters,

congregate living settings—did not have a process in place, nor had they ever considered the need for such a thing, I would say with some degree of pride, having been one of my stakeholders in the past, that the hospitals stepped up to support the entire health care system until which time we were able to mobilize the provincial supplies and to create a system of distribution that was more equitable and robust.

With that, perhaps I'll ask associate deputy Blair to fill in some of the details.

Ms. Alison Blair: Good. And I'm going to ask ADM Kyle MacIntyre to come sit, and I'll get him to talk.

Mr. Kyle MacIntyre: Do I get to ask someone to speak on my behalf? No? Kyle MacIntyre, ADM, health transformation division. Can folks hear me okay? Great. Thank you.

My division is the health transformation division. It's responsible for leading and monitoring transformation initiatives in the health sector, including the establishment of Ontario Health, and working with our partners over at the Ministry of Government and Consumer Services on the centralization of the supply chain. For us, it's the focus on the health sector.

Thank you for the opportunity to speak to this question, to the member, and thanks to the Auditor General for the report and the recommendations.

I think we've talked a little bit before about some of the challenges in the early months of the pandemic. Global supply chains were constrained; equipment as well was severely constrained. The full spectrum of the supply chain was under stress, from our sourcing materials to our manufacturing to our distribution, and we were in a state of high demand across the globe. Countries, including Canada, were struggling to obtain pandemic supplies. Certainly the Auditor General's report identified some of the challenges that Ontario was facing as well.

Thanks to a quick workaround—a lot of people in this room and others who are not here with us today—we worked quickly as one team in government and with a number of health sector partners to respond to these pandemic supply chain issues and the global constraints that I was mentioning. Ontario's front-line workers urgently needed the personal protective equipment, also known as PPE, to keep themselves safe and to keep patients safe as well. We mobilized quickly to respond to those issues. We activated the Ministry of Health emergency operations centre—that was the MEOC that Doug Kent was speaking to before—to better coordinate the health system response. They became a single point of contact to support the health sector in a critical time.

Through partnerships in government, other provincial agencies, the health sector, industry and a broad range of community and local partners, we undertook a unified response with the health of Ontarians as our top priority, as the deputy minister remarked on.

In the early days of the pandemic, the Ministry of Health and the Ministry of Government and Consumer Services partnered with Ontario Health, the University Health Network and the Ontario shared services organizations to create a pandemic supply chain task force. The task force's role and responsibility was to consolidate, at the provincial level, the planning, sourcing, tracking and distribution of PPE and other critical supplies in Ontario. This centralized approach to procurement and distribution of PPE allowed us to leverage the province's purchasing power and capabilities of sourcing, procurement, warehousing and distribution, and the relationships of those who were part of the task force.

Through the work of that task force, we quickly and diligently identified PPE sourcing opportunities to advise on critical procurement needs and support the end-to-end logistics that come with dealing with the supplies coming in and having them go out through the provincial pandemic warehouses that were being discussed earlier. This helped Ontario pursue PPE and other critical global supplies in the global marketplace and compete with larger jurisdictions when the province was a relatively small purchaser in relation to others in the global competition. We knew that many of Ontario's smaller health providers would have difficulty competing for in-demand PPE in the global market, and the task force guided and supported Ontario's providers in acquiring the supplies they needed to maintain high-quality patient care.

A provincial control table was established and it coordinated the oversight, the access and the distribution of the PPE to health and non-health entities and organizations. It was under the leadership of this table that the ethical allocation framework for PPE was developed, ensuring our supply chain planning followed key principles of consistency, stewardship, accountability and public trust. It was always clear that we could better respond to the demands of the pandemic through collaboration, as I was mentioning, with government and sector partners, and we did this throughout the pandemic.

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Dr. Zahn has already emphasized the importance of our partnership with Ontario Health and the leadership role that the new agency has played in supporting Ontario's health sector through the pandemic. Ontario Health was set up to improve coordination across the health system, supporting the system's ability to respond to emergent and acute needs so that patients receive the most appropriate care in the right setting. The strong partnerships and integrated approach established by Ontario health teams and Ontario Health themselves have helped to better position the province to respond quickly and effectively to COVID-19.

These partnerships between Ontario Health, Ontario health teams, hospitals, primary care, home and community care, long-term care and other health entities create a better-connected health care system, supported by a modern and responsive health supply chain.

Even before we had created the task force, Ontario Health was playing a critical role in developing purchasing recommendations for the government's initial COVID-19 response. This helped to strengthen the stockpile early on.

To support the provincial PPE response, Ontario Health also contributed to:

—purchasing and distributing ICU supplies and equipment, beds and testing;

—managing the health system ordering platform for PPE and other critical supplies;

—leading remote care and digital health strategies, which led to reducing the sector's reliance on PPE and less in-person visits;

—ensuring that long-term-care and retirement homes had adequate PPE supplies;

—providing Ontario's most vulnerable communities with adequate testing supplies in the early days of the pandemic; and

—partnering with the ministry and Public Health Ontario.

As well, they helped establish a health system response team to build the infrastructure to maintain the distribution of PPE and other supplies in the face of travel disruptions and import challenges.

Ontario Health also set up regional supply chain tables involving regional executive leadership across the province, with clinical experts and health sector representatives. These tables were often the first point of contact for health service providers in the early days of the pandemic, and they made it easier for organizations to escalate early PPE needs.

This regional network also helped ensure that the province was allocating products from the PPE stockpile equitably, based on the understanding of the local and the regional needs. The tables worked closely with the provincial control table that I was mentioning earlier and other local health system partners to review proactive allocations of PPE from the province, collaborating and managing any PPE-related issues within each region.

They are also a key partner in monitoring regional resource availability and they supported collaboration with hospitals, primary care, home and community care, rehabilitation and other relevant care providers, ensuring the right level of PPE and protection for workers across the various settings.

Through significant collaboration and strength in partnerships across government agencies and the health sector, we were able to respond quickly and efficiently to the rising demands of the pandemic, particularly early on, supporting health service providers who were on the front lines of care.

Work to modernize the Ontario supply chain has already been mentioned, including the pandemic stockpile, and it was under way before COVID-19 arrived at our doorstep. However, the global supply chain collapse of the magnitude that we experienced in 2020 was a significant challenge, as has been recognized, in building and maintaining that pandemic stockpile. It was through these actions that I have articulated that we were able to address and build a response to support local health providers in accessing PPE.

Mr. Stephen Crawford: Thank you very much. I'll pass it to my colleague.

Mr. Toby Barrett: Thank you, Chair. How much time is there left?

The Chair (Mr. Taras Natyshak): You have seven minutes.

Mr. Toby Barrett: Okay. I have two questions, and I may not have time for the second question. I'll wait for the next round, perhaps.

Thank you for the briefing, which covered part of what I wanted to ask. I'm not sure which ministry would want to respond. How have we improved distribution to the broader public sector beyond the Ministry of Health?

I'll give a couple of examples. In the spring of 2020, as this committee knows, things were not going well as far as getting access to masks, for example. As an elected guy, I was contacted by a number of Ontario government agencies, agencies that deal with, say, young people with disabilities in congregate settings, children's aid. There were some issues there. They couldn't get masks because they were not under the Ministry of Health. Now, as it turned out, through a local business person, we were able to get the masks directly from China. We bypassed the Ontario government.

Another example, which, again, is not broader public sector, is with one of our long-term-care facilities. There was a very bad situation. There were people passing away, so a funeral home would be asked to come in—it was one funeral home—to remove people who had passed away. But they couldn't get masks. Their employees were very reluctant to go into this long-term-care facility without the protective equipment. And it was confusing. I know the medical officer of health was acquiring masks for the health unit, and our local hospital was able to acquire some masks, some of them directly from China. But again, the Ontario government was not able to protect people going into this long-term-care facility, who were very concerned, as they were removing people who had passed away, we understand, from the virus.

So I use those two examples. Going forward, say, heaven forbid, we are exposed to the Marburg virus or something else and get overwhelmed, is government able to provide other people who are working in the field—helping out with protection—who are not necessarily working for the Ministry of Health or even working for the government?

Dr. Catherine Zahn: I think Deputy Kulendran will begin.

Ms. Renu Kulendran: I'm happy to jump in to supplement as well. I would say you're right, in that we did not have a very good or centralized way of providing essential PPE and critical supplies to non-health sectors in the short-term. My colleague Kyle has talked about some of the early collaborative work in terms of bringing all the organizations that were involved in supply chain management, as well as essential stakeholders together to understand the needs of the broader public sector.

You heard me talk about 74 sectors. So, how do we get the 74 sectors working very closely with our inter-ministerial partners and health, and working with the Chief Medical Officer of Health, as well as the Ministry of Labour, Training and Skills Development, to understand PPE needs from a health population perspective, as well as from an occupational health perspective, understanding what the needs were for people working in those many

sectors, as well as for the vulnerable populations in those sectors themselves? I would say there was a lot of immediate work with other ministries to identify what those needs were, and also to start looking at a centralized way of providing access to masks and other critical PPE in those early days. I would say we have come a very long way through the work that we have talked about, in terms of working with our inter-ministerial partners, working with sectors, working directly with school boards, working with the Ministry of Long-Term Care, the Ministry for Seniors and Accessibility and many other partners to make sure that we have good and robust data—

The Chair (Mr. Taras Natyshak): Two minutes.

Ms. Renu Kulendran: —around what those needs are. We have an understanding of what my colleagues have talked about in terms of what the needs are against that four-week supply plus what we need to have in the critical and emergency reserve and what the logistics of getting that equipment out look like.

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As a good example, when schools reopened around the 17th after the holiday break last year, we were able to deliver 9.1 million N95s out to teachers across boards—I just want to confirm that number with my colleague, that that's the number—because of the advancement in our logistical capacity and understanding of the data.

I would say, my colleagues, some of whom are here, and on Jackie's team, are in regular contact with entities like school boards and long-term-care homes etc. around those needs, working very closely with our partners at health. I think we've come a long way in being able to support sustained supply and access to supply than in those early days, but it took a lot of collaboration that was probably less formal and then became more formal, and now, we have systems in place to do that. We have data that we collect regularly. We have regular engagement with those 74 sectors. We have regular communication and understanding of burn rates and understanding of what the projected demand looks like against public health advice and occupational health advice. That puts us in a much better position around the distribution capacity to ensure that those kinds of situations don't happen again. I would say that as part of this work—

The Chair (Mr. Taras Natyshak): Thank you very much. Sorry; I have to cut you off.

We are going to move to our second round of 20 minutes. Madame Gélinas.

M^me^ France Gélinas: It will be a big surprise to you, Deputy Zahn, that I will ask you: How many warehouses does the Ministry of Health have now to deal with PPE and other supplies? I don't know if I should ask you or somebody within your team.

Dr. Catherine Zahn: I will ask associate Blair to come and speak to that specifically, but it's an important point and I think we have the broad number as well as the specific number that you're looking for.

Ms. Alison Blair: Thank you very much, MPP Gélinas, for the question, and to the Auditor General for the supplementary. I'll just respond on that. In total, there are 12 warehouses. There are nine metro locations, and for the Auditor General, who is probably raising an eyebrow, there was one that was brought on in 2021, so there were eight at the time of the report. There are nine now for the one that the Ministry of Health holds a contract with, and then there are three that have contracts with MGCS.

Then, if I may, the question about the procurement: Just to be clear, the Ministry of Health stopped doing procurement for PPE. The MGCS took over at the end of March, on March 31, 2021, but at this point, in those 12 warehouses, there's a combination of Ministry of Health-procured and MGCS-procured equipment.

M^me^ France Gélinas: Okay. So the three MGCS ones that you were talking about, where you have your main warehouse and then your two distribution sites—those are the three? I'm looking at ADM Kent.

Mrs. Robin Martin: No, you're not. He's—

M^me^ France Gélinas: Oh, sorry.

Mr. Doug Kent: You were looking at the better-looking ADM.

M^me^ France Gélinas: I apologize.

Mr. Doug Kent: No problem.

Mrs. Robin Martin: You're getting younger.

Mr. Doug Kent: Yes, I was pleased to be younger, actually.

I'm ADM Doug Kent for Supply Chain Ontario. The Auditor General is absolutely correct in that there are warehouses, but there are service providers, and what I was referring to was the service providers. Our service provider has three warehouses that they use to store the stock, and then there is another service provider that we utilize that supports health. We hold the contract, but they support health, so it's another warehouse. Those are the four. Then the warehouse provider for health holds the ones that health outlined. So those are the—I would call them buildings, but they're under the management of different service providers, if that helps.

M^me^ France Gélinas: Yes, it does. When the Auditor General did her audit, health had eight; you now have nine. Then you were talking about three, but we're now at four. I'm strong in math; that's 13.

Mr. Doug Kent: If I could clarify, there are three service providers. One of those service providers will have multiple buildings that they manage on our behalf or on health's behalf. What I was referring to was the service providers and how the service providers worked. They use multiple buildings to support their work.

M^me^ France Gélinas: Are we talking about Plexxus and Mohawk Medbuy here?

Mr. Doug Kent: No, we're talking about Metro logistics, which is the one who runs the warehouses for health. We're talking about Stevens, which runs a warehouse that's under contract with MGCS but largely supports health. And then we're talking about another warehouse company called DSV. They run the buildings for MGCS.

M^me^ France Gélinas: Thank you. I think I've got it.

My next round of questions, away from warehouses, are kind of in line with what MPP Barrett was talking about. At the beginning of the pandemic, I had the same thing. St.

Joseph's Health Centre runs two long-term-care homes, St Gabriel Villa in my riding and one in Sudbury. They had an outbreak—they've had more than one outbreak—and they were having a really tough time getting PPE. They came to me. I asked a question in the House on them. I went and saw the minister.

At the base of it, we were all curious to see the ethical allocation framework. It was sort of weird because we could get the one from British Columbia—not very helpful in Ontario. We were getting all of those, the same as what MPP Barrett was saying, people running group homes, people providing home care—anyway, if you go to Hansard, you'll see all of the questions I asked about this. Why was it that the ethical allocation framework was never made available so people would understand who gets priority and how the limited supply is made available at a time where—I fully understand that things have changed now. Things are way better than they were. But we lived through this. The ethical allocation framework was available in April 2020, yet it was not made public, and I was wondering why.

Dr. Catherine Zahn: Thank you for the question, member Gélinas. I'm not sure if that's the exact right time frame; I think it was a bit later than April 2020, probably closer to the summer. Notwithstanding, it's an incredibly important question. I think you would know that the Ministry of Health and the Ministry of Government and Consumer Services understand that transparency in allocation and distribution are a really important component of the government's commitment to the people of Ontario, especially in that period of time when the supplies were so scarce.

At the beginning of the pandemic, when the supply chains were constrained, this concept of an ethical allocation framework was developed and tailored to support specific risks and vulnerabilities in the context of ensuring that those most in need would be those who were prioritized in acquiring PPE. You would be familiar with the basic ethical principles that would been brought to bear on this, the most important one being justice.

I can tell you, of course, that the considerations were which individuals were most at risk for severe morbidity or mortality from the illness—and that would have been in terms of health care workers and how critical their function was. It ultimately becomes obvious that this wasn't just confined to health care workers but was expanded to front-line workers of all sorts. The one that you may remember being in the news is the meat-packing industry, which was in a very vulnerable situation—and then, of course, the vulnerability of the people we serve.

1400

I came to the ministry in September 2021, so I can't speak directly to a reason why that information would have not been made public. The committee that developed them, I participated in prior to this. So I can't speak any more specifically to that reason. I'm not sure if there would be any further information that my associate Ms. Blair could bring to bear on this.

Ms. Alison Blair: I'll just add to Dr. Zahn's approach.

First, let's talk about when we retired the ethical allocation framework from being used. Officially, on June 10, 2021, the control table provided a decision that we had sufficient supply and that we weren't going to be needing that at that point. I think another consideration on the publication of the allocation framework was that it got down to a level of detail that we didn't need to use.

At no point did we run out of PPE. We were always able to provide an emergency delivery to those who needed it. We knew that at a certain point we might need to be able to say exactly which sectors or which providers within which sectors needed to be providing it, but we were still making it work. It was tight, but we were still making it work at that time.

M^me^ France Gélinas: The auditor does make a recommendation about the ethical allocation framework. We have it now, and it seems reasonable. It would have helped to calm things down a bit at the time, when it was really tough for everybody. You have an executive director of a long-term-care home coming to her MPP to say, "You need to help me." Having had that kind of document available—it was done. I still don't understand the rationale behind—why not make all those types of information available just to calm things down?

Dr. Catherine Zahn: Deputy Kulendran wants to answer the question.

Ms. Renu Kulendran: Specific to the long-term-care homes, I would say that there were certainly initiatives put in place to address sector-specific needs. As an example, in October 2020, the government provided all long-term-care homes with one-time up-to-eight-week access to PPE products so that they had enough of a stockpile to manage outbreaks and were able to anticipate increases. This was in addition to what could be accessed on an emergency basis from the provincial stockpile, and included things like face shields and surgical masks, disposable and reusable gowns, and a number of other products. There were over 28.5 million units of PPE that were supplied through the eight-week program between October 2020 and February 2021. By 2021, over 80% of Ontario long-term-care homes had accessed that program, but there were also other programs that could be accessed by any—

M^me^ France Gélinas: I'm sorry to interrupt you, but I'm more interested in the ethical allocation framework. That's a document that was there. As far as I'm concerned, it was very well done. It had the right priorities in it, but it was not shared. My question is, really, why didn't we share it? Why didn't you share it? I had nothing to do with it.

Dr. Catherine Zahn: Well, then, I'll follow up on that. I didn't have anything to do with sharing at that point.

M^me^ France Gélinas: Okay, we're both okay. We'll ask the rest of the—

Dr. Catherine Zahn: I think the point is, we don't have a firm answer as to why it was not shared publicly. What I will say is, those were extremely difficult times. We were learning as we were moving through it, and we were faced with different challenges on a nearly daily basis. I think it's fair to say that it was understood within the health care

system, at any rate, and we will have to say that there was not an answer that was made obvious to me to why it wasn't published in any way. But we'll go on to say that there will be a COVID-19 guidance document update at the end of this month, I believe, that will include it.

M^me^ France Gélinas: Oh, you will make it public at the end of this month?

Dr. Catherine Zahn: Is that right?

Ms. Alison Blair: I think certainly in April. The end of this month is tomorrow.

Dr. Catherine Zahn: I'm already in April in my mind.

M^me^ France Gélinas: That's okay. Me too.

Ms. Alison Blair: But, in April. The guideline is intended to provide the information on how the ethical allocation would happen. So we have committed and we've provided that commitment, I think, to this committee that we would—I think we said spring 2022, but we'll say April 2022 here.

M^me^ France Gélinas: Okay. My next series of questions kind of has to do with the beginning of the pandemic and the precautionary principle. I was there in 2003-04. I was in the health care system at the time when we went through SARS. I was here for H1N1 but still connected to the health care system. The number of complaints that I got was through the roof from health care workers who wanted access to N95s for the work that they were doing and were denied access to N95 respirators, although the precautionary principle clearly said that they worked with people who had a positive PCR test for COVID. Yet they were not allowed to use N95s.

I see that the—I'll never get it—deputy chief medical officer of health, I think is her title, is there. Sorry for messing up your title. A lot of this came to how come public health did not issue a directive to make N95s available, to apply the precautionary principle, when I think we would all agree that this is one of the main learnings we got from SARS.

Whoever wants to answer this: How were those decisions made and why was it that the precautionary principle was not applied?

Dr. Catherine Zahn: I'll start. Thank you very much for the question. At the beginning of the pandemic—you referenced your experience in SARS, and I think that our expectation was that COVID-19 would be something like SARS, and it was not. It was completely different.

For those of you who are not workers in health care, the precautionary principle simply states that if you're in a situation where there is scientific uncertainty and the potential risks are very high, it's appropriate to accelerate or enable the use of higher-level infection prevention and control measures, not just hand washing, masking, but different levels of masking, ventilation and such things.

What you are referring to, member Gélinas, is, I think, addressed in directive 5. I am not sure if associate Blair or Deputy Yaffe will be wanting to respond to this.

Ms. Alison Blair: Why don't I hum a few bars and then we can have the public health doctor come and talk about it?

The Chair (Mr. Taras Natyshak): You have two minutes remaining.

Ms. Alison Blair: Thank you very much.

Thank you, MPP Gélinas. There are three directives that all address PPE requirements: directives 1, 4 and 5. Certainly, throughout the pandemic, there have been discussions with the labour organizations that are involved in health care provision. But I think, in terms of the application of the precautionary principle, that we have always been evidence-based throughout the pandemic, that this has been something that evolved very quickly, that our understanding overall, globally, of COVID-19 has evolved throughout and that the directives of the Chief Medical Officer of Health reflected that.

But we'll ask Dr. Yaffe to provide some supplementals.

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Dr. Barbara Yaffe: Thank you very much, member. You got my title almost correct. That's very good. I'm Dr. Barbara Yaffe. I'm an Associate Chief Medical Officer of Health in the office of the chief medical officer. As an associate, I provide public health and preventive medicine advice and consultation to public health policies and programs. Specifically, part of my portfolio is providing support on issues regarding personal protective equipment requirements in health care and other settings such as long-term care and retirement homes. Actually, I was the incident manager at Toronto Public Health during the SARS outbreak, so I have that experience as well.

I think it's clear that one of the big lessons learned from SARS was the precautionary principle, and the precautionary principle is saying that, applying it to the requirements, you err on the side of caution to protect public health as the scientific evidence is still evolving. I would say, yes, we have applied it, and we continue to apply it.

How do we determine the requirements in our directives? We look at the available evidence on the modes of transmission of COVID-19, and that is always evolving. We work very closely with Public Health Ontario, which is an agency that was actually created from SARS, to show us what's the most up-to-date scientific and technical advice, as well as applying the precautionary principle—

The Chair (Mr. Taras Natyshak): My apologies, Dr. Yaffe. I have to move on to the final round. It is time for the opposition—or, pardon me, the government side. You'll have 14 minutes in the final round. MPP Hardeman.

Mr. Toby Barrett: I'm not in opposition and I'm not Mr. Hardeman.

The Chair (Mr. Taras Natyshak): MPP Barrett. Sorry. From my line of vision, you're right in front of Ernie.

Mr. Toby Barrett: No problem at all. I've been here 27 years; somebody will figure out who I am. Thank you, Chair—very informative, and giving us direction for future policy, although I think our Auditor General wants us to focus on what went on in the past and some of the problems.

This would be essentially a two-part question, maybe, following up on what I was talking about earlier. I ran out

of time. The question is, more specifically, what has the government done to ensure that, moving forward, PPE purchasing or procurement is better coordinated with respect to the supply chain? Some of this has been covered, but I want to focus on the top end of the supply chain—the source. And further to that, a bit of a subsequent question: How have we changed procurement practices to balance domestic production and internationally produced goods?

Just moving back two years to the spring and summer of 2020, with the crisis and not getting availability, and again, going back to my riding, where there were tremendous demands for supply, not only in my riding but also in the Ministry of Health-run hospitals in our area—I'm thinking of the Hamilton area, for example. Where was the availability of the personal protective equipment? Well, it was in China.

There is kind of a good-news answer to the problems I had with those government agencies. We were able to supply them with the personal protective equipment. Fortunately—this was a godsend—there was a young fellow, a businessman, in my riding who, 10 years previously, was in business with a company in China on another product. He went on to other stuff, but because he had family that were doctors and nurses, he pitched in and phoned the factory, and the loyalty was there. This factory was producing defence items. It was connected with the Communist Party. The products that they were producing also included the masks, the gowns and the gloves, FDA-approved. I have all of the documentation and another stamp—it was all in Chinese; I don't know what that was, but it was an international accreditation to guarantee the integrity of this product.

Being the local MPP, every Monday we would get together and he would let me know that on Friday he could bring in about a million products—mostly masks seemed to be the demand. He was bringing them in. I used to work in shipping. You guys know this stuff inside out, I guess. Out of two ports in China, he'd get them to New York City, rent a truck and get them up to Hamilton and the GTA area.

Then things tightened up in New York City. It was diverted to—they wanted it to stay in the United States. They did not want it to leave the United States. He'd get to Buffalo and—so he had to walk away from that. He had to fly direct from China—UPS—and then things tightened up. He could only get 30% on a freight airplane.

One request to me, which all spring and summer I would ask the Ontario government, was, how can we get it on an airplane? It's there. It can come over. And the prices were really good—rock-bottom prices. He wasn't making money on this. We couldn't get a plane over there. I think the Canadian government sent over a plane and it didn't get landing rights. The Ontario government owns planes. We couldn't do that, so only 30% would come in every Friday.

My second request to government—I could never get a purchase order, so he couldn't sell it to the Ontario government. He would load it on a truck in Toronto and then he'd hit the road, and he'd get on the phone. Maybe there would be a hospital in Hamilton, so he'd swing by the loading dock and the nurses would come down and help unload it. I don't know whether you're aware of this or not. We were just unable to work with the Ontario government as far as procurement or purchasing.

This company made it very clear, because of their loyalty, that he could access an unlimited supply of PPE from China. He was only getting in, say, 30%—because of the airplanes—of, say, a million items. This is my audit, really, because I lived and breathed this for several months and it was actually personally quite frustrating. We were able to supply everybody in my riding and area hospitals, but I'm afraid we did it without the Ontario government. That's my evaluation of what happened.

Can we take that further? Any comments on that, going back to my first two original questions?

Ms. Renu Kulendran: I thank the member for the question. Not having lived those days at the ministry in the earlier days—

Mr. Toby Barrett: Is there someone here that was involved in the earlier days, during that crisis?

Ms. Renu Kulendran: Absolutely. I'm happy to start and then allow my colleagues to talk more about that experience. I just really want to emphasize that we understand that there was a fragmented supply chain that existed and that we had to quickly mobilize around. There were also, from a procurement perspective, and speaking generally, lots of companies coming forward with options around masks, through our Ontario Together Fund but also separately. Part of the process that, as a government, we have to undertake is to ensure that the products meet the requirements of Health Canada, have been tested and are fit for the use intended. So there are all kinds of considerations around procurement, and would they meet specific demand—

Mr. Toby Barrett: So the FDA and the accreditation.

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Ms. Renu Kulendran: Yes, so it's a part of that. And as you're aware, that's part of why we want to make sure we have a strong domestic supply chain going forward—

Mr. Toby Barrett: I'm just talking about the crisis, where there was no domestic supply. As I indicated, we had access to unlimited supply from this one company in China.

Ms. Renu Kulendran: I can't speak to the specifics of that one company, but we can just talk more generally about government procurement practices.

Doug, maybe I'll turn it over to you to talk a little bit about how that's done, if that's helpful.

Mr. Toby Barrett: Yes, and going back to two years ago and why it was not done.

Mr. Doug Kent: To go back two years ago, we had many organizations that identified—and we actually set up, in partnership with the Ontario Together Fund, a portal called the Ontario Together portal. Through that portal, we had many different Ontario companies that put forward that they could support.

Again, I can't speak to the specifics that you're talking about, but there were many companies that submitted to the Ontario Together portal and identified that they had sources in China or other places around the world. We did engage with those companies, and we worked with them to ensure they had the appropriate certifications and qualifications, as I've explained before. We did purchase through many different Ontario companies who had contacts in China and other jurisdictions to bring products in, and we worked either directly with companies that could transport in on our behalf, or we worked with the federal government to transport in on Ontario's behalf.

Again, I don't know about those specifics, but I do know there were many Ontario companies that put their name forward through the Ontario Together portal, and we engaged with them and brought product from China and other places to support our stockpile.

Mr. Toby Barrett: Okay. Thank you.

The Chair (Mr. Taras Natyshak): MPP Babikian?

Mr. Aris Babikian: How much time do I have, Chair?

The Chair (Mr. Taras Natyshak): You have four minutes and 23, 22, 21 seconds.

Mr. Aris Babikian: Thank you very much to all of you for coming and sharing your experience of the last two years with us. I am sure that it is too early to write the entire history of the pandemic and to have the real picture of what happened and what transpired. We will have time to do all that down the road.

But my question is to MGCS representatives: What are the benefits anticipated to come out of the establishment of Supply Ontario?

Ms. Renu Kulendran: I thank the member for the question. Really, the establishment of Supply Ontario is the culmination of lessons learned around the pandemic to date, and I would say that it's part of the broader centralization of the supply chain process that has been undertaken since March 2020.

We've just talked about the challenges of the fragmented nature of the supply chain and how that experience has really validated the government's commitment to centralize Ontario Public Service, broader public sector and health sector procurement through an integrated supply chain. That allows for two things: It allows the public sector to buy as one, and it allows for the oversight necessary to kind of align the system.

As part of Ontario's Action Plan: Protect, Support, Recover in 2020, the Ministry of Government and Consumer Services established Supply Ontario, which is an agency that will transform the province's supply chain system and deliver enhanced value and outcomes to Ontarians. The pandemic supply chain is part of it, but it's really about the broader supply chain and the broader opportunities with respect to supply chain in the broader sector, in terms of other goods and supplies. The agency's mandate is really meant to deliver enhanced value and outcomes more generally around all kinds of category management and drive that better value, whether it's for schools, hospitals and other broader public sector entities; to continue to have the security by leveraging the data collection, inventory, understanding spending against demand; and then really streamline the operations of the system, integrating business systems, leveraging advanced data analytics that will really provide greater transparency on the end-to-end of that supply chain.

My colleague mentioned that we are working with Supply Ontario as it starts up and as it is establishing its foundation, but at maturity, we anticipate that it will be able to provide greater benefits and opportunities by delivering high-quality goods at a scale that anticipates the needs of the entire broader public sector: stabilizing access to critical PPE; supporting the rollout of the Building Ontario Business Initiative by purchasing more Ontario-based goods and also driving innovation of emerging technologies; and, lastly and most fundamentally, by connecting small businesses and entrepreneurs to government and its customers—to government procurement processes—by acting as Ontario's first purchaser for those emerging technologies and businesses.

So we are working with the agency. We anticipate that they will be operational in 2023, and we're happy to report back on that progress to the members of the committee.

The Chair (Mr. Taras Natyshak): Thank you very much.

We will move to our final round. MPP Taylor, you have 14 minutes.

Miss Monique Taylor: Good afternoon, everyone. Sorry about the confusion. My colleague was needed in the House—

Interjection: There she is.

Miss Monique Taylor: Yes, there she is on the screen behind you—so I've quickly been thrown in here, trying to review the Auditor General's report and, definitely, to raise some issues on behalf of New Democrats.

The supply chain was definitely an issue for us, and the lack of supply that was available to many people within the province. I know that since that time, of course, there has been new supply implemented, but I've heard from several of my colleagues that the process of being able to get into the tendering process to be able to supply Ontario-made masks has been an issue.

As I said, I apologize if this has already been part of the questioning, but since I'm here, I will ask on their behalf if there are ways for Ontarians to be able to get into that tendering process, to use masks made here instead of masks made outside of Canada and particularly in other countries.

Ms. Renu Kulendran: I'm happy to take that question. One of the things that we talked about earlier is that part of our objective in terms of the broader supply chain is getting to 100% domestic production. At the beginning of the pandemic, we were at 100% importing critical PPE and supplies, often through Ontario companies but from international sources. Today, we are at 46% in terms of domestic production, through levers such as the Ontario Together Fund and incenting companies to retool and produce domestically. We've had those results, and we're on track through our procurement and sourcing practices to be able to be at roughly 93% in 18 months in terms of those critical

PPE categories that are domestically manufactured, with the vast majority being in Ontario.

With respect to our procurement practices and competitive practices, there are a couple of things that I wanted to indicate. We procure against a lot of what we know to be our sector data, in 74 sectors, burn rate; the needs aligned with public health guidance and occupational health guidance—so there are a number of factors that go into what we have in our inventory. We have thresholds, like demand models, that are based around scenario planning—what's the minimum, what's the worst case, and where do we need our inventory to be?—depending on where that product comes from.

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In the cases where we are reliant on an internationally produced piece of personal protective equipment, we will keep a higher reserve because we want to anticipate that there may be supply chain issues. That's why it's much better to have a domestic supply chain.

I would say, though, because we procure against demand, and we do understand that there's interest from a lot of Ontario companies in terms of procurement, we would be procuring against what we need in terms of that category of spend. So if we have a significant stockpile of N95s, we wouldn't be out to market procuring. But where we do have a need for, say, surgical masks or other pieces of personal protective equipment, we would go out to market and solicit competitive bids.

I can't speak to the specifics of what your constituents may be experiencing, but I'm happy to take any information off-line around some specific circumstances and follow up with you.

Miss Monique Taylor: It works out well that this member is here because it was actually his issue that I was raising.

Mr. Michael Mantha: The procurement of masks: Can you provide me with a name of an Ontario-based company that is producing those masks and providing them to the government? Is there one?

Ms. Renu Kulendran: Yes, I can provide you with at least four that, as part of a competitive procurement, are manufacturing and supplying government. I think one is PRIMED, right? Do you want—

Mr. Doug Kent: PRIMED is manufacturing masks out of Cambridge.

Mr. Michael Mantha: Out of Cambridge. And those are N95s?

Mr. Doug Kent: They're not N95s.

Mr. Michael Mantha: They're not N95s.

Mr. Doug Kent: If you want N95s, then it's 3M, and they're being—

Mr. Michael Mantha: 3M—are they Canadian?

Ms. Renu Kulendran: They're in Brockville.

Mr. Michael Mantha: They're in Brockville, but they're not Canadian.

Mr. Doug Kent: They're manufactured in Ontario.

Mr. Michael Mantha: They're manufacturing in Ontario, but they're an American-based company. Am I correct?

Mr. Doug Kent: They're certainly manufactured in Brockville. I can't speak to—

Mr. Michael Mantha: Yes, but their main manufacturer is from the States.

Mr. Doug Kent: Right.

Ms. Renu Kulendran: But the masks themselves are—

Mr. Michael Mantha: Produced. Yes, I'm aware; of that, I'm aware. Are there any others that are produced—

Mr. Doug Kent: Sure. There's a company called Canada Masq.

Mr. Michael Mantha: Canada Masq?

Mr. Doug Kent: I'll have to get somebody to check. I think it's in Richmond Hill, but I'm not 100% sure.

Mr. Michael Mantha: Are they producing both N95s and surgical?

Mr. Doug Kent: They're producing surgical for us. They're under contract for surgical.

Mr. Michael Mantha: Surgical.

Mr. Doug Kent: There's another company called Viva Healthcare Packaging Canada Ltd. They're in Scarborough and they're producing surgical masks for us.

Mr. Michael Mantha: So other than 3M's, which are being produced in—I believe their plant is in Kitchener; am I not correct?

Mr. Doug Kent: The 3M?

Mr. Michael Mantha: 3M, yes.

Mr. Doug Kent: They're in Brockville.

Mr. Michael Mantha: Brockville. Okay.

Would it be a surprise to you that N95 masks are being produced in great amounts, and can be produced and provided to the province at approximately—I know, from the three plants, they're producing N95 masks; actually, the mask that I'm wearing right now, which is approved and has gone through stringent testing and everything, is being produced out of Dent-X in Vaughan. There are also plants out of two First Nations communities. One is on Manitoulin Island, Wiikwemkoong First Nation, and there is also another one on the North Shore which is called Sagamok First Nation. They are producing masks.

I've been actually raising this numerous times that not even a phone call has been returned to them. They did this with their own investment. They have put in $20 million and hired 240 people in order to produce these masks for Ontario, and not one single mask has been purchased from their businesses, which is shocking to me. I had a conversation a couple of times now with the Premier, and he's quite shocked as well that what we've done is—and I'm glad you brought up 3M, because 3M was the recipient of $25 million provincially and $25 million federally to produce these masks—which is great; it's being produced here—but the entity is actually in the US. We have an Ontario-made company that has invested into their own, provided jobs, developed partnerships with Indigenous communities, and we haven't even returned a call or even looked at purchasing any of their masks that are available here in our own backyard in Ontario. That is shocking to me.

I'm wondering if you have any comments on that. Have you heard of Dent-X or Sagamok First Nation or Wiikwemkoong First Nation? I know Chief Glen Hare has reached out to the various ministries to say, "Hey, we're here. What about us? We've created. We've diversified. What about the fairness? And if we're talking about true reconciliation in this province, what about us? We're right here."

Just a couple of weeks ago—how much time do I have left?

The Chair (Mr. Taras Natyshak): Four minutes.

Mr. Michael Mantha: Four minutes. Just a couple of weeks ago—actually, just last week, we had an uproar in our schools, where students were very concerned with the mask requirements and the protection that they were provided with, because everybody in this room knows that those surgical masks are not as effective as the N95 masks. These can be provided to all of those students. What was shocking to those students is that over 900 million masks were provided by the province—N95 masks were provided to all the dentists across this province, but none of them were provided to students. And those masks that were provided free of charge by the province to the dentists' offices are actually the contracts that Dent-X and all three companies—Sagamok First Nation, along with Wiikwemkoong First Nation—were relying on to keep their employees employed.

These masks are readily available for the province to make those purchases and to establish those businesses, and to make true reconciliation steps where Indigenous communities have taken the steps and made the investments on their own without any government funding.

So I would ask you, is there anything that you could provide to me so I can relay it to them? I'm looking at my friend who is standing in the House right now who is much, much better as far as knowledge. I will be trying to follow her in the House, because I'm going to be raising this on the floor of the Legislature as well, as to what happened. Where's the breakdown? Why haven't we taken advantage of what we have right here in our own backyard?

Ms. Renu Kulendran: I thank the member for the question. There were a couple of questions, I think, in there, which we're happy to answer with respect to—I think you raised what was supplied to schools and with respect to that guidance. But I can't speak to the specifics of the issue that you're raising with respect to the company in question. Member Gélinas also raised this earlier, and I committed to her that I would be happy to follow up with respect to the specifics of that circumstance.

I want to also emphasize that when the government procures personal protective equipment, there is a process that we undertake, and part of that includes the submission of testing data on the products. I'm going to turn it over to Doug to talk a little bit about that process, which also includes a quality assurance process, and the kinds of information that could be submitted for consideration.

The second thing I would mention is that we procure against demand—we have a very robust demand forecast that we work through with our broader public sector partners, including with school boards—and against public health advice and occupational health guidance. So there are a number of parameters and a number of factors that we consider when we are procuring products.

I'm more than happy to follow up with you on the specifics of the company that you raised, but I just wanted to have my colleague speak a little more about what that process looks like. We want to make sure that when we are, as government, supplying these sectors, we are supplying and being able to provide assurances around the meeting of Health Canada standards, and also that what is being prescribed is in accordance with public health guidance as well.

The Chair (Mr. Taras Natyshak): Thank you very much. That is all the time that we have this afternoon. We thank you all very much for appearing before the committee to answer our questions.

At this time, I'm going to ask those who are in attendance who are not a part of the committee to grab their belongings. Have a wonderful afternoon as we move into closed session. Thank you very much.

The committee continued in closed session at 1441.

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