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THE HILL TIMES POLICY BRIEFING

HEALTH

BILL THAT COULD EXPAND **POOL OF ORGAN DONORS RECEIVES ALL-PARTY SUPPORT,** BUT RISKS FAILING TO PASS BEFORE ELECTION

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We're putting mental health at the forefront

Our government devoted needed resources to boost mental health services, launched targeted initiatives to help vulnerable populations, is embracing technology, and leading the charge globally.

John Oliver

Government funding

Many years ago, C.S. Lewis lamented that it's "easier to say 'My tooth is aching' than to say 'My heart is broken.'" Decades later, his remarks speak to a fundamental truth about mental health: many still don't think of it as health at all.

As our government works to ensure Canada's health-care system remains a point of pride for years to come, we must change the discourse surrounding mental health so it takes its rightful place in the health-care conversation.

Led by a prime minister who has courageously shared his own family's experience with mental illness, our government has taken bold action to bring mental health to the forefront.

What does this look like? First, we devoted badly needed resources to improve and expand mental health services. Second, we are launching targeted initiatives to help vulnerable populations. Third, we are embracing technology. Fourth, we're leading the charge on the world stage.

From left, Conservative health critic Marilyn Gladu, Canadian ambassador to the UN in Geneva Rosemary McCarney, Canada's chief public health officer Dr. Theresa Tam, and Health Minister Ginette Petitpas Taylor at the World Health Assembly in May, where the minister helped launch the Alliance of Champions for Mental Health & Wellbeing.
Photograph courtesy of Ginette Petitpas Taylor's Twitter

Our work started with ensuring our health-care system has what it needs to address mental health. For too long these services have been underfunded. No longer.

Last year, our government made the largest ever investment in mental health in Canadian history. The 2017 budget pledged a groundbreaking $5-billion to mental health and addiction services for provinces and territories—new funding that is transforming how we approach mental health care.

These funds are going where they're needed most, including support for youth and early interventions. Most importantly, this funding will provide mental health support for half a million young Canadians who previously had no access. Furthermore, we are now measuring the outcomes of these investments to ensure they are having the greatest possible impact.

We started with an historic investment, but we didn't stop there.

Our government knows that marginalized groups face unique challenges in all aspects of their lives, especially when it comes to their mental health.

Indigenous peoples in particular have suffered from negligence, colonial barriers, and systemic discrimination, leading to high rates of depression, problematic substance use, and suicide. This is why our government is investing more than $350-million annually in community-based mental health and addictions programming on reserves and in the North.

We've also made significant investments in appropriate, effective, and accessible mental health programs for Black Canadians, recently launching a fund to support mental health initiatives in the Black community.

As with all aspects of the health-care system, we must always be looking to the future, where technology presents exciting opportunities for innovation and change.

In a country as vast as ours, technology can make a major difference. Exciting advances in tele-psychiatry and tele-medicine are making mental health care more accessible and convenient.

A great example is the Hope for Wellness Help Line, a culturally sensitive hotline aimed at Indigenous communities available 24 hours a day, seven days a week, totally free. The hotline has already answered more than 7,000 calls.

While the anonymity of technology is often perceived negatively, here it might actually be positive. Mental health is still stigmatized, and, for many, seeking help is extremely difficult. By allowing young Canadians to remain anonymous, services will reach more people, especially those who are scared, embarrassed, or simply reluctant to reach out.

Our government's commitment to mental health extends beyond Canada's borders. While typically not considered an issue of global health, in many ways mental illness is the most global of them all—affecting every nation, without exception.

That's why Health Minister Ginette Petitpas Taylor joined her colleagues from the United Kingdom and Australia in May to found the Alliance of Champions for Mental Health and Wellbeing, a group of nations driving global progress on mental health. She recently spoke at the first-ever United Nations event dedicated to mental health and represented Canada at the inaugural Global Ministerial Mental Health Summit.

While we're proud of these major strides, there remains much to be done. We have only begun our work to make sure that Canadians' mental health is treated with the same care and compassion as our physical health.

As we strive to transform our health-care system, we will continue to promote positive mental health, fight stigma, and ensure everyone gets the help they need. We invite all Canadians to join us in this quest.

John Oliver is a Liberal Member of Parliament who represents Oakville, Ont., and is the parliamentary secretary to the health minister.

The Hill Times

Despite initial 'disappointment' over make-up of pharmacare advisory council, pharma industry content with consultations

The pharmacare implementation advisory council will submit its final report to the health and finance ministers by the spring of 2019.

BY NEIL MOSS

After initial concern over not having a direct representative on the advisory committee for the implementation of a national pharmacare plan, industry stakeholders say they are pleased with their level of involvement in the consultations.

When the advisory council was formed last June, the Canadian Pharmacists Association (CPhA) said in a press release that it was "disappointed" that there were no pharmacists on the council.

But since that time, Joelle Walker, public affairs director at the CPhA said the group has been "happy" to participate in the council's consultations and has had "good representation" in roundtable meetings. The group also met with the council privately to speak about how the system currently works from a pharmacist's perspective.

"We were disappointed that the council didn't recognize the very front line expertise that pharmacists can provide—it's certainly a gap on the council as it exists," Ms. Walker said in an interview with *The Hill Times*. "But… we've tried to provide our best feedback throughout the consultation process in the round tables, and meeting with the council as well."

Asked if the voices of pharmacists are being appropriately heard, Ms. Walker said it is "hard to tell at this time," but that the CPhA has provided its "best advice."

She said there is no indication yet where the council will go with its report.

The Liberals announced the creation of the council in the 2018 budget, with former Ontario health minister Eric Hoskins appointed as its chair in February. The other six council members were named in June.

A 2015 Angus Reid Institute poll found that 23 per cent of Canadians, or someone in their household, did not take prescribed medication because of the cost.

In a report stemming from a study that began in 2016—and took two years to complete, hearing from nearly 100 witnesses—the House of Commons Health Committee recommended the adoption of a universal pharmacare program.

In a response to the committee's report, Health Minister Ginette Petitpas Taylor (Moncton-Riverview-Dieppe, N.B.) said the government supports the "intent" of the report and its recommendations, and said as the government moves forward with a plan it has to consider the "full range of options."

The advisory council has travelled to every province and territory to speak to a wide mix of interested parties and to look into the right way forward for Canada's national pharmacare plan, said council member Diana Whalen, a former deputy premier and finance minister in the Nova Scotia legislature.

A "solid groundwork" has been laid with the pharmaceutical industry as the council has had a number of meetings with pharmaceutical and pharmacist stakeholders, said Ms. Whalen, adding that as things progress there may be an opportunity for more discussions.

"I do feel it's been a general effort to include [voices from the pharmaceutical industry] in every one of the stakeholder meetings across the country," she said.

"We have a strong appreciation that pharmacists play a big role, and are very important as well," Ms. Whalen added.

Jim Keon, president of the Canadian Generic Pharmaceutical Association, said he feels that the advisory council has given his group the time to be heard.

Mr. Keon said his association was not prescriptive on the structure of a national plan, but instead focused feedback on how a plan can be affordable and accessible for all Canadians. He added he didn't have a preference between a fill-in-the-gaps approach and a universal program.

"Our straightforward message to the advisory council is to take advantage of these savings [of generic drugs], recommend strong, pro-generic… policies, and that's going to really help with the long-term sustainability of a national pharmacare program," he said.

NDP MP Don Davies (Vancouver Kingsway, B.C.), his party's health critic, said the pharmaceutical industry's testimony was "very measured," neither opposing nor strongly endorsing a universal pharmacare plan during the committee's study. He added a universal program could benefit the pharmaceutical industry as the market for its drugs should expand with every Canadian covered.

But Mr. Davies said, since the committee's report, he has detected a "clear and consistent" opposition to universal coverage from the industry in its social media postings.

NDP MP Don Davies says he will be 'pleasantly surprised' if the advisory council recommends a universal pharmacare plan. *The Hill Times photograph by Andrew Meade*

Council members are 'really aware' of deadline to submit report: Whalen

Ms. Whalen said the council is "really aware" of the spring 2019 deadline to get a report into the health and finance ministers. A March briefing note for Dr. Hoskins, that was obtained under the Access to Information Act, has the group submitting its final report between March and mid-April 2019.

"Time is short," she said. "We're at the point where we're very well aware that time is narrowing and we have to work hard now to do the rest of the thinking, and the modelling, and the testing of ideas, so that we can have a strong report."

Ms. Whalen said the options for a plan are diverse, and said the patchwork system that has developed in Canada has served some "well," and others, "not so well."

Finance Minister Bill Morneau (Toronto Centre, Ont.) told the Economic Club of Canada in February that a pharmacare plan won't be universal and will cover Canadians that aren't already covered by a drug plan, according to media reports of his remarks.

Mr. Davies said a patchwork system for Canada was not the recommended approach by health-care policy experts who appeared before the Health Committee. Those experts thought the best way forward was a universal plan.

He said he would be "pleasantly surprised" if Dr. Hoskins came back with the recommendation for a universal plan. But he said he is "worried that they won't," because of the "silence of their political masters" in support of a universal plan.

Timeline of advisory council report is partisan: Davies

The panel was structured, says Mr. Davies, so it has to report within one year of the appointment of the last council member, which would land on the last week of the parliamentary sitting near the end of June 2019.

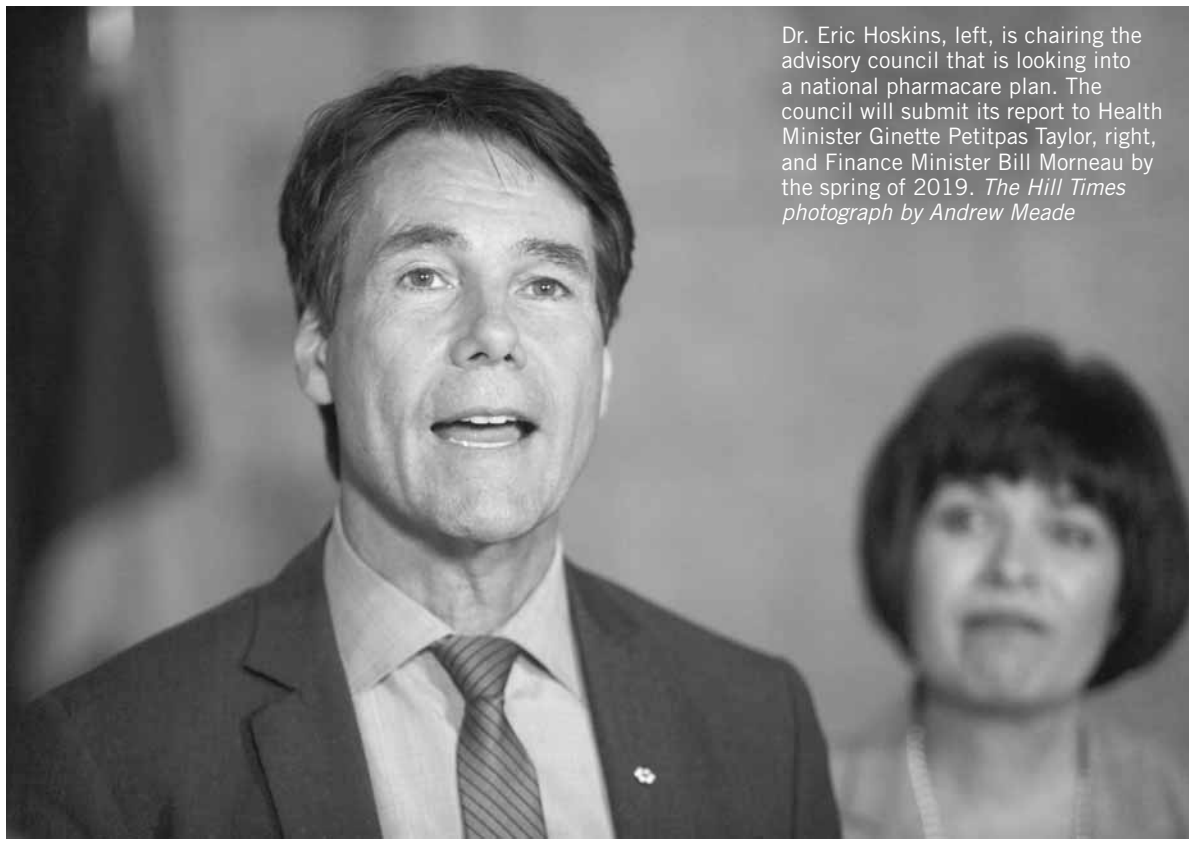
"That means that Parliament will not even have a chance to examine or debate the panel's recommendations," he told *The Hill Times*. "Instead that panel will report and then we'll go right into an election in September."

"Clearly the Liberals' interest in pharmacare is to use it in a partisan way, and not implement pharmacare as a very essential development in our health care system."

Mr. Keon said he didn't expect the plan to be implemented prior to the election.

"What happens after really depends on which government comes back," he said. "[The] earliest [time] before we got some real movement on it will be sometime in 2020."

nmoss@hilltimes.com
The Hill Times



Dr. Eric Hoskins, left, is chairing the advisory council that is looking into a national pharmacare plan. The council will submit its report to Health Minister Ginette Petitpas Taylor, right, and Finance Minister Bill Morneau by the spring of 2019. *The Hill Times photograph by Andrew Meade*

Advisory Council on the Implementation of National Pharmacare members

Dr. Eric Hoskins: chair of the council and former Ontario health minister
Mia Homsy: vice-chair of the council and director general of the Institut du Québec
Dr. Nadine Caron: Canada's first female Indigenous surgeon
Vincent Dumez: co-director of the Centre of Excellence on Partnership with Patients and the Public (CEPPP) at the University of Montreal's Faculty of Medicine
Camille Orridge: senior fellow at the Wellesley Institute and former CEO of the Toronto Central Local Health Integration Network
Diana Whalen: former deputy premier and Nova Scotia finance minister
John Wright: former Saskatchewan deputy minister of health and deputy minister of finance and former president and CEO of the Canadian Institute for Health Information

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Let's have an adult conversation about how to improve Canadian health care

Conservative MP Marilyn Gladu

Health costs

It's important to look to the future needs of the health-care system and ensure that the plans of today meet the demands to come.

Canada has an aging population. One in six citizens is a senior today, a figure that within 10 years is predicted to be closer to one in four. An aging population means more chronic disease than acute, end-of-life services on the rise, and a shortage of front-line health-care workers of all kinds to meet the demand.

The doctor shortage in Canada is a crisis. In many jurisdictions across the nation, whether you live in an urban or rural setting, the shortage of family doctors is a problem. In Cape Breton, N.S., the community is short 52 emergency physicians, a vascular surgeon, and many family doctors. If you cut an artery in Cape Breton, you may lose a limb or die before you can be transferred to Halifax.

Wait times to get a family physician in our capital city of Ottawa can be in excess of five years. In British Columbia, some doctors choose to be emergency room physicians rather than open a family practice, because the remuneration without overhead helps them pay back their huge student-loan debt. In Ontario, the violation of doctors' rights of conscience through medical-assistance-in-dying policies is causing some doctors to move to other provinces or retire. Finance Minister Bill Morneau's tax changes have also affected medical practices, again causing some physicians to shut down or cut services.

Our hospitals are log-jammed because of the lack of long-term care facilities. In addition, there is not adequate home care to allow seniors to remain in their homes. Wait times are too long in many cases, and patients who can't afford their medications end up at emergency rooms with conditions more expensive to treat than those who are able (i.e. can afford) to control their illness with prescribed medicine.

So, where is the Liberal government's plan to ensure universal and portable health care for Canadians? If it exists, I haven't seen it. There are some basic elements that need to be in it, such as actions to address the root causes of the many chronic diseases, like cancer, heart and stroke, diabetes, and respiratory disorders, that make up 74 per cent of Canadian deaths.

This means working with the provinces, territories, and Indigenous people to address obesity and nutrition, reduce alcohol intake, drug addiction, and smoking.

It means ensuring treatments and medications are available to all. It means figuring out how to pay for additional palliative and home care, drugs for rare diseases, and new (and sometimes extremely expensive) life-saving procedures and devices.

Some of these elements are currently being tackled, although somewhat ineffectively. Pharmacare, front-of-package labelling, plain packaging for cigarettes, and the prohibition of the marketing of unhealthy foods are all ideas intended to address these causes, but they miss the mark in their current form.

The choices seem to be that either more tax revenue will need to be devoted to health, services will decrease, or other alternative and innovative ideas must be explored. The issue of privatization of certain health services is a hot potato for some Canadians, but if we look to other universal health-care systems in the world that have better health outcomes than Canada does, we need to consider their approaches.

The World Health Organization considers France to have the best health outcomes from its universal system—yet its system consists of 24 per cent privatized services. France also has incentivized reimbursements to encourage people to choose the lower-cost treatment option. Sweden, considered to be in the top tier in terms of quality health-care outcomes, has also largely privatized services. The United Kingdom is taking similar measures in an effort to continue to afford its health-care system. This is not an endorsement of privatization, but rather a call to have an adult conversation about the potential of leveraging ideas that have been successful elsewhere.

The World Health Organization considers France to have the best health outcomes from its universal system—yet its system consists of 24 per cent privatized services, writes Conservative health critic Marilyn Gladu. *Photograph courtesy of Chris Sampson*

In summary, Canada needs a clearly laid-out strategy to address the silver tsunami and increasing costs of health care. The plan will have to look at the other universal health-care systems of the world and leverage ideas that are working, to produce better outcomes for Canadians. As the shadow minister of health, I am providing input to the government on what the plan should be, for the betterment of Canadian health care.

Conservative Member of Parliament Marilyn Gladu represents Sarnia-Lambton, Ont., and is the official opposition health critic.

The Hill Times

Bill that could expand pool of organ donors receives all-party support, but risks failing to pass before election

The bill is sponsored by Conservative MP Len Webber, who has championed the cause of organ donation and transplantation in his time in national and provincial legislatures.

BY JOLSON LIM

A Conservative private member's bill that would offer Canadians another way to sign up to become organ donors has received the support of all federal parties, although its sponsor is worried that it may not become law before Parliament is dissolved ahead of next year's federal election.

Bill C-316, An Act to amend the Canada Revenue Agency Act (organ donors), would allow Canadians the option to check off whether they would like to become organ donors on their annual tax return forms. Their information, provided they give consent, would then be passed onto provincial organ donor rolls.

On Nov. 7, the bill passed its first major test and received unanimous support in the House of Commons, moving it from second reading to study by the House Health Committee.

However, with less than a year left before the next federal election has to be held, and rumblings of an early election being called in 2019, the bill's sponsor said he's worried that it may not move through Parliament fast enough before the current slate of bills are wiped off the table.

"I am concerned about the possibility… of an early election," said Conservative MP Len Webber (Calgary Confederation, Alta.). "If that's the case it could just bring this bill tumbling down."

The bill was first tabled by Mr. Webber in October 2016 but sat awaiting second reading until early this month, when 272 MPs voted in support of it being referred to the House Health Committee for study. It will then have to clear the Senate before Parliament is dissolved, giving it roughly between now and June 2019 to pass.

Mr. Webber, a member of the committee, said each of its members support the bill and "are passionate as well getting this bill further on in the process." He said one Senator has already signalled interest in sponsoring the bill in the Upper Chamber.

"I am certainly going to be working with the passion I've had now to ensure that this bill does make it through every process," he said, adding that he's lobbied his peers over the last two years to support it. "It's a no-brainer. I believe it will be a lifesaving change to the act."

Health Committee chair and Liberal MP Bill Casey (Cumberland-Colchester, N.S.) said that given the time left in the current Parliament, Mr. Webber's bill "has priority."

"We're going to find a way to expedite it as quickly as we can," he said. "That's the feeling of all members."

Continued on page 19

Mr. Casey called the bill "a simple way of increasing organ donations in Canada."

"If it results in a handful of new successful donations, it will be worth it," he said.

Currently, there are about 4,600 Canadians on a wait list for a life-saving organ transplant. In 2016, 260 Canadians died while waiting for a transplant.

While Canada saw a recent uptick in organ donations from deceased individuals—increasing to a rate of almost 21 donors per million people in 2016, up 42 per cent since 2007—Canada still lags behind the United States, United Kingdom, and Spain.

In Spain, where residents can opt out of organ donation as opposed to signing up, the rate is 43.4 donors per one million people.

However, between 2007 to 2016, living organ donation rates in Canada had decreased 11 per cent.

Organ donation policy falls under provincial jurisdiction on health care delivery, and each province has its own donor list and institutions that administer donations. Since organs only have finite time to be out of a body and transplanted, the odds of someone receives a lifesaving organ can depend on geography.

Deceased organ donation rates in Ontario, British Columbia, and Quebec were above 20 per one million people in 2016, but lower than that in Prairie provinces.

Ronnie Gavsie, president and CEO of Trillium Gift of Life Network, the Ontario agency responsible for the province's organ donation system, said the provincial government has provided strong support since the network's founding in 2002, resulting in a more-flexible system for donation and transplantation. The province has the highest deceased donation rate in

Conservative MP Len Webber, second from right, is pictured at a House Health Committee prior to a meeting in October 2016. He is the sponsor of a private member's bill that would offer Canadians the option to register as an organ donor on their annual tax return forms. *The Hill Times photograph by Sam Garcia*

Continued from page 18

Canada, with 25.2 donations per one million people.

Ontario has a mandatory referral system requiring hospitals to refer a potential donor to the network to see if there is a medically suitable match for transplant and whether or not the person has registered consent. Ms. Gavsie also said hospitals across the province also have trained co-ordinators to help families and potential donors, while Ontario has a province-wide resource centre to act as a main hub.

"These are the kinds of initiatives that other provinces are starting to take up," she said, "some to a greater degree than others but these appear to be the keys to success."

In 2016, Conservative MP Ziad Aboultaif (Edmonton Manning, Alta.) tabled a bill that would have created a national registry for organ donors. However, the Liberals defeated the bill, with the Liberal government saying it could infringe on provincial powers.

Mr. Webber said given that hurdle, it made sense to propose offering Canadians another option to sign up as organ donors.

"What better way than to tap into almost every Canadian through their taxes, and their tax forms," he said. "I hope eventually that all federal and provincial forms will ask the same questions."

Health Committee recommends stronger federal role in donations

The same House committee that will examine Mr. Webber's idea also studied the overall issue of organ donation and transplantation this year, releasing its report in September.

The multi-party committee said the federal government has a "leadership role to play" in strengthening Canada's organ donation and transplantation system.

It specifically recommended that the feds provide sustained funding to the Canadian Blood Services, establish a working group with provincial and territorial ministers to review best practices in organ donation legislation Canada-wide, and study Spain's model of presumed consent.

MPs also suggested that Ottawa create more opportunities for Canadians to register as donors, and to invest in national public education and awareness campaigns to promote conversations among family members regarding organ donation.

Mr. Webber said one in five Canadian families are saying "no" against the wishes of a loved one who consents to donating an organ, something he said was "shocking."

While he understands that it can be a lot of ask for a family, particularly when their loved one is dying, he hopes more Canadian households will talk about organ donation earlier on, instead of when a loved one is dead or near death.

Ms. Gavsie said two ways the federal government can support organ donation is through providing more ways for Canadians to sign up as donors, such as on passport forms, and a nationally co-ordinated awareness campaign that can raise greater awareness that organ donation does indeed saves lives.

"We are not embracing all of the opportunities that are available across the country," she said.

Mr. Webber, who advanced a provincial private members' bill on organ donation in 2013, when he was an Alberta MLA, said his passion for the issue was spurred because his late wife, Heather, was saddened she was unable to donate her organs due to a cancer that spread through her body. She died in 2010.

"I thought I would do anything I can to honour her wishes through other people, by encouraging others to donate their organs," he said.

jlim@hilltimes.com
The Hill Times

Deceased donor rate, by province:

British Columbia: 20.3 per one million people
Alberta: 16.1 per one million people
Saskatchewan: 12.2 per one million people
Manitoba: 12.1 per one million people
Ontario: 25.2 per one million people
Quebec: 20.4 per one million people
Nova Scotia: 18.2 per one million people
New Brunswick: 17.2 per one million people
Newfoundland and Labrador: 13.2 per one million people
Canada: 20.9 per one million people

Organ donation in Canada, by the numbers in 2016:

20.9—Canada's deceased donation rate per one million people
22—the per one million people donation goal set by Canada Blood Services and other organizations in 2011
4,492—the number of people on the donor waitlist
260—the number of Canadians that died while waiting for an organ donation
2,903—the number of transplant procedures conducted in Canada
758—the number of deceased organ donors
544—the number of living organ donors

—Canadian Blood Services' Organ Donation and Transplantation in Canada 2016 System Progress Report Update

Does this headline say what you need to decide whether to read the article?

Of course not, in the same way nutrition labelling on the back of food packages doesn't communicate what we need to know before buying food.

Fabio Gomes

Nutrition

Supermarkets are crowded with around 40,000 products, yet most shoppers spend fewer than 10 seconds selecting an item. That's certainly not enough time to review current Canadian nutrition labels, which are on the back or side of packages and contain detailed information that's often too complex for many consumers to understand.

But nutrition labelling is about to change in Canada and that's good news, both for our health and for informed consumer decision-making.

Health Canada is currently developing new "high in" nutrition alert labels for the front of food packaging. This is consistent with best practices and evidence on how to provide consumers with quick and easy information about the levels of saturated fats, sugars and/or sodium in food and drink products.

How does it work?

When a product has more than a specified level of certain nutrients, it must have a prominent black label on the front of the package that says simply, depending on the nutrient in question: "high in sugar," "high in fat," or "high in sodium." There are no numbers or symbols that require further interpretation. Importantly, the simple but powerful words "Health Canada/Santé Canada" should also be on the label to convey the alert symbol has legitimacy and authority.

This is an excellent step forward and will make Canada the first G7 country to mandate such labels, if the current plan proposed by Health Canada is approved and implemented.

Why did Health Canada choose this option?

Research, including work awarded the Nobel Prize, has consistently demonstrated that consumers do not spend a great deal of time and effort in purchasing situations, especially when it comes to repetitive decisions, which is the case when buying food. Current nutrition facts, unfortunately, do not sufficiently influence shoppers' choices towards healthier products.

Why is this the case? Because food and drink nutrition labels are frequently difficult to find, hard to read and obscured by competing claims on the packaging.

There are often prominent but misleading claims by manufacturers on the front of the packages that may be at odds with the nutrition label on the back. Images of natural foods, such as fresh fruits and cartoon characters, as well as colorful designs, can also distort consumer perceptions about certain foods.

A good nutrition label needs to cut through the hype.

The key to an effective front-of-package labelling system is that it must be both simple and interpretive. Simple means that it shouldn't require any nutritional knowledge to be understood. Interpretive means that information should be given in the form of guidance to the consumer, rather than simply providing numbers.

Consumers invest little time in making a purchasing decision, so the system has to also facilitate quick recognition and processing of the information.

Various other promising front-of-package labelling systems have been developed to help consumers make better food choices. Some involve traffic lights—green, yellow and red to indicate low, moderate or high levels of nutrients. Others use numbers and percentages to depict the level of nutrients and some use stars—the more stars, the healthier the food.

But research has generally found that these systems are not as effective at helping consumers steer away from foods that are "high in" sodium, sugar, or saturated fat. And these ingredients are linked to the diseases that are the major causes of death and loss of years of healthy life in Canada, such as cardiovascular diseases, cancer, and diabetes.

Health Canada was also able to rely on international experience when making their decision. The "high in" labelling approach is already being used in Chile—and approved for use in Peru and Uruguay.

Evaluation of the first year of use in Chile shows that 93 per cent of Chileans reported they understand the labels and 92 per cent found it influenced their purchasing decisions. Manufacturers may also be improving the nutritional content of their product to avoid the negative labels. Food manufacturers in Chile reformulated 18 per cent of their products prior to the implementation of the labelling system in order to avoid having the label on their products.

Canada and many other countries face an epidemic of obesity and diet-related chronic diseases with serious and expensive health consequences for individuals and societies. Front of pack "high in" nutrition labels will help consumers make healthier and more informed food choices.

Dr. Fabio da Silva Gomes is an adviser in nutrition and physical activity with the Pan American Health Organization/World Health Organization and a contributor with EvidenceNetwork.ca based at the University of Winnipeg.

The Hill Times

Inequality in system no reason to criminalize paying for fertility services, says Grit MP Housefather

In surrogacy and fertility services, there's always an exchange of money—just not to the surrogates and donors, says expert Dave Snow.

BY NEIL MOSS

The ability to pay surrogates as well as sperm and egg donors for their services will largely benefit wealthy and middle class people seeking to be parents, and not those of less financial means, but that's no reason not to move forward with decriminalizing payments to surrogate mothers and donors, says the author of a bill seeking to do just that.

Liberal MP Anthony Housefather (Mount Royal, Que.) introduced in May a private member's bill that seeks to change the Assisted Human Reproduction Act, which currently criminalizes payments to surrogates and fertility donors, with a punishment of between four to 10 years imprisonment, and a possible fine of between $250,000 and $500,000. The bill would make it legal for those over the age of 18 to be paid for their sperm or ova donations, and for those over the age of 21 to be paid as surrogate mothers.

"You need money to have a baby," Mr. Housefather said in interview. "Just because only some people can use it, nobody should be allowed to use it?"

He added that the current regime means the country has few domestic donors, leading to Canada importing the majority of the supply of eggs and sperm, which drives up the price more than if Canadians were paid to donate eggs and sperm. This would ultimately lead to greater availability for working-class Canadians, he said.

"The main thing we should all agree with is people shouldn't fear going to jail because [they] make a mistake in the way they offer to pay a surrogate," he said.

Currently, there is a two-tier surrogacy system where those who use surrogates belong to higher economic backgrounds, said Dave Snow, a University of Guelph political science assistant professor who specializes in the intersection of politics, law, and assisted reproduction. The decriminalization of payments won't alter the system where surrogacy is already monopolized by the rich.

"Poor people are not commissioning surrogates, and having children through surrogates," Prof. Snow said.

Even when surrogates aren't being paid, having a child through surrogacy requires "lots and lots of money," he added.

Liberal MP Julie Dzerowicz (Davenport, Ont.), who flanked Mr. Housefather at a press conference in support of his bill in May, said regulating costs could be an option for the government to make sure fertility services are available to those who want to start a family.

Prof. Snow said it is "unlikely" for the government to fund the services, as there are more pressing needs to fund in Canada's health-care system.

Even if the government subsidized surrogacy or fertility services, it wouldn't necessarily be obtainable for working-class Canadians, as even with payments there won't be a flock of people coming forward to be surrogates, and fertility services still require an expensive drug regimen.

Prof. Snow said he is, "broadly speaking," in favour of Mr. Housefather bill, C-404, since in surrogacy and fertility services there is already an exchange of money, but the only person not seeing a payment is the person donating eggs or sperm, or the surrogate.

He said the current system is a "far more exploitive arrangement" than one where the surrogates or donors get paid for their labour.

Tories likely to have 'free vote' on bill, says Marilyn Gladu

Mr. Housefather's bill still has to go through the shadow cabinet and Conservative leadership for discussion, but Conservative MP Marilyn Gladu (Sarnia-Lambton, Ont.), her party's health critic, said because it is a private member's bill and involves "conscience issues," she thinks the Conservative caucus would have a "free vote."

Ms. Gladu said there is a problem with the level of screening of the egg and sperm supplies for Canada, as Canada currently gets the great majority of donations from the United States, and it doesn't have the same rigorous screening as Canada does.

NDP MP Don Davies, left, questions if the for-profit sale of bodily fluids is the right path for Canada. Conservative MP Marilyn Gladu, middle, says Conservative MPs will likely have a 'free vote' on Liberal MP Anthony Housefather's, right, private member's bill on the topic. *The Hill Times file photograph, by Andrew Meade, and by Sam Garcia*

Ms. Gladu's NDP counterpart, MP Don Davies (Vancouver Kingsway, B.C.), said generally the NDP sides with those who think organs, tissues, and bodily fluids should not be commodified or subject to for-profit sale. However, he said he hasn't studied the bill, as it has yet to be referred to the Health Committee.

Mr. Davies said he would be open to looking at the evidence, but he said Canada's approach to not commodifying organs, tissues, and bodily fluids has served it well.

"I'm not sure opening up the sale of human fluids to private for-profit sales is the way to go," Mr. Davies said.

Mr. Davies said the NDP remains opposed to for-profit health care, and services shouldn't be subject "to the size of someone's bank account."

"One thing we all share—and I share with Mr. Housefather—is we'd like to make sure that Canadians who would like to have children and can't have children have access to the best technology we have, and a system that can assist as many people as possible," Mr. Davies said. "Whether that extends to paying people for surrogacy for the present system, I think the case has to made by Mr. Housefather… because it's certainly inconsistent with the approach we've taken up to now."

Mr. Housefather said his bill has the support of the Liberal women's caucus, many Liberal and Conservative MPs, and Green Leader Elizabeth May. (Saanich-Gulf Islands, B.C.)

New regulations for donor, surrogate reimbursement

On Oct. 26, Health Minister Ginette Petitpas Taylor (Moncton-Riverview-Dieppe, N.B.) announced new regulations that would allow for the reimbursement for some expenses that donors or surrogates may have, including medical and work-related costs.

But for Mr. Housefather, the new regulations are insufficient.

He said it is good to have clarity on what can be reimbursed, but it is trying to resolve the wrong issue.

Just knowing what expenses are covered doesn't solve the problem that you can't pay people beyond their expenses, and everyone's expenses are different, Mr. Housefather said.

"We would be far better off to recognize that it shouldn't be a criminal act to pay someone for their sperm or their eggs, or be a surrogate," he added, "and allow provinces to regulate and take it out of [jurisdiction of] the criminal [system]."

nmoss@hilltimes.com
The Hill Times

Indigenous peoples left behind by unfair, unequal health services

Independent Senator Yvonne Boyer

Indigenous services

Canada's health-care system is a source of national pride. This conviction is challenged, however, when one considers the growing body of research that has identified an unequal and unfair application of health policy.

There are significant discrepancies in the way health-care services are delivered to and accessed by First Nations, Métis, and Inuit as compared to the non-Indigenous population. These differences are rooted in the evolution of colonialism.

Since Confederation, the Canadian government has regulated most aspects of Indigenous lives. In doing so, it has ingrained what the law has characterized as a guardian-ward relationship, where the state assumes a paternalistic role in making decisions concerning the health and well-being of Indigenous peoples. It was not until 1984 that the Supreme Court of Canada redefined the Indigenous-Crown relationship, describing it as one involving a legally enforceable and compensable fiduciary obligation based on constitutional and statutory rights. This fiduciary relationship extends to situations where Canada has discretionary control over Indigenous health care. Thus, Canadian health-care policy should reflect these obligations rather than outdated colonial theory.

The guardian-and-ward theory continues to permeate Canadian health policy. This perspective underpins beliefs and attitudes of some health-care providers and finds particular expression in the differing standards that First Nations and Inuit peoples must satisfy when submitting claims for extended health benefits under the Non-Insured Health Benefits (NIHB) program. When claimants qualify for benefits under a private plan or a public program, the "payer of last resort" policy requires them to submit their claims to those programs first before sending them to NIHB.

NIHB claims made for medically necessary devices and services regularly require the claimant to demonstrate they are capable of caring for the device and adhering to the prescribed treatment for a set period of time where it is not required under provincial programs.

For example, in Saskatchewan, patients diagnosed with obstructive sleep apnea are treated using continuous positive airway pressure (CPAP) machines. The machine is a take-home device that requires the patient to wear a mask while sleeping. It delivers constant pressure flow to ensure the person's airway is maintained.

Individuals covered by NIHB must complete a three-month CPAP rental period and prove they have been adhering to their treatment before the program will insure a CPAP purchase. Conversely, individuals covered through Saskatchewan Health are loaned these machines at a discounted cost and can take the machine home without having to prove they can care for it. This policy is indicative of the outdated and humiliating guardian-and-ward beliefs.

In northern Ontario, First Nations children in remote communities cannot access the health-care providers they require to obtain specialized assessments, order medical therapies, and be recommended treatments for certain conditions and ailments. The NIHB travel policy often does not cover the cost for health-care professionals to travel to these communities. NIHB adjudicators have interpreted this policy as applying strictly to providers who bill the Ontario Health Insurance Plan directly (in other words, doctors) and not to those who are publicly funded through provincial bodies (occupational and/or physical therapists, for instance). As a consequence, children in need of assistive devices or accommodations for learning challenges are unable to receive the help they urgently require. In aggregate, First Nations children are being left behind by a system that appears apathetic to the changes necessary to meet the standard of universal access and coverage promised to all Canadians.

Recent actions by the federal government have given rise to the prospect of Indigenous communities reclaiming some degree of autonomy and control over the design of their health programs. On Sept. 6, Indigenous Services Minister Jane Philpott announced that Canada would commit $68-million over three years to improve health services in Indigenous communities. While this is a welcomed start towards restoring the decision-making capacity of Indigenous communities, more action is required to rectify the underpinning causes of inequities that Indigenous people continue to experience.

Ontario Senator Yvonne Boyer is a member of the Independent Senators Group. She is a member of the Métis Nation of Ontario and has a background in nursing. She came to the Senate from the University of Ottawa, where she was the associate director for the Centre for Health Law, Policy, and Ethics.

The Hill Times

Canadians deserve better health care. Patient's Medical Home can get us there

Independent Senator Mohamed-Iqbal Ravalia

Family medicine

I became a family doctor because providing comprehensive, compassionate care gave me meaning. In the small community I served in Twillingate, N.L., I have watched infants I cared for grow up and I've watched people reach the end of their lives. I am a part of this community and the relationships I've developed are central to what it is to be a family doctor.

I know that my patients also value these relationships. They know I see them as a person and not just as a collection of ailments to treat. I am able to offer treatment plans or advise healthier lifestyles based on what I know about my patients' socio-economic situation and their family environment—right down to knowing whether they are likely to follow my advice.

Family medicine is rewarding and complex, more so now than ever before. However, it is becoming more challenging to address this complexity using traditional practice organization.

For example, a patient who is dealing with a chronic condition while managing a series of medications and coping with family issues needs support from a community-based team of health professionals to effectively take care of their health. To address this complexity, improve service, and meet the evolving needs of patients, provinces are experimenting with a variety of primary care models.

The College of Family Physicians of Canada launched its vision of the future of family practice in 2011. It's called the Patient's Medical Home (PMH) and the model has caught the attention of provincial decision-makers and health-care providers across Canada.

PMH is best described as a family practice serving as a central hub for providing care that is responsive to the needs of individual patients and their communities.

The model embraces health information technology, which includes electronic records to store and share information across points of care, allowing health professionals to communicate efficiently.

Evidence shows that PMH models of family practice lead to better care, better outcomes, lower health-care costs, and increased satisfaction for providers and patients. When the model works well, it is associated with reduced reliance on emergency rooms, better adherence to treatment plans, better access to after-hours care, and improved patient follow-up.

Recognizing the variability of health-care delivery across Canada, the PMH is not based on mandatory criteria; rather it is a set of pillars that supports the need to be responsive to communities. The further a practice is aligned with the PMH vision, the better it can deliver on the full potential of the model.

To realize the vision of better care and better outcomes for all, the PMH needs support from provinces, territories, the federal government, decision-makers, health-care providers, and the public, who will ultimately benefit from the model's results.

With government support and joint participation from the health professionals who make it possible, the PMH can deliver care that is accessible and responsive to Canadians' needs. The progress made in the past seven years is impressive, but more work is before us.

What I have valued most as a family doctor in Twillingate has been working with a good team with the common goal of improving people's lives through better access to person-centred care.

The Patient's Medical Home vision can make this achievable and accessible for everyone in Canada.

Senator Mohamed-Iqbal Ravalia is a former family physician. He is a member of the Independent Senators Group and represents Newfoundland and Labrador in the Senate.

The Hill Times

Canadians want a label on it

Make it simple. Make it right. Make some reasonable exceptions.

The federal government is proposing **visible, easy to understand front-of-package nutrition labels** to help Canadians make healthier choices.

These alert labels will provide busy shoppers the quick direction they need that the nutrition facts table doesn't provide. They are based on the **best scientific evidence** and **supported by 87% of Canadians**.

Heart & Stroke supports this approach and urges government to consider **some exemptions for dairy products** that are high in important nutrients.

Heart & Stroke™

Single-payer pharmacare is a cure worse than what ails the system

A federal intrusion that disrupts coverage for three-quarters of the population, requires tax hikes and spending cuts, and leads to less drug access hardly seems like a political winner. But neither is silence on the other side of the debate.

Sean Speer

Drug coverage

As we approach the 2019 federal election campaign, we seem to be moving towards to a major policy conflict between political parties on pharmacare and the federal role.

The debate will hinge on whether we should pursue targeted or sweeping reforms, whether we prioritize clinician and patient choice or cost control, and whether we wish to see a more or less expansive role for Ottawa in health care.

This debate will only unfold, however, if both sides present credible plans. It won't be enough for pharmacare critics to merely critique the flaws of national pharmacare. That's the easy part. It will behoove opponents to develop and put forward a better alternative that targets those who need greater public support without harming those who are well served by the current mix of public and private insurance.

We don't know precisely where the government will ultimately land on the file. But we have some signs. Its members on the House of Commons Health Committee have strongly endorsed a pan-Canadian, single-payer scheme. Eric Hoskins, the chair of the government's advisory panel currently studying the issue, has spoken positively of the "the vision of national pharmacare."

This impulse isn't wholly unjustified. There's a small yet vulnerable share of the population without private or public drug coverage. There are also some who lack catastrophic coverage for high-cost drugs. And out-of-pocket spending, which tends to be regressive, has been rising across the country. These are legitimate public concerns that require a policy response.

But a single-payer pharmacare scheme is a cure that's worse than what ails the system. It would disrupt coverage for the 77 per cent of the population generally satisfied with the status quo. It would impose significant new costs on the federal government. It would almost certainly involve poorer drug access and less clinician and patient choice. And it would thrust Ottawa into provincial jurisdiction with no competency or expertise.

A federal intrusion that disrupts coverage for three-quarters of the population, requires tax hikes and spending cuts, and leads to less drug access hardly seems like a political winner. But neither is silence on the other side of the debate. Ignoring the real challenges facing a small yet growing share of the population is a recipe for ending up with a deeply flawed pharmacare policy.

What would a better policy alternative entail?

It would start by recognizing that the current mix of public and private coverage generally serves most Canadians well. The goal then should be to build on what's currently working and fill gaps where they exist.

The two areas where there seems to be a problem are: (1) the cohort without any insurance, and (2) the cohort without catastrophic coverage. These are the two groups that Ottawa ought to target.

The Medical Expense Tax Credit is presently too small to make much of a difference. It's non-refundable and the generosity is too limited. But it can form the basis of much greater federal support for the purchase of private health insurance and catastrophic drug spending. It should be reconfigured and redesigned as a new, refundable tax credit that significantly defrays the cost of health-related expenditures, including insurance premiums.

Suppose you set the value of the credit at $5,000 per family or $2,500 per individual for purchasing insurance. There would be room to adjust these amounts based on income or health status. This would provide substantial public support for individuals and families to purchase different forms of private insurance ranging from basic plans to more enhanced benefits. It would leverage the best features of the current model and eschew the worst parts of government-run pharmacare.

The impending pharmacare debate is shaping up to have parallels to the child-care debate in the 2006 federal election campaign. That debate was similarly focused on a choice between a one-size-fits-all, government-centric option and a more targeted and flexible model that empowered individuals and families. The latter won out in that instance and has since reshaped the federal role in child-care policy.

A sensible alternative to national pharmacare can have the same policy and political effect. But it will require a combination of confidence and ideas, just as it did then.

Sean Speer is a Munk senior fellow at the Macdonald-Laurier Institute. He previously served in different roles for the federal government including as senior economic adviser to former Conservative prime minister Stephen Harper.

The Hill Times

Two ways forward for national pharmacare

The 'fill-the-gaps' approach is mere code for more of the same: high prices and problems with access.

Patrick Fafard, Colleen M. Flood, Asad Ali Moten & Bryan Thomas

Drug coverage

The case for universal pharmacare is compelling and clear-cut. But as the federally appointed advisory group led by former Ontario health minister Eric Hoskins prepares the blueprint for a national plan, Ottawa must brace itself for negotiations with the provinces and territories.

Canada is the only OECD country with universal health insurance that does not include prescription pharmaceuticals. One in five Canadians reports that they or someone in their household are not taking their medicine as prescribed, owing to concerns about costs. Although provinces provide coverage for some groups, including the poor and elderly, up to 20 per cent of Canadians have no drug insurance at all. Our limited access also doesn't save us money: Canada has among the highest per capita drug expenditures in the OECD. This patchwork mix of public and private drug programs leads to access gaps and high costs that threaten the health, and the very lives, of thousands of Canadians annually.

But it doesn't have to be that way. Ottawa and the provinces and territories have the chance to change lives with a robust, Canada-wide pharmacare program.

A clear set of objectives is essential for a successful outcome of negotiations between Ottawa and the provinces and territories. To be sure, there are many challenges. We need look no further than the bitter federal-provincial talks over health funding to recognize the delicate nature of such negotiations.

Complicating matters even more, governments have overlapping, and at times confusing, jurisdiction over health care under Canada's constitution. As the Supreme Court has clearly and repeatedly indicated, which level of government has primary jurisdiction depends on the particular issue at hand.

Currently, the federal government exercises some of its constitutionally mandated powers to shape and direct pharmaceutical policy—playing a larger role in this domain than with respect to other parts of health care. This includes the regulation of patents and safety and efficacy of medicines. It also funds prescription drug benefits for specific populations, such as prisoners, members of the Armed Forces and the RCMP, and veterans.

Arguably, this provides a foundation for Ottawa to take a far stronger leadership role in the establishment of universal pharmacare than it has to date. In our recent study for the Institute for Research on Public Policy, we outline two constitutionally viable policy options for a national pharmacare framework.

Under the first option, the provinces would agree to delegate the power to administer drug insurance plans to a federally funded agency. This process was used to establish Canadian Blood Services in the 1990s. Through public tendering and bulk purchasing, the CBS has been able to achieve dramatic cost savings for certain pharmaceuticals on behalf of the provinces. Its success shows that intergovernmental collaboration to implement universal delivery of health-care products can be achieved where sufficient political will exists.

As a second option, the federal government could adopt legislation similar to the Canada Health Act and provide annual transfers for pharmacare to the provinces and territories. The funding would be contingent on compliance with two criteria: (1) universal coverage for a basket of essential drugs, with no copayments or deductibles; and (2) decisions over what to include in the basket to be made by an arm's-length body (or bodies).

Dr. Eric Hoskins, chair of the Advisory Council on the Implementation of National Pharmacare, speaks to reporters to announce the remaining members of the council on June 20 in the House foyer. They are set to release their final report in spring 2019. *The Hill Times photograph by Andrew Meade*

The forces in opposition to change are extremely formidable, including private insurers and pharmaceutical companies. There will be repeated calls that the status quo is not that bad and only minor changes are required.

We should learn from the experience of the United States health-care system, that the "fill-the-gaps" approach is mere code for more of the same: high prices and problems with access. It is imperative that the federal government makes a firm commitment to leading the country toward universal pharmacare. In negotiations with the provinces and territories, Ottawa's bottom line must be ensuring the overarching principles of universality and accountable decision-making.

Colleen M. Flood, Bryan Thomas, and Patrick Fafard are professors of health policy and law at the University of Ottawa Centre for Health Law, Policy & Ethics. Asad Ali Moten is a freelance legal researcher in Toronto. They are authors of Universal Pharmacare and Federalism: Policy Options for Canada, published by the Institute for Research on Public Policy.

The Hill Times

Why is Health Canada thwarting Parliament's will?

In the fight to implement Vanessa's Law, it comes down to Big Pharma vs. the health of Canadians.

Green Party Leader Elizabeth May

Legislation

The problem of regulators becoming captives of the regulated is not new. It's the idea that a regulator is basically an instrument of the industry it's meant to regulate. Former Alberta Liberal leader Kevin Taft wrote about it in his book *Oil's Deep State*. I see it all around us—in the National Energy Board approach to pipelines, for instance (though it says its decisions are based on evidence and not any predetermination), and in Nav Canada describing airlines as its clients.

But something rotten is going on in Health Canada.

In the 41st Parliament, when Rona Ambrose was health minister, the crusading MP from Oakville at the time, Terence Young, accomplished the near impossible: the Canadian government took on Big Pharma. Young would never have been a thorn in the side of multinational drug companies if his daughter, Vanessa, hadn't died in 2000 at the age of 15 after suffering complications while taking the prescribed drug Prepulsid for minor indigestion issues.

She collapsed at the foot of the stairs at home, in front of her father, and died. In 2001, a coroner's inquest found that Prepulsid was a contributing factor in her death.

No law required her doctor to know or the drug company to communicate to her mom and dad that eight children had died during clinical trials for Prepulsid 10 years before and the FDA could not rule out that the drug played a role in some of those deaths.

The tragedy that hit the Young family was not that unusual. Used as directed, it is estimated that prescription drug use leads to about 150,000 deaths every year in North America.

In 2014, the Protecting Canadians from Unsafe Drugs Act (Vanessa's Law) received royal assent. Under Vanessa's Law, the health minister may require drug companies to release clinical trial data to independent researchers. Even after the Thalidomide disaster of the 1950s and '60s, Health Canada had only the powers to ask the drug companies for a voluntary recall. It also opened up the secretive culture of protecting data that could hurt a drug company's profits. Vanessa's Law requires the companies to publish results from drug trials. It was with a non-partisan spirit and a sense of triumph that our House and Senate passed Vanessa's Law.

Former MP Terence Young's daughter Vanessa died in 2000 at the age of 15 after suffering complications while taking the prescribed drug Prepulsid for minor indigestion issues. The drug has since been taken off the market. *The Hill Times photograph by Cynthia Münster*

Since then, we are more aware of how Big Pharma has contributed to one of Canada's current health emergencies. Canada has a particularly high rate of opioid addiction, as the population with the second-highest rate of prescription opioid use in the world. In the 1990s, the drug OxyContin was marketed as a great pain reliever, but the marketing minimized the risk of addiction. It was true that OxyContin is 1.5 to two times more potent in relieving pain than morphine. It was completely untrue to claim that it was less addictive than other painkillers.

But four years after Vanessa's Law received royal assent, not a single regulation associated with it has been put in place. Worse, draft regulations undermine the act's purpose. Already, the guidance document, created by Health Canada to implement the law, protects Big Pharma and undermines the health of Canadians.

This was all revealed in detail by Young, now a former MP and chair of Drug Safety Canada, in a recent article he wrote for *iPolitics*.

Young chronicles the obstacles put in place by Health Canada. In order to access data, Health Canada requires researchers to sign confidentiality agreements. A Maryland researcher, Peter Doshi, challenged the rejection of his application.

"On July 9, Justice Sébastien Grammond of the Federal Court... ordered the data released for several reasons, including contradicting the purpose of Vanessa's Law—to improve clinical-trial transparency—and for failing 'to assess the effects of its decision on Mr. Doshi's freedom of expression,' as guaranteed in the Canadian Charter of Rights and Freedoms.

"Health Canada breached the Charter. Yet the offending policy is still posted on its website three months later."

So what was going on as Parliamentarians passed Vanessa's Law? Were people deep in the bureaucracy at Health Canada quietly reassuring Big Pharma? Were they whispering: "Parliament may think it can expose your secrets to protect the health of Canadians, but we'll strangle their naïve zeal in implementation"?

Why do we enter trade agreement after trade agreement expanding the profit margins of big-name pharmaceutical firms?

Why do we allow drug companies to enjoy obscene profit margins that increase the strain on our health-care system?

And what the hell is going on in thwarting the will of Parliament by blocking Vanessa's Law?

Health Canada needs to be shaken by its ankles until the answers come tumbling down. I'll bet anything that this intransigence is not being directed from the minister's office. This is a captive regulator working for Big Pharma.

Elizabeth May is the leader of the Green Party of Canada and the Member of Parliament or Saanich-Gulf Islands, B.C.

The Hill Times

We need a holistic approach to health care

The patient needs to be heard, not simply seen.

Independent Senator Mary Jane McCallum

Indigenous services

Looking back, I now realize that I learned many fundamental lessons of good health care at a very young age. The traditional life skills my people demonstrated while living off the land taught that responsibility and resilience through social capital (we-chi-e-twin) were instrumental to the concept of preventing sickness, starvation, and other ailments.

I mimicked these important life skills in my own play. Through this, I saw the need to provide food and keep warm, as well as to work hard and nurture family and community. These issues were not separate, but rather interwoven in such a way that allowed generations of Indigenous peoples to not simply survive, but thrive off the land. Through this, I got my first glimpse of holistic health care.

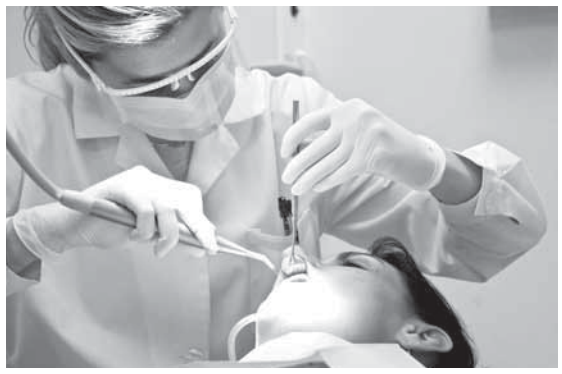
In 1956, at the age of four, I visited the nursing station on my reserve because of a sty on my eyelid. As I started to tell this to the nurse, in a very loud voice, she said: "Don't tell me what's wrong with you. I'll tell you what's wrong with you."

I was silenced. I was afraid. This was my first, but unfortunately not last, experience with lateral violence and shame from a health professional. It marked the start of my loss of power and spirit. I was taught that others had to take care of me because I was unable to take care of myself. It was with this entrenched belief that I was incapable of self-care that I slowly lost the concept of prevention. This encounter became the catalyst of my personal loss of voice and loss of responsibility, to be steadily replaced by increased anxiety.

Over the next many years, I blindly accepted that the institutions in which I found myself knew what was best and should not be questioned. During this time I gradually abandoned my narrative of self-purpose and self-worth, and accepted the new story given to me in which I was expected to be silent and subservient.

This included my 11 years as a student of residential school, which I left as a vulnerable young woman without any tangible life skills or critical thinking skills. In its own way, this also included my time as a student of health professions, whose rigid view of health care put a premium on the voice of the health-care provider while often working to stifle the voice of the patient. This was my first experience of the economy of illness, whether it be mental, physical, psychological, or social.

I regret that it took many years for me to decolonize from the Western way of providing health care. The current system, by and large, dictates that the health-care professional should simply treat the individual illness, or body part in question, and move on to the next patient. However, it is this narrow approach that has continued to result in a greater deficiency in health status, especially for those who are already marginalized in society.



The current system, by and large, dictates that the health-care professional should simply treat the individual illness, or body part in question, and move on to the next patient, writes Sen. Mary Jane McCallum. *Photograph courtesy of Conor Lawless*

Health care cannot fully succeed in this silo-driven approach. After years as a health-care provider myself, I relearned that I was responsible for my patients when they entered the doorway of my clinic and I needed to honour the commitment. The patient needs to be heard, not simply seen. It is by learning their situation and circumstance that we can better achieve a more targeted course of action for more effective, and holistic, treatment.

During my time as a dentist, I have had patients come back every two years to have fillings replaced. These individuals, often Indigenous, frequently do not have the basic securities of food, housing, and employment. Without access to these basic necessities for survival, how can we expect them to spend resources on more advanced health care?

We, as a country, need to re-evaluate our health policies. We need to re-evaluate our methods of health education. And we need to ensure that, through these structural improvements, the patient is heard and upheld in a way that will result in truly preventative health care.

Manitoba Senator Mary Jane McCallum is a member of the Independent Senators Group, a First Nations woman of Cree heritage, holds a doctor of dental medicine, and has provided dental care to First Nations communities across Manitoba.

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