February 8, 2021 | The Hill Times

HEALTH

POLICY BRIEFING

Supply delay offers opportunity to get mass vaccination campaign right, experts say

With Canada's supply of COVID-19 vaccines dropping below initially expected numbers in the coming weeks, experts argue this period presents an opportunity to ensure the mass-vaccination campaign runs smoothly.

BY AIDAN CHAMANDY

Issues with COVID-19 vaccine manufacturing in Europe has left Canada receiving fewer doses in recent weeks than the federal government initially predicted, but the drop in supply offers an opportunity for governments to get the planning right for when mass vaccinations begin later in the year when supply ramps up again, experts say.

"We should use this time, when supply is low and demand is restricted to certain sectors of the population, to make ourselves ready for the mass vaccination," said Saibal Ray, professor of operations management at McGill University.

"We have an opportunity now, all governments, to learn the lessons from the initial rollout, see where the challenges are, but really prepare for the summer when we're going to have to start administering millions of doses," said Kumanan Wilson, a professor of epidemiology at the University of Ottawa and doctor at The Ottawa Hospital. Dr. Wilson is also the founder and CEO of CANImmunize, a digital logistics company that has helped some provinces and territories with information technology infrastructure associated with the rollout.

Both Pfizer/BioNTech and Moderna products, the only two vaccines currently approved for use in Canada, announced delivery delays in the past weeks.

Canada is expected to receive around 180,000 shots of the Moderna vaccine in the second week of February, down from an initial promise of more than 230,000. A Jan. 29 document prepared by the Public Health Agency of Canada obtained by CBC News said the second shipment pegged for the week of Feb. 22 will also be affected, but the company cannot confirm to what extent. The document was signed by Maj.-Gen. Dany Fortin, who is in charge of federal vaccine logistics. Moderna was originally set to send 249,000 doses doses the week of Feb. 22. A table on Health Canada's website no longer provides information on Moderna shipments past the week of Feb. 1 to Feb. 7.

Prime Minister Justin Trudeau (Papineau, Que.) was pressed in Question Period on Feb. 3 on how much the Moderna supply will be affected in weeks to come, but he didn't offer a direct answer.

He was visibly frustrated by the questions.

"I have already said this 15 times in Question Period today, but I am happy to continue reassuring Canadians. We will receive the six million doses promised by the end of March. We are on track to receive 20 million doses in the spring and we will ensure that every Canadian who wants it can be vaccinated by the end of September 2021," he said.

"The week of [Feb. 22] will also be impacted, but Moderna cannot confirm allocations for that week yet," the PHAC document said.

Mr. Trudeau also previously assured Canadians that the first delay won't affect the total number of vaccines the country is supposed receive in the first quarter.

"This temporary delay doesn't change the fact that we will still receive two million doses of the Moderna vaccine before the end of March," he told reporters at a press conference last week, in reference to the initial cutback.

Canada is also set to receive far fewer doses of the Pfizer/BioNTech vaccine after the company began retooling its manufacturing plant in Belgium to produce more vaccines. The company said the renovations will cut Canadian shipments by around 80 per cent, but that the renovations will allow them to produce around two billion total vaccines in 2021, up from the initial promise of 1.3 billion. Mr. Trudeau said he discussed the possibility of Canada receiving more Pfizer/BioNTech vaccines in the second quarter after Pfizer CEO Albert Bourla told him in a call that the company could "move up the delivery of some doses that were earmarked for later in the year."

Maj.-Gen. Fortin later said that Pfizer is expected to send up to 335,000 doses the week of Feb. 15, which is 91 per cent of the initial allocation for that period. The shipment is expected to increase to up to 395,000 doses the week of Feb. 22.

The Health Canada website also removed the table outlining Pfizer's shipments.

The global vaccine-sharing initiative COVAX released a document on Feb. 3 showing Canada will receive 1.9 million doses of the AstraZeneca vaccine by the end of June. The COVAX program was created with the intention of providing equitable access to the vaccine for middle- and lower-income countries. Canada is one of the wealthiest countries, and the only G7 country, listed as a recipient in the document. It also shows other wealthy countries are set to draw on the COVAX supply. New Zealand will receive a little less than 250,000 AstraZeneca vaccines, South Korea will receive less than 2.6 million, and Indonesia a little more than 13.7 million.

Canada is lagging behind most G7 countries on vaccination pace. Canada is only doing better than Japan, which has not begun its vaccination campaign yet. The country plans to begin vaccinations for health-care workers in late February, and priority groups like seniors in late March or early April.

NDP health critic Don Davies (Vancouver Kingsway, B.C.) said he does not have confidence in Mr. Trudeau's statements that all Canadians will be vaccinated by September.

Maj.-Gen. Dany Fortin, right, and Deputy Chief Public Health Officer Howard Njoo, pictured on Dec. 8, 2020, speaking with reporters about the government's vaccine rollout. *The Hill Times photograph by Andrew Meade*

"Given that they have failed to meet any of the targets that they've stated so far, and, frankly, the fact that they've misled Canadians and actually been wrong so many times, that can't give anybody confidence," he said.

"There's a serious credibility problem," he added.

The lack of vaccine supply is making is difficult to gauge how effective Canada's actual vaccine rollout has been, Dr. Wilson said.

Canada's limited vaccine supply "is making it really hard to judge right now how we're doing. It's apparent that the systems need to be further developed. It's a bit of a double-edged sword, that the delay getting our vaccine is an opportunity to be better prepared," Dr. Wilson said.

"We have not had the volume [of vaccines] that a country like the United States has had where we know how good our logistical systems are actually working," said Mahesh Nagarajan, professor of logistics at the University of British Columbia.

For Alice Zwerling, an epidemiologist at the University of Ottawa, the lack of transparency on vaccination targets and how long it has taken to vaccinate people in priority groups, like those in long-term care homes, suggests the rollout "has not been ideal."

She said that given long-term care homes provide a single site to administer vaccines, in theory it should be easier to do than a mass vaccination campaign.

According to a vaccination tracker by University of Saskatchewan student Noah Little, 86.4 per cent of vaccines delivered to the provinces have been administered. That varies wildly depending on the jurisdiction, with Nunavut having administered just more than half of its vaccines, while Quebec, B.C., and Saskatchewan have administered upwards of 90 per cent.

The tracker shows that 871,323 Canadians have received at least one dose, while 129,664 Canadians are fully vaccinated.

For all Canadians to receive at least one dose by Sept. 1, a little more 200 days away, around 180,000 Canadians will need to receive at least one dose per day, which far outstrips the current pace. In the past three weeks, Canada's daily vaccinations peaked at just less than 40,000 on Jan. 20 and have dropped to just more than 15,000 on Feb. 3, according to the vaccination tracker.

By the time the vaccine supply steadies, the mass vaccination plans should already be in place "so that when we come to April and the most vulnerable have already been vaccinated, and we go to vaccinate a more general population, we can do the mass vaccination as quickly as possible," said Prof. Ray.

Prof. Ray pointed to sites like the Palais des Congrès in Montreal as prime targets for mass vaccinations. Quebec Health Minister Christian Dubé said the convention centre is ready to administer more than 1,000 doses per day.

Prof. Ray said in the coming months, when winter is still keeping temperatures low, indoor sites that haven't had much traffic because of the pandemic, like convention centres, malls, universities, hockey arenas, and concert venues will be extremely important.

"Anything that is covered, empty, and accessible we should use," he said.

Prof. Ray said that winter temperatures will act as a constraint.

"Until May, indoor is perhaps better. Perhaps by May there can be more of an opportunity for going outdoors," he added.

Accessibility will be another major constraint, Prof. Nagarajan said.

"You want to have an equitable measure. You don't want people to be driving 40 miles to come to a stadium," he said.

Many schools and major stadiums, like NHL arenas, will only be available for mass vaccinations in the summer once the regular occupants are out, Prof. Ray said, but that shouldn't stop the planning from starting now, Prof. Zwerling said.

Schools are particularly well suited, because the location is based on population density, Prof. Zwerling said. Major sporting arenas and concert venues are often only in major cities and might not be in a place that is easily accessible, "so I'm not sure if those are really the best approaches to doing these mass vaccinations," she said.

Prof. Zwerling cautioned against relying too heavily on big buildings.

"Successful mass vaccinations in the past have employed and engaged pharmacists, family, doctors, local clinics, a much more decentralized approach, as opposed to having one centralized facility that requires logistical support and infrastructure, which, unfortunately has not been developed," she said.

Another key component will be the information technology infrastructure used to coordinate scheduling mass vaccinations and following up, Dr. Wilson said.

"The ideal system will have the vaccine recipient, the health-care provider and the public health provider with the same data in real time and shareable. The individual has to be part of the solution, they have to be able to have access to their vaccine records. And health-care providers need to know exactly which vaccine this individual is given, that individual needs to be able to report adverse events as they would occur," he said.

Dr. Wilson said one of the key things he learned in running trials using his CANImmunize platform and from other jurisdictions is that effective scheduling "is one of the most important aspects. The scheduling processes really sped up the clinic management."

"It helps from two perspectives. Booking online is easy, but you can also start to auto-populate the data needed at the time of vaccination when the person fills in that data. So the vaccination is so much quicker—there's not much data entry at the point of vaccination, because already most of the information is auto populated," he said.

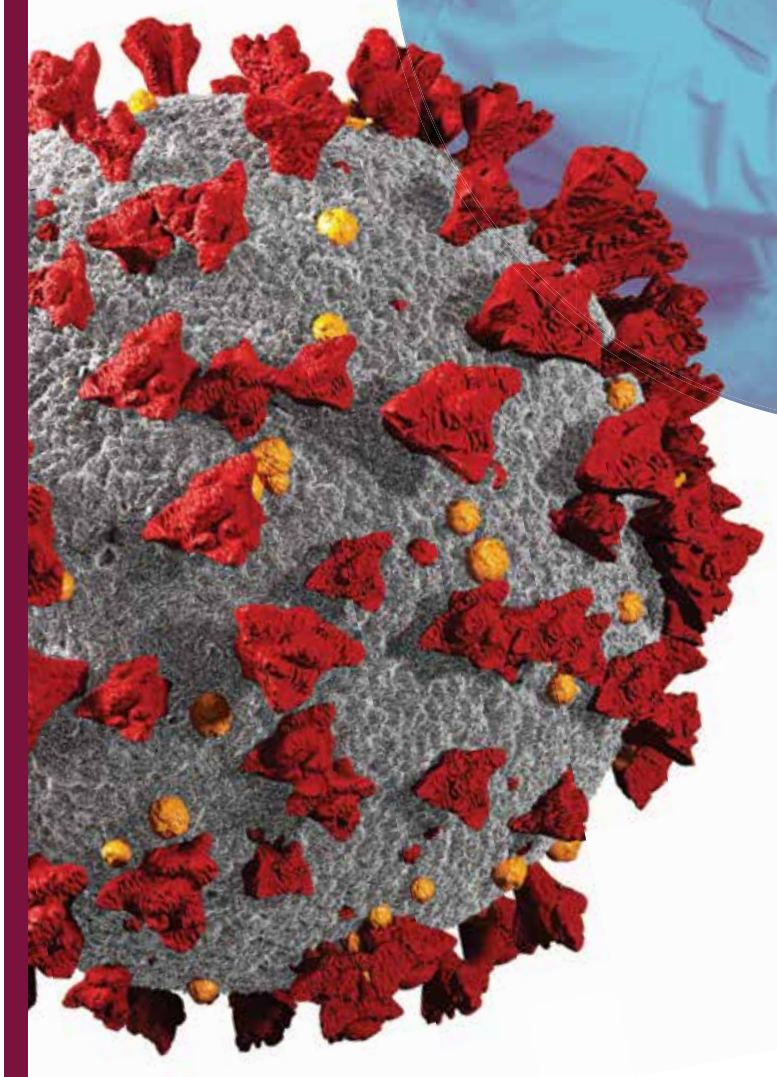
achamandy@hilltimes.com
The Hill Times

McMaster University

Canada's Global Nexus for Pandemics and Biological Threats

Charu Kaushic (right), scientific director, CIHR Institute of Infection and Immunity and postdoctoral fellow Allison Felker

Karen Mossman (right), vice-president, research and postdoctoral fellow Arinjay Banerjee



LEADING THE WAY

Canadian solutions for a global crisis

Based at McMaster University, **Canada's Global Nexus for Pandemics and Biological Threats** is focused on shared goals: beating COVID–19 and preparing for future pandemics.

Building on a world-leading track record of infectious disease research, Canada's Global Nexus is bringing together researchers, government, industry, health care and global partners to help make Canada a leader in solving the existing health crisis while preparing for the next.

Learn more at globalnexus.mcmaster.ca

BRIGHTER WORLD

No time to waste on health-care reforms

Green Party leader Annamie Paul, pictured, says that addressing the structural weaknesses in health care, rather than merely reacting to each crisis as it arises, is the best strategy going forward. *Photograph courtesy of the Green Party of Canada*

It is not too late for Canada to convene an intergovernmental COVID-19 task force, led by health experts, to develop and deliver a coordinated national response to the pandemic

BY GREEN PARTY LEADER ANNAMIE PAUL

The COVID-19 pandemic has taught us painful lessons about the weaknesses in Canada's health-care system. Low-income and racialized communities have been disproportionately impacted, as have seniors and the disabled.

More than ever, the current crisis demonstrates why preventive health care plans are best made in ordinary times, rather than in the middle of a crisis with all the additional pressures it brings. Health promotion and disease prevention in times of stability are the best preparation for times of crisis or outbreak. While we will be reckoning with this pandemic and its accompanying health-care failures for some time, we must still begin planning for the future. Modernizing our health-care systems should be high on the agenda, and the federal government can and should lead the way.

As we continue to grapple with Canada's greatest health crisis in over a century, there is no time to waste. The Green Party has asked the prime minister to convene an intergovernmental COVID-19 task force, led by health experts, to develop and deliver a coordinated national response to the pandemic. Countries that have been more successful in protecting their populations have adopted such an approach, including the new president of the United States, who appointed a national COVID-19 coordination team on his first day in office. It is not too late for Canada to do the same.

When we search for answers on why the pandemic's death toll in Canada continues to rise, one answer stands out: conditions in long-term care facilities. More than 80 per cent of Canada's COVID-19 deaths have been in long-term care, and Canada ranks second amongst wealthy countries for the proportion of COVID-19 deaths in long-term care facilities. This crisis affects both long-term care residents, staff, and the loved ones who provide essential care. This is a humanitarian crisis, and there is overwhelming consensus among experts on what needs to be done.

The short-term solutions to our LTC crisis are clear, implementable, and would have an immediate positive effect on reducing deaths: accelerated vaccination, rapid testing, increased staffing, improved training and pay for workers, and four hours of regulated daily care for each resident. We need an urgent first ministers' meeting to agree on a plan to end the mounting deaths in long-term care that includes the immediate implementation of these recommendations. There should not be one more death in long-term care facilities caused by inaction and lack of political leadership.

Throughout the past year, we have been reminded of the importance of evidence in guiding public health decisions—a standard that should be adopted well beyond this pandemic. Science and data have been critical to understanding how different communities are impacted by the pandemic. We must collect socio-demographic data in government-funded research moving forward in order to make evidence-based decisions on how to provide the right support where it is most needed.

If we are serious about addressing health-care shortcomings in Canada more broadly, we cannot overlook the skyrocketing costs of pharmaceuticals. Canada is the only country with a universal medicare system that does not include doctor-prescribed medication, and one in three Canadians is forced to pay for their prescriptions. To achieve lifesaving goals, and economies of scale, we must establish a national universal pharmacare program, a bulk drug purchasing agency, and shorter patent protection times for new drugs. The drug assessment process must be free of conflicts of interest, and bulk purchases of prescription drugs must be evidence-based.

The opioid crisis is a national tragedy that has skyrocketed during the COVID-19 pandemic. From 2016-2020, nearly 18,000 Canadians died from opioid overdose, many of which were due to fentanyl contamination. We need to declare a national health emergency to address the opioid crisis as a health-care issue, not a criminal issue. Drug possession should be decriminalized, and users should have access to a screened supply and the medical support they need to combat their addictions. We must also prioritize the expansion of rehabilitation services. A harm-reduction approach is the only way to address this emergency and save lives.

A through-line of the conversation about health in Canada is mental health. The COVID-19 pandemic has negatively impacted many Canadians' mental health, straining an already overburdened mental healthcare network. Establishing a national mental health strategy is common sense—we need to address the very real stressors plaguing Canadians such as inequality and affordability, the precariousness of work and housing, the climate crisis, social isolation, and the trauma and anxiety the pandemic has caused. A suicide prevention plan and immediate investments in both community-based service organizations and provincial and municipal mental health services are a critical first step.

The COVID-19 pandemic has highlighted health issues, but they are unfortunately not new. Addressing the structural weaknesses in health care, rather than merely reacting to each crisis as it arises, is the best strategy.

Annamie Paul is the leader of the Green Party of Canada.

The Hill Times

Why healthy aging must be the upshot of the COVID-19 pandemic

It would be in everyone's best interest to focus now on ways to prevent frailty by investing in policies that ensure healthy aging for all Canadians.

John Muscedere

Opinion

Last month, while the world was distracted by political turmoil and the pandemic's roaring second wave, a very significant proclamation came and went with little fanfare. The United Nations General Assembly launched 2020-2030 as the Decade of Healthy Ageing, calling for a decade of concerted global action to extend the health and well-being horizons of the world's one billion people over the age of 60.

In contrast to a common misperception, aging alone isn't what sidelines older people—frailty is. While aging is inevitable, frailty is not.

Frailty is defined as a medical condition of reduced function and health; it becomes more common as we age. Frailty increases vulnerability to disease, resulting in the need for intensive and costly health-care interventions. Today, 1.6 million Canadians live with some form of frailty. In 10 years, it will be 2.5 million.

Living within the guardrails of a pandemic has aged everyone. And we are getting a glimpse into how the seeds of frailty are sown—through loneliness and isolation, loss of structure and routine, mental and emotional stress, physical exhaustion, loss of freedom and a sense of control, disruptions in eating and sleeping habits, weight gain, muscle loss and deferring routine medical appointments to avoid the virus.

Our response to the global pandemic now, and in the coming years, should include robust policies for healthy aging which in large part are composed of strategies to address these contributors to frailty.

Most COVID-related deaths in Canada to date have occurred in people over the age of 70. It's a glaring statistic—one that, left unfiltered, might prejudice people's understanding about this age group and its capacity.

Persistent news coverage about the vulnerability of older people in the early days of the pandemic inadvertently fuelled ageist attitudes. In its most extreme form, some people wrongly concluded that the economy should not have to shut down just to prevent the virus from killing the eldest members of society. After all, this demographic contributes the least, right?

From both a moral and economic standpoint, this is a deeply flawed viewpoint.

More and more, out of choice or necessity, healthy older Canadians are remaining engaged in paid labour beyond conventional retirement age. In 2010, 14 per cent of people 55 and over were active in the labour force. By 2031, this number is expected to rise to almost double.

More recently, we also saw experienced health-care workers risking their lives by coming out of retirement to work on the front lines of the pandemic.

The unpaid labour of this age-group often goes unrecognized. A life of accumulated skills and knowledge is poured freely into raising funds for community projects and organizations, coordinating events, caring for children in the absence of childcare options, coaching sports and passing knowledge and skills on to young people. Or even worse, we sideline these skills by not putting in place ways that we can better harness this experience.

Statistics Canada reported that, in 2013-14, 36 per cent of seniors performed volunteer work. Those aged 65 and up volunteered 223 hours a year, well above the national average of 156 hours. In 2012, baby boomers and senior adults clocked one billion volunteer hours.

This informal support is a gift to communities and is especially true in rural Canada where the loss of a community-minded elders often leaves an unrepairable social gap.

In strictly fiscal terms, Canadians aged 65 and older also have money to spend. Many continue to benefit from earnings-based retirement plans and other progressive senior-focused social and financial policies launched in the late 20th century.

Older Canadians are an economic pillar, one that will crumble in the absence of supports for healthy aging that enable people to remain active and engaged in their communities.

The past year has been a valuable lesson on the importance of nurturing our functional ability, especially in older people. Let's turn insight into action. It would be in everyone's best interest to focus now on ways to prevent frailty by investing in policies that ensure healthy aging for all Canadians.

John Muscedere is the scientific director and CEO of the Canadian Frailty Network (CFN) and a professor in the School of Medicine at Queen's University and an intensivist at Kingston Health Sciences Centre.

The Hill Times

Vaccination, trust in science and patience is the only way out of this pandemic

As Canada's nurses, we want to encourage all those living in Canada to receive the vaccine as soon as they are able. Together, we can contain this virus, end the pandemic and take part in Canada's post-pandemic recovery, writes Linda Silas. *Image courtesy of Pixabay*

We will need Canadians to roll up their sleeves and get vaccinated. But we will also need to be patient. Immunizing the country won't happen overnight. It will be an incremental process informed by science and one that seeks to immediately stem the loss of life.

Linda Silas

Opinion

A COVID-free future is within our reach, a future where it's safe to hug again and where our smiles no longer need to be hidden behind a mask. To get there, we will need a robust vaccination drive. We will need Canadians to roll up their sleeves and get vaccinated. But we will also need to be patient. Immunizing the country won't happen overnight. It will be an incremental process informed by science and one that seeks to immediately stem the loss of life.

Earlier this month, the Canadian Federation of Nurses Unions encouraged all health-care workers, all essential workers and the general public to receive the vaccine when they become eligible. We also urged governments across Canada to speed up the rollout of the vaccine, especially to those most likely to experience severe illness, such as seniors, Indigenous people and racialized people—all of whom have been shown to be most at risk of infection.

Nurses have also signalled that they are ready and willing to step up and help the government with the vaccine rollout by joining health care teams at vaccination clinics across Canada. While the news of some delays in delivery of the Pfizer vaccine may give us pause, governments must strive to speed up the immunization and rapidly increase the number of clinics where the vaccine is available. This is how we will contain this virus and counter its spread.

What's also been lacking in Canada's vaccine delivery program is evidence-based information. Within this vacuum, misinformation, vaccine myths and mistrust have thrived. Sadly, many Canadians are hesitant to get vaccinated, particularly among marginalized communities who, we recognize, have all too often experienced negative interactions with the medical community.

As nurses, we believe that any risk posed by the vaccine is far outweighed by the benefits in being protected from COVID-19.

As with any other medical treatment, informed consent is required. It's our job, as health professionals, to provide facts—and yes, empathy—when patients express concerns about being vaccinated. Everyone who gets the vaccine must understand the benefits of immunization, as well as any potential risks. All Canadians should be empowered to make an informed decision.

Some individuals have expressed concerns about the record turnaround time for these vaccines. Producing multiple vaccines in less than a year was the result of a momentous global effort, harnessing the ingenuity of a scientific community united in a common objective. Large-scale trials on the efficacy of vaccines involved tens of thousands of participants, including many from diverse backgrounds. The trials resulted in high rates of protection with few or no reported serious adverse events. Despite the compressed timelines, no shortcuts were taken: the same standards were applied to these vaccines as for any other vaccines that have been developed.

In Canada, we know the approval process by Health Canada is safe and effective; their assessment of scientific and clinical evidence is done independently and is known to be stringent. We also know that historically, immunization programs have saved countless lives worldwide. The COVID-19 vaccines approved thus far have the potential to provide much-needed protection against the continued spread of the SARS-CoV-2 virus but this will only happen if sufficient numbers choose to be vaccinated.

As Canada's nurses, we want to encourage all those living in Canada to receive the vaccine as soon as they are able. Together, we can contain this virus, end the pandemic and take part in Canada's post-pandemic recovery.

Linda Silas is a nurse and president of the Canadian Federation of Nurses Unions, representing nearly 200,000 nurses and student nurses across the country.

The Hill Times

What's up (or down) with drug shortages?

Our chronic shortages and the current vaccine situation remind us to ask why must we be buffeted about by unpredictable shortages, originating elsewhere and often impacting well established yet critical products, the recipes for which are neither secret nor protected.

BY JACALYN DUFFIN & JON PIPITONE

With complaints and fears swirling around COVID-19 vaccine supply, we take up our devices once again to report on drug shortages in Canada. When we last communicated in *Hill Times* back in April 2020, Canada had already spent a decade facing severe shortages of prescription drugs. We argued that COVID-19 might exacerbate those shortages and, at the same time, serve as a wake-up call to get to the bottom of the problem.

Alas, nothing much has happened.

Today, Canada reports more than 1,500 actual drug shortages. The good news is that this number is 400 fewer than last April. The bad news is that no matter how you look at it, it is still a shocking number, and worse, it is misleading. Our national shortage database is woefully thin, as it doesn't account for provincial, regional or hospital-level shortages. We also wonder if the decline since April is more apparent than real. After all, in that same time, 197 drugs were reported to be discontinued, and 330 drugs were cancelled post-market. If a drug is no longer on the market, it is not "in shortage"—it remains utterly unavailable. Additionally, over the last two years, nearly a third of our shortages involve medications that we would deem critical or "essential", priority medicines needed for effective function of a basic health-care system: items such as antibiotics (cefalexin, amoxicillin), common heart medications (amlodipine, ramipril, candesartan). These individual shortages are numerous and long-lasting.

Early in the pandemic, Canada did experience temporary shortages of drugs for managing COVID-19 symptoms and ICU patients needing intubation—epinephrine, midazolam, propofol, phenylephrine, etc. And like the hydroxychloroquine example of last spring (when Donald Trump's evidence-free claims spawned panic buying and shortages for those who relied on it), shortages have emerged in Canada (and elsewhere) for every remedy, old or new, thought to be helpful in the pandemic: remdesivir, dexamethasone, ivermectin and oseltamivir. Possibly we'll soon see the same for the ancient gout treatment, colchicine, recently reported effective by researchers at the Université de Montreal.

Numerous American and European studies have documented the negative impact of shortages on patient outcomes and health-care budgets. But the reasons for shortages, according to manufacturers, reveals a pattern, dominated by manufacturing disruptions, that has gone basically unchanged during the pandemic.

In March 2020, the minister of health signed an interim order to monitor potential and actual shortages and allow importation of drugs that may not fully meet regulatory requirements in order to protect supplies of threatened medications. Why is the Canadian medication supply chain so fragile that we needed this stop gap measure? Another interim order came in late November 2020 to protect vulnerable stocks from American poaching

Without a national strategy for responding to shortages, pharmacists initially resorted to invoking the tried-and-true mechanism of restricting dispensed quantities to 30 days. But they encountered outrage and political interference. Citizens, especially those out of work, objected to paying extra dispensing fees and to the inconvenience and risk of more frequent trips to the pharmacy. Some provinces opted to cover the extra fees, but pharmacists were shocked when various provincial governments intervened, ordering an end to the practice or canceling extra fees, effectively legislating a rollback in income. The policy eventually melted away.

Unlike more than 100 other countries, Canada still does not have an essential medicines list (EML)—critical medications for which the government is mandated to protect supply, much in the same way as the recent interim orders aspire to do. At least one Canadian team is working on developing an EML, but the effort is not yet recognized by our government. Nor does Canada do much to understand the extent and impact of shortages. It does not analyze the shortages, year-by-year, month-by-month, or by type, to uncover whether or not its feeble policy gestures are making any difference. And, as the public has become painfully aware, Canada lost its own, once robust drug- and vaccine-making capacity long ago. Even the Ontario Medical Association has exceptionally released a statement recommending several actions, including more domestic production.

Our chronic shortages and the current vaccine situation remind us to ask why must we be buffeted about by unpredictable shortages, originating elsewhere and often impacting well-established yet critical products, the recipes for which are neither secret nor protected. In the face of pandemic threats to our medication supply, Canada has shown it can take temporary steps to protect our most critical medicines. Shouldn't we now move to properly and permanently secure our supply with a national essential medicines list and revival of our own industry?

Jacalyn Duffin, MD PhD, is professor emerita at Queen's University, and Jon Pipitone, MD, MSc, is a resident in psychiatry at Queen's University.

The Hill Times

If the disaster that has befallen long-term care in Canada during the COVID-19 pandemic has taught us anything, it is that we must demand greater oversight and accountability in health care, particularly when already disadvantaged communities might be impacted by our decisions, writes Ian Stedman. *Image courtesy of Pexels.com*

Maybe artificial intelligence will drastically change health care, but who will benefit?

Our federal and provincial governments have proven they can unite around issues of national importance in health care and they must do so again if we are going to have any chance of AI playing the role many believe it can in helping us move toward personalized health care.

Ian Stedman

Opinion

Governments across Canada have signalled that they believe artificial intelligence will play an important role in the country's economic future. Major investments have attracted more computer scientists to our post-secondary institutions and have benefitted the private sector by opening up a growing pool of AI talent. If we want to build this data-driven economy in a responsible manner, however, then we also need to protect Canadians by modernizing our information and privacy laws.

But as we move to strengthen our privacy laws, we must also pay close attention to the impact those strengthened laws have on AI innovation. We should not prioritize unbridled innovation over privacy, but if governments want taxpayers to buy in to the great hope of an advanced AI economy, then they also need to be clear about what that economy might look like and how Canadians stand to benefit. The content of our modernized privacy laws will send clear signals about where our governments think AI has the most potential to benefit society.

At present, the idea that AI has the potential to improve our everyday lives is perhaps most widely acknowledged within the health-care space. We have long heard from people affected by rare diseases, for example, that we need a more personalized approach to health care because one size does not in fact fit all. By using AI in health care we will be better able to predict and prevent disease, to make quicker diagnoses, to understand disease progression and even to discover new therapies that could improve patient outcomes. It may also be possible for AI to operate in conjunction with other new and emerging technologies like DNA sequencing, gene therapy, bioprinting, and genome editing. The question should no longer be if, but how can we use AI to help us effectively and equitably personalize our health-care systems?

To build a personalized health-care system we will need to collect, store, and analyze more data than we ever have. Not just patients' personal health information, but also data about how socio-economic factors can have an impact on patient experiences and health trajectories. We will also need to make deeper investments into building and sustaining the infrastructure, the talent, the tools, the policies, the regulatory oversight, etc., needed for a personalized, learning health-care system.

But did you know that artificial intelligence is already being used in some Canadian hospitals?

Many computer scientists who were inspired to pursue an education and build their career in Canada are working in labs that are connected to research hospitals. Some of these hospitals also have foundations that are fundraising in order to build and sustain the data analytics infrastructure needed to leverage AI. Believe it or not, patients who go to these hospitals already benefit from the use of data analytics tools that aren't available elsewhere.

It may surprise some to learn there are hospitals where AI is already in use. These are research hospitals though, so we should expect that they will take risks as they try to innovate. What we need to focus on now is ensuring that these AI tools can be equitably integrated across different sites. Failing to ensure equitable access to these tools that can help us to personalize health care will only serve to exacerbate already existing inequalities.

Because we do not yet have an explicit regulatory pathway in place, health-care AI in Canada is being developed and deployed in an ad hoc, site-by-site manner. Hospitals are taking it upon themselves to determine what AI is needed and how to conduct fairness assessments, mitigate risk from bias, ensure equitable access, demonstrate accountability to stakeholders, integrate AI tools into care, and generally earn the public trust needed to deploy AI in the hospital.

Recognizing that a laissez-fair approach to health-care AI is inadequate, a task force convened by CIFAR published a report in July 2020 called, "Building a Learning Health System for Canadians." In this report, the task force calls for the development of a national strategy and a "collaborative vision for AI for health in Canada." A national strategy is needed to address things like inter-provincial data sharing, ethical protocols for developing and deploying AI, and consensus frameworks that can help accelerate the design of regulatory standards in order to ensure accountability for how healthcare AI is implemented. Meaningful oversight could also help us focus on ensuring that healthcare AI is deployed across many different sites, rather than only being able to benefit patients at a select few hospitals.

If the disaster that has befallen long-term care in Canada during the COVID-19 pandemic has taught us anything, it is that we must demand greater oversight and accountability in health care, particularly when already disadvantaged communities might be impacted by our decisions. It is not good enough to allow health-care AI to develop in what is effectively a leadership and regulatory vacuum. Our federal and provincial governments have proven they can unite around issues of national importance in health care and they must do so again if we are going to have any chance of AI playing the role many believe it can in helping us move toward personalized health care.

Ian Stedman is an assistant professor of Canadian public law & governance in the School of Public Policy and Administration at York University. He also serves on York University's Artificial Intelligence & Society Task Force and sits as a legal member of the research ethics board at the Hospital for Sick Children in Toronto.

The Hill Times

Aging? What's to be done?

The pandemic is exposing many cracks in Canada's already porous seniors' care system. We don't have much time to fix the problem, so we better get started.

Don Drummond & Duncan Sinclair

Opinion

Some 60 years ago, about the time the last of the baby boomers were being born, people over 65 made up about 7.5 per cent of Canada's population. Now they are 17.5 per cent and will be nearly 25 per cent (10.8 million) in twenty years. And they are living longer. Currently the fastest growing cohort are centenarians, people over 100. Soon the majority will be 75 and over, at ages when the manageable but incurable chronic diseases of old age make necessary more costly and frequent hospitalizations and physicians' services, health care as opposed to the much less expensive health-support services needed to meet the needs of most seniors.

That Canadians are living longer is good news. What's not to like about living to a ripe old age provided you can age well—happily settled in housing appropriate to your needs, with a stimulating social life with old friends and new, where you can pursue an active, lifestyle, and have available the reliable support and care needed to maintain the activities of daily living and robust good health?

The problem is that it is not easy to meet those provisos in Canada. Relative to many other countries, notably Japan, Denmark, and others noted for enabling seniors to age happily and well, Canada and its provinces and territories do not score well. We spend far less on long-term care overall and disproportionally much more on institutional ($6) than on home and community ($1) care, the reverse of comparable ratios in Denmark and other leading nations. There, the predominant policy thrust is not to institutionalize or, crudely, "warehouse" seniors, but to facilitate their "aging in place." Canadian seniors, like others, strongly prefer to retain their independence and to age in place for as long as possible in their own homes and communities with the support of an expanded range of home care and community support services with which they are familiar and comfortable. Ironically, meeting their preferences would be much cheaper for both the affected seniors and for the public purse; daily care in a hospital costs upwards of $850 to $950, in an LTC-home $150 or more, and with support and care at home about $45.

Given the still building wave of aging seniors and the Canada's foreseeable economic circumstances, continuing with the same policy choices defies comprehension. First, as COVID-19 has made clear, care-homes are both expensive and dangerous places; some 80 per cent of deaths in the first wave in Canada were in LTC-homes. Second, they are not where our senior citizens want to be. Third, the numbers make it clear that continuing with our warehousing propensity is just not on; the care-home beds that would be required is simply beyond what we could afford. And fourth, adding together the capital and ongoing operating cost of institutional accommodation and care to the residents, their families, and to the public purse, exceeds by far what it would cost to provide an extended range of seniors' needs through beefed-up home and community support services. That will be expensive too, but it's an approach that would both help seniors age well, certainly better than at present, and one that our country could afford.

What do we need to do to get to it?

Governments have to work together, federal, provincial and territorial, and municipalities, given latter's funding of so many community services out of the property tax base and the charitable giving of the residents.

Solutions and their implementation are primarily under provincial and territorial ownership, apart from our Indigenous communities where the feds are on the hook. The federal government must decide what role it wants to carve out in facilitating a coordinated response to a problem that is both bigger and will extend well beyond what was foreseen in the 2015 election platform and its promise of $3-billion over four years, and the 2017 budget in which it was proposed to invest $6-billion over 10 years for home care and the fall 2020 fiscal statement with its offer under conditions of $1-billion between this year and next for long-term care. The provincial and territorial governments at the very least have to refocus their policy objectives from institutionalization to ageing in place and work with one another and the federal government, with the provinces and territories, on the development of appropriate national standards and with municipalities on their implementation and enforcement.

And we have to hurry! The problem is real, here right now, and time is short.

Don Drummond is the Stauffer-Dunning Fellow at Queen's University. He is a former senior official at Finance Canada and the chief economist at TD Bank. Duncan Sinclair is an adjunct professor and distinguished fellow at Queen's University and a member of the Canadian Medical Hall of Fame.

The Hill Times

Minster of Seniors Deb Schulte, pictured on the Hill on Sept. 25, 2020, is tasked with working with provincial and territorial governments to manage long term care issues stemming from the pandemic. *The Hill Times photograph by Andrew Meade*

Pandemic exposing critical gaps in health workforce planning

Burnout was far too common in the healthcare workforce before the pandemic. COVID-19 has made it much worse. Poor health workforce planning is to blame.

Ivy Lynn Bourgeault

Opinion

Health workers in Canada experience endemic levels of burnout directly related to understaffing and work overload. Leaves of absence from work for mental health and stress related issues are 1.5 times higher among health workers than the rest of the population. Increasingly, health workers are significantly reducing their hours worked, just to cope, or leaving their jobs altogether.

That was before the pandemic. With COVID-19, we are witnessing levels of stress, overload and burnout among health workers previously unimaginable.

Downstream responses of mindfulness and free access to psychotherapy, albeit helpful, are at best band-aid solutions. We have to look upstream to the source of the crisis.

Health worker burnout is directly linked to poor health workforce planning. That we continue to operate our health system blindfolded to very basic data about our systems key resource—its health workers—is remarkable.

Health workers account for more than 10 per cent of all employed Canadians and over two-thirds of all health care spending, not including the personal and public costs for their training. This amounts to $175-billion (2019) or nearly eight per cent of Canada's total GDP.

Health workforce science—and the data research infrastructure necessary to support it—is critical to making the best decisions about this essential human resource. We need to advance health workforce science in Canada now.

Canada lags behind comparable OECD countries, including the U.K., Australia and the U.S. on big data analytics and a digital research infrastructure that would give us vital information for health workforce planning. Significant gaps in our knowledge have caused serious systemic risks for planners to manage during this health crisis.

Absent timely and relevant health workforce data, decision-makers cannot optimally deploy health workers to where, when and how they are most needed. As a result, health workforce planning activities across Canada remain ad hoc, sporadic and siloed, generating significant costs and inefficiencies. The consequences include everything from sub-optimal health workforce utilization and poor population health outcomes to health worker burnout.

What data do we have?

The data we have are profession-specific and say little about how health workers function as teams in 'real world' patient care pathways. The data are also collected differently by various stakeholders, so are not easy to analyze across jurisdictions. Notable absences are workers in older adult care and mental health care—two sectors heavily impacted by the pandemic.

What we need are a standard set of data across a broader range of health workers in support of inter-professional and inter-jurisdictional planning.

Ideally these data would be collected uniformly, include diversity (racial, Indigenous and more inclusive gender identity), and address practice characteristics (e.g., setting, scope and service capacity). These data should also be linked to relevant patient information, including healthcare utilization and outcome data.

Robust data would allow us to better understand the range and characteristics of health workers caring for patients, the types of care they provide and the outcomes experienced by patients.

Right now, we are making decisions in the dark, without using essential data that most other developed nations have had for years.

So how do we get there?

Canada needs a more robust and centrally coordinated health workforce data, analytics and science infrastructure. This would address a critical gap that has held us back, and which has become only more apparent, since COVID-19.

We can't claim to have been blindsided. Already in 2010, the parliamentary standing committee recommended a designated health workforce agency, and this call was endorsed across all parties and by several stakeholder organizations that provided testimony to the committee. Since then, almost nothing has happened on this front.

The absence of central coordination and implementation of integrated health workforce data, analytics and planning activities, combined with diffuse governance responsibilities inherent in a federated health system leave us with blurred lines of responsibility and poorly coordinated efforts.

Other countries have managed to overcome these challenges. Now that the pandemic has made the need crystal clear, Canada no longer has any excuse.

The federal ministers of health, labour, and innovation need to make the health workforce data infrastructure a top priority. The pandemic may be the impetus that enables us to make necessary significant advances in health workforce data infrastructure.

We need to stop simply clapping our hands in support of health workers—and start planning to create better workforce conditions for them. Let's make improved health workforce science in Canada a key legacy in support of our health care workers.

Dr. Ivy Lynn Bourgeault is a professor of sociological and anthropological studies at the University of Ottawa and the lead of the Canadian Health Workforce Network.

The Hill Times

Vaccines give long-term care crisis a brief reprieve, but cannot stand as the solution

Returning to normal cannot be an option because the normal we operated within in delivering long-term care was not only unjust, but unsustainable. The vaccine is a reprieve, a gift that will step in to protect older Canadians after we failed to live up to the job; but it is just that, a reprieve.

Janice Keefe

Opinion

This time last year, I had the great privilege of authoring another editorial for *The Hill Times* in an effort to amplify the call for change within our nation's long-term care sector. Like others, I struggle to reflect back on the relative innocence of 12 short months ago, in the "before times" of the pandemic.

"The sheer number of individuals turning 65 is not the cause of our current challenges in long-term care (LTC) in Canada," I noted in that opinion piece. "It is the cumulative effect of years not prioritizing resources to support quality of life for older residents. Consequently, LTC is not prepared for or equipped to meet the complex care realities of today's and tomorrow's residents."

In reading this today, after we have seen what we have seen, these words relay an eerie premonition of the chaos and havoc that would soon rage through long-term care residences from one coast to another.

I would argue that for most people reading that piece, there would be tacit agreement to the position I was asserting. I am equally as confident that this base acknowledgement in no way prepared Canadians for the horror that was about to unravel when the pandemic made a landing in these long-term care facilities.

As we do in the aftermath of any disaster, we seek emergency relief. In this case, relief arrived in the form of a vaccine—which has prioritized long-term care residents to be among the first recipients. To be clear, vaccines are an absolute necessity, but we cannot fool ourselves into believing they will address the horrendous shortfalls we bore witness to throughout the pandemic.

Vaccines are not the panacea that will fix the long-term care system; yet, I worry we will tell ourselves it is.

SALTY (Seniors Adding Life to Years), a research initiative I lead alongside some of Canada's most acclaimed researchers and academics, has evidence on how we can improve the quality of life of long-term care residents. Moreover, I was privileged to work on the Royal Society of Canada's report 'Restoring Trust: COVID 19 On the Future of Long-Term Care in Canada,' which provided thorough recommendations on how we can address the gaps in how we approach care for older Canadians in both the short and long-term.

These recommendations have been followed by countless other reports, a number of them written as part of provincial inquiries conducted following the first wave of COVID-19, including: the Ontario patients' ombudsman, Nova Scotia's first wave review, Quebec's ombudsman report. The list goes on and the refrain is consistent.

The reports' call to immediately address staff needs—including more direct care staff, increased training, better pay, stronger focus on recruitment and retention, and mental health support.

The reports' highlight the significant gap in mandatory infection control and prevention practices, the need for comprehensive plans to prevent and to manage infectious disease outbreaks, as well as access to supplies (PPE and safe work).

In addition, the Royal Society report and others have called for the development and implementation of national standards in LTC, as well as allocating additional, and targeted, LTC funding to provinces to execute the recommendations above.

There should be no doubt that this collaboration among governments is needed.

To date, over 70 per cent of COVID-19 fatalities have taken place in our long-term care facilities. This reflects the precarious state of the sector in Canada, and that the calls to action being repeated like a broken record by advocates such as myself are more than just an ask for "nice things to have."

Rather these calls foreshadowed the reality we know today, that we have been playing a dangerous game of Jenga in the care of our older citizens within the long-term care sector. In defiance of evidence, we continue to undervalue care work, maintain outdated staff levels and models, ignore sector pleas for support while continuing to add more stress and pressure by admitting higher acuity residents , relying only on a whim and a prayer that the whole thing won't crash to the ground.

The façade has indeed crumbled.

Returning to normal cannot be an option, because the normal we operated within in delivering long-term care was not only unjust, but unsustainable. The vaccine is a reprieve, a gift that will step in to protect older Canadians after we failed to live up to the job; but it is just that, a reprieve.

"LTC is not adequately prepared or equipped to meet the complex care realities of today's and tomorrow's residents." I said this a year ago, and I will repeat it again today.

Changing this truth is entirely up to us and the policy decisions we must be bold enough to make.

Janice Keefe is professor of family studies and gerontology, the Lena Isabel Jodrey Chair in Gerontology and director of the Nova Scotia Centre on Aging at Mount Saint Vincent University

The Hill Times

COVID-19 is not gender-blind

The pandemic has affected men and women differently, which is why deliberate focus on the gendered experience of the pandemic could help in reducing these inequalities.

Jaunathan Bilodeau & Amélie Quesnel-Vallée

Opinion

Women are at greater risk both of direct exposure to the virus due to their over-representation in health care and service settings, and of pandemic-related job losses. Quarantine, isolation, unemployment, financial insecurity, violence, and a fragile work-family balance are all health risk factors exacerbated by the pandemic. All these may lead to persistent economic and health inequalities between women and men well beyond the pandemic.

It is therefore imperative to consider the gendered experience of COVID-19 in the design of policies implemented in response to this pandemic and the subsequent economic recovery.

Gender is a structuring determinant of health. It exposes men and women differently to social constraints and associated stressors. Despite sustained decreases in the gendered division of household labour in Canada, women still bear more of the burden than men. And we are not alone: even in an egalitarian country such as Finland, women spend up to 2.5 times more time on regular household chores and twice as much time on childcare than men.

Gender is also constructed through the meaning and importance given to everyday situations, resulting in differential vulnerability to stressful situations. Some women may thus be more concerned than their spouse about the difficulties experienced by a child or a parent, a situation commonly referred to as "mental load" (Conseil du statut de la femme 2015). This, in turn, can exacerbate stress, and anxiety, and their deleterious health consequences.

The recognition that the structural nature of gender results in differential exposure and vulnerability to stressors explains, in part, why it featured so prominently on many governments' (including Canada's) and international organizations' policy agenda before the pandemic.

Covid-19 mitigation measures such as remote work and schooling, layoffs, childcare closures, and the choice of essential services have shaped the daily constraints faced by all Canadians since March 2020. The structural nature of gender exposed above has likely resulted in greater exposure to these constraints among women, for example through increased domestic responsibilities, along with increased vulnerability, such as perceived family-work conflict.

Mindful of these effects, the former G7 Advisory Board on Gender Equality recently sounded the alarm bell, calling for prioritizing the gender dimensions of the pandemic and preventing a deterioration of women's equality and rights. The United Nations Population Fund went a step further, stating that "pandemics exacerbate existing inequalities for women and girls."

A gender-based analysis of mitigation measures is urgently needed

In 2018, finance minister Bill Morneau announced that gender-based analysis plus (GBA+) was henceforth applied to all federal budget decisions. This commitment may need to be reiterated or made more explicit in the pandemic response, as it is not currently obviously driving decision-making. Provincial and territorial partners should also be brought onboard, as many domains of importance in the pandemic mitigation response fall under their jurisdiction (e.g. education and health).

Previously, the government recognized the need to increase the data on which to base its analyses. This need is even more pressing in the current context. For example, women who are victims of domestic violence are particularly vulnerable during the quarantine period. However, there is no data to document this phenomenon.

How can the impact of the pandemic on gender-related health inequalities be avoided or limited?

Action must be mobilised on several fronts. Rigorous documentation of the gendered experience of the pandemic is needed. Facilitating access to flexible working conditions, including the 10-day leave proposed by the federal government, would also have a positive effect.

Employers are also proving to be essential levers for equality. The current crisis is an opportunity for them to participate in this transformation by promoting, for example, flexible hours, time banking, family leave or reduced work weeks. Women who have access to such measures report less psychological distress than those who do not. The pandemic could prove to be an opportunity for more gender equality during the recovery if these flexible work arrangements persist.

Even during a pandemic, the increase in health inequalities between men and women should not be inevitable. A deliberate focus on the gendered experience of the pandemic could help in reducing these inequalities.

Jaunathan Bilodeau is a post-doctoral fellow in the department of sociology at McGill University. Amélie Quesnel-Vallée is a professor and the Canada Research Chair in policies and health inequalities. She is cross appointed to the department of sociology and the department of epidemiology, biostatistics and occupational health at McGill University.

The Hill Times

Pharmacare, patient groups, and the need for open discourse

Sharon Batt

Opinion

Will Canadians ever have the universal national pharmacare program that repeated investigations show will support fair, appropriate health care and that 86 per cent of Canadians say they want? The long-simmering question is once again on the minds of voters. In his supplementary mandate letter, the prime minister called on Health Minister Patty Hajdu to "accelerate steps to achieve a national, universal pharmacare program," including establishing a Canada Drug Agency, implementing a national formulary, and a rare-disease strategy.

As Peter Cleary of Santis Health told *Hill Times Research*, failure to enact this legislation could "push away progressive voters." On Feb. 24, the NDP will up the pressure, with a private member's bill. Other commentators cite political barriers, including the ongoing pressures of COVID-19, lack of provincial ministers' support, and the pharmaceutical industry's vociferous but unsurprising opposition to a policy agenda designed, in part, to rein in drug prices.

Less obviously, an array of vocal patient organizations stands against key aspects of a plan meant to serve the public interest. Without dismissing other political headwinds, I believe these organisations are the actors with the greatest potential to derail the national pharmacare plan we need. Challenging Big Pharma is one thing; taking on sick people is no one's idea of heroism.

Politicians should listen to patients, but—unlike many prominent patient advocates—I believe Big Pharma has systematically co-opted much of the patient advocacy movement, through strategic partnerships. Canadian health policies accept, even encourage, public-private partnerships. I agree with ethicist and lawyer Jonathan Marks who says society needs public health actors to actively defend the public interest. A collaborative agreement with the private sector makes this impossible.

In Canada, we don't know how much the industry spends on patient organizations, because no laws require disclosure (a transparency law passed by the Wynne government in Ontario lays dormant under Doug Ford's leadership). Best Medicines Coalition, a group representing 25 patient advocacy groups, submitted a brief to HESA, the House of Commons Health Committee, describing what "Pharmacare for All Canadians" should look like. The funding the coalition and many of its individual members receive from major pharmaceutical companies went unmentioned, and the brief's claims contained more industry spin than sound health policy.

We don't have to demonize industry actors to recognize they enter partnerships with well-honed strategies to achieve their goals, says Marks. Partnerships with trusted public-sector actors create "health halos" that burnish corporate reputations, but imperil the public interest through "asset exchanges." Groups receive money, information and advice, and help companies with marketing, clinical trial recruitment, and lobbying about drug access and subsidy.

In the U.S., which has a sunshine law requiring companies to declare funding to patient advocacy groups, 14 major pharma companies collectively spent US$163-million on patient advocacy groups in 2015—more than twice what they spent lobbying politicians the same year. Patient groups in Missouri echoed and amplified industry messages that contributed to the state's opioid crisis. Industry-funded patient groups sponsored a campaign that opposed legislation to contain prices of drugs covered by U.S. Medicare.

My research in Canada found that the industry has successfully carried out variations of these strategies. Scores of Canadian patient organizations now rely on industry, not just for funding, but for information about the drugs being marketed for their condition and advice on influencing government policy. Some groups resist; the group I co-founded in Montreal passed a corporate policy that prohibits taking funds from drug companies and other corporations that contribute to, or profit from, cancer.

We don't all think alike and vigorous debates over any policy should be encouraged. With pharmacare in the balance, I've joined with other health advocates independent of the industry to put our views on pharmacare on the public record. In briefs and petitions and a presentation before HESA, we've argued that a universal, national, publicly funded pharmacare program, well-designed, funded and implemented, would improve drug safety and effectiveness, take collective opportunity gains into account, fairly prioritize access, and increase transparency.

We've met resistance from the industry-funded patient community. When I attempted to present our perspective at a meeting of CADTH, three prominent activists heckled me so vociferously, my talk was shut down. Such personal attacks undermine democratic debate, but unfortunately are not isolated. Staff at the Patented Medicines Price Review Board have received hostile phone messages and Twitterstorms from advocacy group members calling them "non human robots" who are "sacrificing the lives of the most vulnerable to save money." At a meeting of the House Health Committee to discuss changes to the Patented Medicines Review Board, NDP MP Don Davies objected when Twitter followers accused some members of not caring: "We all care" he said.

It's disturbing then to see a webinar presentation by Innovative Medicines Canada the latest postponement of the implementation of the new guidelines end with a shout-out to five industry-funded patient advocacy groups: "Stakeholder voices are having an impact: your continued engagement on these consultations is crucial. What can you do? Get involved." Some of the groups listed have engaged in hostile attacks. Whether or not the industry condones these harassment tactics, I question the ethics of Big Pharma's rallying patient groups to advance its agenda.

Health policy, by its nature, arouses strong passions and any major change in the status quo can feel threatening, but Canada stands alone among high-income countries in excluding prescription drugs from its national health-care program. The pharmaceutical industry will adapt to some loss of profit, as it has in all other countries that have national pharmacare plans. Meanwhile, policy-makers might reflect on the words of Roy Vagelos, a scientist-turned CEO who ran Merck for a decade, beginning in the mid-80s: "The biopharmaceutical business is different than selling buttons and bicycles." Vagelos was more interested in making new drugs than in making money. And Merck's stock price did extremely well.

Sharon Batt is an adjunct professor in the department of bioethics at Dalhousie University and author of Health Advocacy Inc.: How Pharmaceutical Funding Changed the Breast Cancer Movement.

The Hill Times