Health Policy Story

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 ADIAN 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 vaccination campaigns 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 microbiology at the University of Ottawa and an infectious disease specialist at St. Joseph's Hospital. Dr. Wilson is also the vice-president of public health at the Public Health Agency of Canada.

"I'm really preparing for the summer to make ourselves ready," said Wilson.

The lack of vaccine supply is "a serious credibility problem," he added.

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 doses 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.

South Korea will receive less than 2.6 million doses, and Indonesia a little more than 13.7 million.

Canada is lagging behind most G7 countries on vaccine pace.

The federal government initially promised to begin vaccinating medical workers and long-term care home residents with the Moderna vaccine 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.

"Given that they have failed to deliver on the vaccine rollout and 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 it difficult to judge 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 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 vaccine 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, 800-84 per cent of doses 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 80 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

Prof. Ray said that winter temperatures will act as a constraint. "Until May, indoor is perhaps not going to be a major constraint, really there may be more of an opportunity for going outdoors.""The supply delay will be another major constraint, Prof. Nagarajan said. "You want to have an equitable measure. You don't want people to be in line for months 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 in population density," Prof. Zwerling said. Major sporting arenas and concert venues are often ten only in major cities and might not be in a place that is easily accessible or convenient. "It's not really the best approaches to doing these mass vaccinations," she said.

"We want to have an equitable measure. You don't want people to be in line for months to come to a stadium," he said.

"The ideal system will have the vaccine recipient, the health-care provider and the public health provider," said Dr. Wilson. "They have the same data in real time and sharable. 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 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 succeeds really quiet wiped up the clinic management."

"It helps from two perspectives. Booking appointments is one, but you can also start to auto-populate the data needed at the time of vaccination and have that all be filled in that data. So the vaccination is so much quicker—there's not really much about the speed of vaccination, because already most of the information is auto populated," said Dr. Wilson.

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The Hill Times
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
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.

**Health Policy Briefing**

**No time to waste on health-care reforms**

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.
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.

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 elder 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

WHY NOT CHIROPRACTORS?

Hundreds of thousands of Canadians rely on chiropractors to assess, diagnose, and treat spine, muscle and nervous system conditions. This includes back, neck, and knee pain, as well as osteoarthritis. But unlike other primary care providers, chiropractors are not authorized to assess and certify the Disability Tax Credit.

That needs to change.

In December 2018, the House of Commons Standing Committee on Finance acknowledged this oversight and recommended that the government address it by amending the Income Tax Act.

Budget 2021 offers an opportunity to close this gap and streamline access for eligible patients.
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 worst, 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 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, phenytoin, 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, that we thought to be helpful in the pandemic: remdesivir, dexamethasone, ibevermectin and oxitamivir. Possibly we’ll soon see the same for the ancient gout treatment, colchicine, recently reported effective by researchers for the ancient gout treatment, colchicine, possibly we’ll soon see the same urgency and resources as we have for physical health.

The COVID-19 pandemic has exposed our vulnerability -- not just to the threat of emerging pathogens, but also to our inability to face the threat while maintaining the economic and social health of our nation.

Social workers see it every day: even prior to the COVID pandemic, the mental health of our nation was steadily declining -- and without visionary leadership by all political parties, the road to recovery will take many years. The time has come to stop reacting with short-term solutions, and to make the permanent changes necessary to meet the challenges of this new normal. Canada must lead the world by adopting a Universal Basic Income and legislating Mental Health Parity, so we may not only recover, but thrive.

Even at the best of times, it is illogical and ineffective to rely on corporate Canada to lead the way on mental health. Long before COVID, cracks were showing in Canada’s piecemeal and largely privatized mental health services: individuals and associations, like ours, have been urging the federal government to make change.

And now, COVID has only intensified the existing “shadow pandemics” of skyrocketing opioid-related deaths, escalating domestic and intimate partner violence, and growing income inequality. Social Workers have consistently called for a Universal Basic Income and for Mental Health Parity in Canada because they know how gaping the holes in our “safety net” really are. Now, they are witnessing, and experiencing first hand, the compounding effects of the COVID pandemic on their clients’ and their own families and communities.

Mental Health Parity requires creating a system that supports mental health care equal to physical health care. Adopting Mental Health Parity right now will force the system change required to support the long-term recovery of our nation with the same urgency and resources as we have for physical health.

This past year, the pandemic has touched the lives of every single Canadian. Through this, we have witnessed global suffering matched by rapid responses from governments around the world. This has also highlighted the lack of pre-emptive action on behalf of Canada’s government to move on the desperate need for universal economic and mental health parity.

The Canadian Association of Social Workers (CASW), alongside many of our colleagues from other health and social professions, are bitterly disappointed that the federal government has failed to provide the visionary leadership so many Canadians call for, and are dismayed -- and, frankly, mystified -- that the official opposition has not used this opportunity to present the kind of bold ideas required to actually change conditions in our country.

The time has come to no longer rely on corporate Canada to lead the way. To truly end stigma and the lack of access to mental health services, the Government of Canada, in collaboration with all national political parties and Indigenous leaders, must lead the way and champion mental health and economic parity.

Joan Davis-Whelan, MSW, RSW
President
Canadian Association of Social Workers

BY JACALYN DUFFIN & JON PIPITONE

In March 2020, the minister of health signed an interim order to monitor potential and actual shortages and allow immediate 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 drug 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.

BY JACALYN DUFFIN & JON PIPITONE
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.

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, 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, 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 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. While 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-faire 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 7.3 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 provisions 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 disproportionately much more on institutional care ($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, 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

Policy Briefing Health

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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. The severe lack of mental health services and the stress related issues is 1.5 times higher among health workers than the rest of the population. Increasingly, health workers are significantly reducing their health workforce just to cope, or leaving their jobs altogether.

This 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 the lack of 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 40 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 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.

Canada lags behind comparable OECD countries, including the U.S., in health workforce data and analysis capacity 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 sidelined, generating significant costs and inefficiencies. The consequences include everything from sub-optimal 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 workforce domains and across 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 how outcomes have come or not come 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. How do the data we have even approach those benchmark?

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 inter-professional healthcare workforce data analytics and planning activities, combined with diffuse governance responsibility and a fragmented health care system that created situations we are seeing across provinces and territories were not sustainable.

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. These steps 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.

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.

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 national formulary, and a rare-disease strategy.

As Peter Cleyer of Santis Health told The 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 sold like this, in part, to rein in drug prices.

Less obviously, an array of vocal Canadian health-care analysts against key aspects of shared approaches to COVID: “Instead of the common pandemic awareness messages of ‘stay home’ and ‘wash your hands,’ I believe these organisations are the groups 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.

Pharmacists should listen to patients, but—unlike many prominent patient advocates—I believe Big Pharma has systematically opted out 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.

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. Stacked advisory groups, for example in Missouri, are federally funded industry partnerships, with members calling them the “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 NMAA with a shout-out to five industry-funded patient advocacy groups: “Stakeholders – industry has been playing an important role in the continued engagement on these actions.”

How can the impact of the pandemic on gender-related health inequalities be overcome? Action must be mobilised on several fronts. Rigorous documentation of the gendered experience of the pandemic is needed. Facilitating access to flexible work arrangements, including the 10-day leave proposed by the federal government, would also have to be a priority.

Employers are also proving to be essential levers for equality. The government should heighten public awareness of the need for flexibility and this opportunity for them to participate in this transformation by promoting, for example, flexible hours, telebanking, 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 were extended.

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.

J 대한 한국 친구 말씀 드린다.

Dr. Sharon Batt is an adjunct professor in the department of bioethics at Dalhousie University. She is the Canada Research Chair in bioethics at Dalhousie University. She is an expert in the field of bioethics and has a particular interest in reproductive rights and patient advocacy. She has conducted extensive research on the impact of the pharmaceutical industry on patient advocacy groups and has written extensively on the subject.

Pharmacare, patient groups, and the need for open discourse

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