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# HEALTH

THE HILL TIMES POLICY BRIEFING



# Canada will need 'intensive collaboration' between provinces, territories, and federal government for next pandemic, say experts

A new approach to health-care governance and an increased focus on the social determinants of health are two crucial and key lessons, experts say, to learn from this pandemic and to prepare for the next one.

AIDAN CHAMANDY

In the fall of 1918 thousands of Canadians were dying on the battlefields of Europe in the First World War. Once the war ended on Nov. 11, 1918, however, the dying continued on the home front.

The Spanish flu was reaching its crescendo that fall having first appeared in the spring, though it went "basically completely unnoticed," according to Wilfred Laurier University historian Mark Humphries in his book titled *The Last Plague: Spanish Influenza and the Politics of Public Health in Canada*.

The period of mid-September to early-December 1918 would turn out to be the second of three waves of the epidemic, and "is the one that everyone thinks about when they think about" the Spanish flu, Prof. Humphries said.

"The severity of the epidemic was not recognized in Canada until late September, when major outbreaks had occurred in most parts of the country and beyond," writes University of Toronto historian Christopher Rutty in a book titled *This is Public Health: A Canadian History*.

The third wave "came sporadically from January to June 1919," he said. By the time the epidemic was over, some 55,000 Canadians had died, according to Prof. Rutty.

The sporadic nature of the Spanish flu highlights a key difference between the COVID-19 pandemic and the great outbreak a century prior, Prof. Humphries said.

"It's not like this, where we've been living in a constant pandemic for more than a year. That's not something anyone experienced" during the Spanish flu, he said.

"So the opportunities to learn lessons are very different because the timeframes are so compressed in 1918," compared to the protracted pandemic facing the world today, he said.

Many of those lessons came a few years later, after medical officers of health in the provinces released reports "written often 18 months after the pandemic," he said.

There was no federal department of health at the time, but the pandemic was one of several factors that led to its creation, Prof. Rutty wrote. In the February 1919 Speech From the Throne, the Borden government committed to a larger federal role in health and introduced the bill that established the department in April 1919.

The new department led to "some effort at the federal level" to "think about planning for the next pandemic, but that drops off very quickly. Within a couple of years the department moves on and people forget about the pandemic," Prof. Humphries said.

"This is the first pandemic we've lived through where you can actually track these things in real time," he said.

There are key lessons to learn from Canada's 13-month (and counting) experience with the COVID-19 pandemic, experts say. There are also key lessons to relearn from past pandemics. Two of the most important lessons, they say, touch on governance issues related to Canada's federal system, and having appropriate respect for social determinants of health and incorporating those factors into a public health response.

## Governance

"It's a fundamental property of Canadian public health politics that this is likely going to always be a decentralized approach," said Kumanan Wilson, a professor at the University of Ottawa and senior scientist at the Ottawa Hospital, who has researched and written scholarly articles on federalism and public health.

That has led to a "fairly fractured response," according to Matthew Oughton, a professor of medicine at McGill University and physician at the Jewish General Hospital in Montreal.

"It would be far easier to have more in-depth and understandable statistics that would be accessible faster if there were a common set of definitions, a common way of collecting and sharing this data. And we quite simply don't have that," Prof. Oughton said. "One of the things we should learn from this pandemic is we need to have some structure by which every province is not just inventing their own set of policies and definitions, but there has to be some means of having a harmonized approach."

He acknowledged how difficult that would be in a federation, "but nonetheless, it's very important if you want to be able to have a rapid and accurate picture on a national basis as to the effects of the pandemic."

The solutions offered split into two categories: a larger role for the federal government through emergency powers or more inter-provincial collaboration.

"For a decentralized federation," said Gregory Marchildon, a former senior public servant at the provincial and federal levels and now a professor of health policy at the University of Toronto, there is an "absolute importance of very intensive collaboration" between the provinces, territories, and the federal government.

During COVID-19, "there needed to be closer and more intensive collaboration among the 13 ministers of health and the federal minister of health than there has been in this case," he said.

"It's absolutely essential that there be some agreement on a pan-Canadian basis. It's a little more complicated in a federation like this, but nonetheless it needs to be achieved," he said.

He stressed that health ministers are best placed to be the focus of coordination.

"You don't want it in the hands of first ministers because the discussion will be about money and jurisdiction as opposed to the policies and programs," he said.

Prof. Marchildon also suggested using the Council of the Federation or a new intergovernmental body "that would be like a technical working team and reporting to the ministers and deputy ministers in this kind of a crisis."

Dr. Wilson also said that "the answer is going to be interprovincial collaboration. Provinces have to work with themselves and each other. We had a good model in the Atlantic bubble," he said.

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Intergovernmental Affairs Minister Dominic LeBlanc and Health Minister Patty Hajdu, pictured Sept. 29, 2020, on the Hill, are responsible for two files that are crucial to the government pandemic response and building the capacity to fight the next one, experts say. *The Hill Times photograph by Andrew Meade*

## VOX POPULI ON PANDEMIC:

"Epidemics are not random events that drop from the sky without warning. Epidemic outbreaks follow the fault lines of society, where they begin to entrench more" along racial and economic disparities.

*Sandra Hyde*
*Professor of medical anthropology at McGill University*

"We're treating this like a scientific challenge and a medial challenge, but it's a huge social challenge. The idea that there's this virus that should be, in some sense, equal opportunity, but the impacts have been so vastly different. And the experiences of people, of both the virus itself and the policy responses, have been so vastly different" depending on socioeconomic factors.

*Erin Strumpf*
*Professor of economics and epidemiology at McGill University*

"I think we need to have separate emergency public health legislation. The problem with the Emergencies Act is it came out of the War Measures Act and that was used during the Quebec crisis and nobody wants to touch it. It's too draconian anyway, it's zero or 1,000."

*Kumanan Wilson*
*Professor at the University of Ottawa and senior scientist at the Ottawa Hospital*

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*Matthew Oughton*
*Professor of medicine at McGill University and physician at the Jewish General Hospital in Montreal*

# Policy Briefing

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Dr. Wilson said the Canadian Blood Services could serve as a model for greater interprovincial collaboration. It's a not-for-profit charitable organization primarily funded by the provinces, minus Quebec. It's responsible for providing blood and related products and services like transfusions and organ donations, and more. It operates a national registry for services like organ sharing that all subnational jurisdictions can tap into.

The other option is an update to or rework of federal emergency legislation, Dr. Wilson said.

"I think we need to have separate emergency public health legislation. The problem with the Emergencies Act is it came out of the War Measures Act and that was used during the Quebec crisis and nobody wants to touch it. It's too draconian anyway, it's zero or 1,000," he said. Separate legislation would "be helpful just to get it out of the whole stigma of the War Measures Act and and allow a bit more flexibility."

He suggested a tiered approach to the proposed legislation. "We can have different levels of this emergency. The initial stages mandating transfer of data. If you do get to a 'level five' emergency, you can start to deploy people from other regions to help with it."

He pointed to a plan proposed by the Canadian Medical Association in 2003 that was considered in the 2003 post-SARS Naylor Report. Writing in a 2006 paper for the academic journal, *Healthcare Policy*, Dr. Wilson identified three key points in that plan.

"The first is the authority to oversee the response to an emergency. Second, and related, legislation should provide the federal government with authority to have access to surveillance data on an emerging outbreak so that it may then serve as a conduit for information transmission to provincial and international officials," he wrote.

"Third, and most contentiously, the federal government should also have the option of intervening at an early stage if it perceives that a national response team could better manage the outbreak," he wrote. "The first two powers should be available to the federal government at the outset of an outbreak that is potentially of national concern. A clear federal test would have to be described for the third power to be utilized. It would be logical that if the WHO declares a public health emergency of international concern, the emergency would immediately be a federal matter."

He wrote that the new legislation would need to be paired with money to ensure there's no financial burden placed on the provinces and territories, and an acceptance of the political implications.

"The federal government must be prepared to pay the cost of exercising those powers. Therefore, the federal government must ensure that it has the appropriate capacity to utilize any new powers," he wrote. "Such capacity would require investment in local surveillance networks, establishing emergency response capability and general investment in public health personnel. The federal government must also be prepared to accept the political responsibility that would accompany these powers."

## Social determinants of health

The other key lesson is to elevate the social determinants of health to the same level as traditional biological metrics when assessing the severity of an outbreak and how to respond, experts say.

Social determinants of health refer to how socioeconomic factors, like racism, income, education, sexual and gender identity, and more, impact individual or population-level health outcomes.

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# The COVID-19 vaccine rollout debacle: how did we get here?

The COVID-19 vaccine rollout campaign illustrates how the government reverted to bounded rationality in its decision-making throughout the crisis, being reactive instead of being proactive. As a result, at the time this is written, Canada ranks 42nd in the world in vaccination rate.

**Ramy Elitzur**
*Opinion*

In 1957, Herbert Simon came up with the idea of "Bounded Rationality," for which he eventually won the Nobel Prize in Economics in 1978. Bounded rationality states that, because of cognitive limitations, we do not make decisions rationally, but only try to get by or manage. The term that was coined in this context is "satisficing" (a combination of satisfy and suffice). This idea became the cornerstone of what we know today as behavioural economics, which investigates decision-making biases.

The COVID-19 vaccine rollout campaign illustrates how the government reverted to bounded rationality in its decision-making throughout the crisis, being reactive instead of being proactive. As a result, at the time this is written, Canada ranks 42nd in the world in vaccination rate.

As vaccines were developed, the Canadian government chose to apply a scattergun approach, an understandable strategy due to the inherent uncertainty in vaccine development. It is questionable, however, why it would bet heavily on a Chinese vaccine during the time of heightened tensions between Canada and China. Moreover, Canada came late to the dance and negotiated badly with the leading candidates (namely, Pfizer, Moderna, and AstraZeneca).

Part of the government reticence was related to vaccine costs, failing to recognize the opportunity costs of not having vaccines. In contrast, the Israeli government strategy involved their prime minster having long discussions, well into the night, with the CEOs of Pfizer and Moderna, explaining why Israel should be prioritized in getting the vaccines.

Moreover, the Israeli government was willing to pay $30 per dose (compared to $15 by the EU and $20 by the U.S.). The math was quite simple: if every person in the country (about nine million people) would get two doses, costing $30 each, the total vaccine cost would be $540-million, less than the cost to the economy of half a week of lockdown.

Had Canada agreed to pay the same price, the total cost of the vaccines would be about $2.1-billion, a relatively minor amount compared with the economic effects of lockdowns (not to mention, the costs of programs such as CERB). To put this in perspective, the vaccine cost would have been about 0.12 per cent of Canada's 2020 GNP. As a result of this failed strategy, Canada had a low vaccine priority compared with other countries (for example, at the end of January, Canada was the only country in the West that received zero vaccines).

To exacerbate the problem, the initial vaccination effort was accompanied by serious execution blunders. For example, the CNE in Toronto was meant to serve as vaccination site for several thousand health-care staff. Unfortunately, the Ontario government sent a generic link for registration to these people, who passed it on to their family and friends. So instead of vaccinating several thousand, the site had to deal with a tidal wave and had to be shut down after only two days.

As vaccines were developed, the Canadian government, led by Prime Minister Justin Trudeau, chose to apply a scattergun approach, an understandable strategy due to the inherent uncertainty in vaccine development. It is questionable, however, why it would bet heavily on a Chinese vaccine during the time of heightened tensions between Canada and China. Moreover, Canada came late to the dance and negotiated badly with the leading candidates (namely, Pfizer, Moderna, and AstraZeneca), writes Ramy Elitzur. *The Hill Times photograph by Andrew Meade*

Moreover, as the result of the vaccine shortage, the government decisions tilted even more towards satisficing. For starters, the government has administered the second shot four months after the initial shot, basically vaccine rationing, which violates scientific protocols (for example, the U.S. Centers for Disease Control sets the maximum limit at 42 days after the first shot). Moreover, this translates to an unethical and immoral (and probably also illegal) experiment on Canadian citizens without their consent.

Another satisficing decision was pushing the controversial AstraZeneca vaccine, which was surrounded from the beginning with questions about its efficacy. AstraZeneca ran sloppy trials, making errors in the dosage it gave to the trial subjects. Even after it corrected this baffling fiasco, the efficacy of the vaccine was only 79 per cent (compared to over 94 per cent for Moderna and Pfizer).

One counterargument often made is that, while the AstraZeneca vaccine provides much lower protection against infection, it is still likely to prevent hospitalization. However, research shows that the AstraZeneca vaccine does not provide almost any protection against the South African variant, while Pfizer provides a high degree of protection.

The problem with aggressive virus mutations is that, because of their higher proliferation rate, they tend to quickly dominate infections, and so the South African variant might cause a high number of hospitalizations in Canada, including people who received the AstraZeneca vaccine. Moreover, although the AstraZeneca vaccine may prevent serious disease, there is still the issue of long-term morbidity, which can happen even to people with mild disease (e.g., fatigue, "brain fog," chest pain, depression, and other serious symptoms).

Another counter-argument often made about the low efficacy of AstraZeneca is that its trials took place in another period than the other two vaccines, and so efficacy is not comparable among the three vaccines. However, the Pfizer efficacy is now validated by a large real-world evidence, as opposed to controlled trials, refuting this argument. This real-world evidence with millions of observations shows that almost immediately after its massive vaccination campaign, hospitalization and mortality levels in Israel approached zero, and that the ultimate efficacy of the Pfizer vaccine is about 91 per cent (the country, by the way, has fully opened its economy).

Last, the AstraZeneca, as opposed to the other two vaccines, has been linked to cerebral blood clots, raising more doubts on the choice of this vaccine by the government. While the AstraZeneca vaccine is better than nothing, this is not the right comparison for Canadian citizens. What we want is not a better solution than the worst outcome, but the best available vaccines.

*Ramy Elitzur is a professor of financial analysis at Ryerson University.*

*The Hill Times*

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Canada's Chief Public Health Officer Theresa Tam, pictured Jan. 5, 2021, in Ottawa.The Public Health Agency of Canada was established in 2004 after the SARS outbreak exposed massive failings in our country's public health infrastructure. The agency was specifically mandated to be Canada's lead organization for planning and coordinating a national response to infectious diseases that pose a risk to public health. *The Hill Times photograph by Andrew Meade*

# Scathing audit highlights PHAC failures

Attention and accountability are urgently needed to address the shortcomings highlighted in the auditor general's report.

**NDP MP Don Davies**

*Opinion*

The federal government's failure to prepare for the gravest public health crisis in a century is something that should concern every Canadian. Recently released audit reports reveal a litany of errors and omissions by PHAC that led to a profound inability to respond effectively to the COVID-19 pandemic.

Most alarming, this happened despite decades of warnings.

We should recall that the Public Health Agency of Canada (PHAC) was established in 2004 after the SARS outbreak exposed massive failings in our country's public health infrastructure. The agency was specifically mandated to be Canada's lead organization for planning and coordinating a national response to infectious diseases that pose a risk to public health.

Canadians rightly expected their federal government would build and maintain the capacity to protect them from future threats. Instead, it was allowed to atrophy under successive Liberal and Conservative governments.

On Jan. 22, 2021, an internal probe of PHAC's COVID-19 response was released to the public through a parliamentary production order. This deeply disturbing report exposed extensive disarray and a troubling lack of capacity at PHAC.

The report noted limited public health expertise—including epidemiologists, psychologists, behavioural scientists and physicians—at senior levels.

It found a lack of emergency response expertise and capacity for risk communications within the Agency.

It exposed that essential senior medical expertise needed to support Canada's Chief Public Health Officer Theresa Tam was slow to be put in place and likely still remains insufficient. It documented that Dr. Tam's office often received information in the wrong format or with inaccuracies.

On March 24, 2021, the Auditor General of Canada, Karen Hogan, released another devastating assessment of the federal government's pandemic preparedness, surveillance, and border-control measures.

The Auditor General's report found that PHAC had not tested or updated its readiness plans, in direct violation of internal standards. It also stated that PHAC failed to resolve shortcomings in Canada's health surveillance information and data systems first identified by the Auditor General in 1999, and again in 2002 and 2008.

Further, the audit found that PHAC did not assess the pandemic risk posed by COVID-19 or the potential impact were it to be introduced to Canada. As a result, the Agency "underestimated" the potential danger of COVID-19 and continued to assess the risk as "low" until March 16, 2020—nearly a week after the WHO had declared a global pandemic. By then, Canada had already recorded over 400 confirmed cases and community spread was underway.

Despite Dr. Tam's assertion that PHAC's assessment that COVID-19 posed a low risk to Canadians was accurate in that moment, the Auditor General found the methodology used to reach that conclusion was neither formally evaluated nor approved.

Alarmingly, the auditor general found that Canada's Global Public Health Intelligence Network (GPHIN) did not issue an alert to provide early warning of the novel coronavirus. The auditor general was unable to determine the reason for this oversight. However, the auditors did note that GPHIN issued an alert in May 2019 for an Ebola-like illness in Uganda, as well as an alert in August 2020 for a virus infection caused by tick bites in China.

The auditor general's report revealed that PHAC failed to verify compliance with quarantine orders for two-thirds of incoming travellers and did not consistently refer travellers for follow-up who risked not complying.

Upon releasing the report, Auditor General Karen Hogan noted that she was "discouraged that PHAC did not address long-standing issues, some of which were raised repeatedly for more than two decades."

This extensive list of errors and omissions has had a serious and negative impact on the federal government's ability to protect Canadians throughout the COVID-19 pandemic. These failures have been compounded by a total lack of accountability from those responsible.

The buck ultimately stops with cabinet. But rather than taking responsibility, the current Health Minister Patty Hajdu has blamed her predecessors for the erosion of Canada's public health infrastructure.

This is unacceptable.

Given that successive federal governments failed to address repeatedly identified gaps in Canada's pandemic response capacity, it's not enough to simply accept the auditor general's recommendations, or pass the buck.

Those responsible for this public health failure must be held accountable. The serious errors must be corrected. A clear timeline with transparent reporting of progress must be established.

Meaningful steps are needed to ensure this never happens again.

*NDP MP Don Davies, who represents Vancouver Kingsway, B.C., is the NDP's health critic.*

*The Hill Times*

# Canada should be on the frontlines of developing and manufacturing new vaccines, therapies and other technologies, so we can enjoy those everyday moments.

**Prime Minister, we can work with you to build a world-class life sciences sector to make this happen.**

## AN OPEN LETTER TO PRIME MINISTER JUSTIN TRUDEAU FROM CANADA'S LIFE SCIENCES, RESEARCH AND BUSINESS COMMUNITIES

A year ago, Canadians could not have anticipated how a new coronavirus would so profoundly change and disrupt their lives or harm them or their loved ones.

But even before the pandemic was declared and the first COVID-19 restrictions came in mid-March 2020, scientists were working on vaccines and treatments. Some Canadian innovators had already started developing them and contributing to the global effort. That's how the world got the first COVID-19 vaccines in record time before the end of the year. They promise to be our ticket back to health, socializing with family and friends and economic recovery.

These vaccines are flagships of an exciting new era of medical innovation. We are mining genetic secrets to discover not just how to stop viruses but also to create new therapies and vaccines for some of our most intractable illnesses such as cancer, cystic fibrosis and Alzheimer's disease among many others.

Canada can and must be a leader in this new era.

Prime Minister, we can work together – our companies, your government and the provinces, Canada's researchers and health institutions, and the patient community – to ensure the life sciences ecosystem we built in Canada over the past 30 years can grow and be put to work even more effectively for the benefit of Canadians and our economy.

**To succeed, we need to do both more and less.**

**More collaboration to solve for the pandemic today and future health challenges.**

**Less uncertain and complex regulations that are blocking our ability to move at the speed of science.**

**We can achieve this with a coherent life sciences strategy.**

Now, more than ever, we need public and private sector leaders to continue to work together to address these issues and other serious challenges.

We applaud your government's initiatives on biomanufacturing, but more needs to be done to create a competitive commercial environment for the full life cycle of health technologies: from labs to the frontlines of healthcare.

Building together a world-class life sciences sector will enhance Canada's resilience in the face of challenges and ultimately help ensure our health and economic security.

**We are asking you to join us to make this a lasting positive legacy of COVID-19.**
**Sincerely, Canada's life sciences, research and business communities.**

**Anie Perrault**
Executive Director
BioQuébec

**Bob McLay**
Chair
The Canadian Forum for Rare Disease Innovators (RAREi)

**Brian Lewis**
President & CEO
Medtech Canada

**Carl Viel**
President & CEO
Québec International

**Charles Milliard**
President & CEO
Fédération des chambres de commerce du Québec

**David Wojcik**
President & CEO
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**Scott Moffitt**
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**Wendy Hurlburt**
President & CEO
LifeSciences BC

**Meaghan Seagrave**
Executive Director
BioNB

# Learning from the mental health challenges of the pandemic

The lesson to be learned from these predictions is that we must be careful not to extrapolate from historic situations to this pandemic experience. Data, not emotions are needed to help guide policy. *Photograph courtesy of Pixabay*



Mental health is not simply about feeling good all the time. It is about learning how to traverse the existential challenges we face, by supporting each other and by having our federal government invest in improving access to and quality of health care, and addressing the social determinants of health, especially for those whose lives are most precarious.

**ISG Senator Stanley Kutcher**

*Opinion*

The COVID-19 pandemic has led to concerns about potential mental health impacts globally. In Canada, various interventions have been implemented by the federal government intending to mitigate these repercussions. Now a year later, we can reflect on what has been seen, done, and what can be learned to better inform future policy.

Several dire predictions made by some pundits, mental health advocates, and practitioners did not occur. For example, predictions that suicide rates would rise significantly have been wrong. Available data shows that suicide rates have generally fallen. Similarly, predictions of an overwhelming "parallel pandemic" of mental disorders, have been incorrect. While there may be increased demands for treatment for eating disorders, there is no robust evidence that the prevalence of mental disorders in general has significantly increased. Surveys have demonstrated higher rates of mental distress, but this is not the same as an increase in mental disorders.

The lesson to be learned from these predictions is that we must be careful not to extrapolate from historic situations to this pandemic experience. Data, not emotions are needed to help guide policy.

Various polls purporting to quantify the mental health of Canadians have led to popular perceptions that we are all experiencing a mental health crisis. But careful consideration does not support this interpretation. Most of these polls suffer from significant methodological problems in design and measurement and thus do not accurately capture Canadian's mental health status. For example, there is confusion in the use of terms that denote pathology, such as anxiety and depression and a lack of focus on more nuanced states such as worry or unhappiness. Most did not distinguish mental disorders requiring treatment from perceived stress, nor did they separate out situationally appropriate mental states from those requiring clinical interventions. Rarely did they measure adaptation, functioning, positive emotions or use of mental health services. Increased rates of distress have often been "a-priori" interpreted as pathology without due consideration for the expected and necessary role of distress as part of normal adaptive responses to external threats. Additionally, there has been a scarcity of comprehensive studies examining subgroups in the population that may be at greater risk for mental health problems—such as racialized groups, those living in poverty, those living with family violence, those with precarious employment and so on.

The lesson to be learned from this is that we need much better data to understand what is going on. The federal government needs to lead a more robust national approach to obtaining valid data that is of sufficient quality to be able to guide mental health policy.

In response to the pandemic, the government instituted an electronic mental health intervention, Wellness Together Canada. However, to my knowledge, there has not yet been any reporting of what this has achieved. Independent analysis is necessary to determine if this intervention was of value or not, and if so, to what degree and for whom. This is particularly important as pre-existing research has raised questions about the effectiveness of various types of electronic mental health interventions.

The lesson to be learned from this is that without comprehensive independent evaluation, it is not possible to determine if further investment in this intervention is warranted or if modifications could be helpful to improve impact and value. Such review could also help government consider how it will move forward in researching and regulating electronic mental health interventions.

The above issues notwithstanding, it is possible that the greatest positive impacts on the mental health of Canadians were realized through federal government interventions that decreased the rates of premature death from the pandemic (for example, deployment of the military into long term care facilities) and those that cushioned its economic impact on individuals and families (for example: the Canada Emergency Response Benefit, the supplementary Canada Child Benefit payment and the Canada Emergency Student Benefit to name a few).

Perhaps the most valuable lesson to be learned from this pandemic may be that mental health is not about feeling good all the time. It is about learning how to traverse the existential challenges we face, by supporting each other and by having our federal government invest in improving access to and quality of health care, and addressing the social determinants of health, especially for those whose lives are most precarious.

*Senator Stanley Kutcher is a member of the Independent Senators Group from Nova Scotia and a professor emeritus of psychiatry at Dalhousie University.*

*The Hill Times*

# Canadians Are Ready to Embrace "Virtual First" in Health Care

**By Shelagh Maloney**

From the evidence we've been collecting for years, we know virtual care is a viable care delivery option that can improve access to care, save patients time and money, and enable them to better manage their care. Over the past year, the pandemic has necessitated the adoption of virtual care, and Canadians are mostly embracing this change. At the very least, they want an alternative to routine in-person visits.

Well before the pandemic began, Canada Health Infoway engaged Environics Research to consult with Canadians about their needs, expectations and concerns about the future of their health system, and the role of technology in the delivery of better health care. We called this consultation *A Healthy Dialogue*, and it reached more than 58,000 Canadians through a national survey (including a representative sample of Indigenous people), online focus groups, an online engagement forum, interviews with people who are underserved by the health system (e.g., new immigrants, members of the LGBTQ community), and focus groups with Indigenous people in their communities.

After the dramatic shift to virtual care during the first weeks of the pandemic, we felt it was important to see whether the attitudes of Canadians had changed, so a second survey was undertaken last June with a representative sample of those who had participated in the first survey.

The second survey found that seven in 10 Canadians who sought medical care during the pandemic used virtual care, 91 per cent were satisfied with the experience, and 86 per cent agreed that virtual care tools can be important alternatives to seeing doctors in-person. Regardless of whether they had used virtual care during the pandemic, 76 per cent are willing to use it in the future. That's up from 64 per cent in the first survey.

This growing appetite for "virtual first" is very encouraging. Our research also found that the appetite for digital health in general is growing. Ninety-two per cent of Canadians want technology that makes health care as convenient as other aspects of their lives, and 84 per cent say they would use technology tools to help manage their health. They have seen how technology has transformed banking, commerce and many other areas of their lives, and they have a strong desire for health care to catch up.

Canadians also recognize the benefits of digital health tools and services. Nine in 10 who had used health technology in the past year said it saved them time, eight in 10 said they were better able to manage their health, and 53 per cent said it helped them avoid an in-person visit. Eighty-six per cent also agree that technology can solve many of the issues with our health care system and 80 per cent believe investing in health care technology should be a top priority for government.

The findings were not all positive, however, and it's clear that there is still work to do. For example, nearly four in 10 Canadians say their level of understanding of their health information and/or their comfort with technology is a barrier to their use of digital health, while nearly six in 10 feel they don't know enough about digital health apps and services. Canadians also want assurances that privacy and security of personal health information will be a top priority and they say this is the main barrier that prevents them from fully embracing health care technology.

Some Canadians face additional barriers. Twenty-six per cent say they don't have access to the reliable internet service needed to use health technology. Those who typically face discrimination in the health system are also more concerned about privacy, and they need greater assurance that their personal health information will be protected and not used to marginalize them further.

Governments, health care organizations, health care providers, industry and other partners should choose to view these challenges as opportunities. Opportunities to improve digital health literacy and Canadians' access to their personal health information, and to alleviate concerns about privacy and security of that information. Opportunities to bridge the digital divide. And opportunities to address the very real concerns of underserved groups, especially related to equity in our health system.

We can also use the pandemic as an opportunity to make lasting changes to our health system. Let's build on what we've learned about digital health and virtual care over the past year, and work together to ensure that these tools and services are available to all Canadians for the long term.

*Shelagh Maloney is Executive Vice President, Engagement and Marketing at Canada Health Infoway.*

Canada Health **Infoway**

# A nurse is not just a nurse

Nurses are under-appreciated and underrepresented. They have a wide variety of skills that make them an essential part of the healthcare system. We need nurses to be at the decision-making table. We need to give a voice to those driven young nurses who will be our leaders come the next pandemic.

**Erna Snelgrove-Clarke**

*Opinion*



Recently, well-known health-care journalist, André Picard wrote that "a bed is not just a bed." In the context of patient care, a bed, in and of itself, doesn't guarantee that a patient is getting the right kind of care in the right place. The bed, and more importantly the type and location of the bed, matters.

The same analogy can be made for nursing. Though it is tempting to see nurses as homogeneous, the profession is wildly diverse. In fact, it is this diversity that has positioned our profession as one of the critical frontline professions in this last year. A nurse is not just a nurse, and there is no better time to elevate our collective opinion of this important profession.

Throughout the pandemic, we have seen nurses organize, advise, and take charge. We have witnessed commitment, dedication, and perseverance to stand up to and overcome this deadly virus, all at a cost to self. When the going got bad, when supplies were not there, when staffing was low, nursing stayed at the forefront of health care. And while nurses overextended their commitment to the workplace, the next generation of nurses has been raising their hands.

This year, we are experiencing an exponential increase in the desire to become a nurse. In many of our Canadian universities, applications to nursing programs have increased by greater than 60 per cent. Why, in a pandemic, is this occurring?

I believe that the younger generation is seeing possibility and hope, and they want to take part in and be part of, healthcare. When we reflect on the role of nursing in Canada, we see a variety of opportunities. Patient caregiver, manager, CEO, educator, and researcher to name a few. Today's nurse takes the premise of the school-learned 'care plan' and applies this framework to the realities of their daily lives. What data do we have (assessment), what strategies do we need to put in place for an effective outcome (intervention and evidence), and did it work (evaluation)? Regardless of the role of a nurse, all these steps form the premise of a nurse's actions. Within a holistic, person-centred framework, nurses come together to deliberate, problem solve, and tackle what lays before them. What an adventure to be a nurse. And isn't it great that it is being seen by the next generation?

And yet I have to wonder. Are nurses really seen in the current context? Are there spaces for these future nurses in health-care leadership? Representing one of the largest work forces in Canada, nurses remain underrepresented at many decision making tables, in government bodies, and in hospital planning. When the pandemic began, had nursing been truly heard, I believe we would be in a much better position against the virus than we are today. Inherent in a nurse's training is the ability to look ahead, to think holistically and to find creative solutions. We have the expertise, but it needs to be harnessed if it is to provide value. There is no better time than now to look to nurses for expert guidance.

If the Canadian government is looking for wellness, dedication, and perseverance towards health and well-being, it is time to focus on nursing. With a dearth of nurses in Ontario, no time is better than to consider the numerous roles of a nurse and to expend efforts to enhance the many skills a nurse has to offer. We need nurses to be at the decision-making table. We need to give a voice to those driven young nurses who will be our leaders come the next pandemic.

If our goal and our shared value is health, then it is as a collective that we can be the strongest. All persons need to be included. Those who offer direct patient care and those who make the financial and political decisions about the delivery of that care. Can the table be made big enough?

If we make that table bigger and we add a nurse, here is what you'll get: an organizer, a planner, an educator, and a decision maker. A person who wants to share in the challenges, the hardships, and the growth of all. A person who brings a wealth of knowledge, perseverance, and skill.

As we open the doors of education to our future healthcare providers, let's remember to provide opportunity and care for those coming, if we want to be cared for ourselves.

*Erna Snelgrove-Clarke is the vice-dean of the faculty of health sciences and the director of the school of nursing at Queen's University.*

*The Hill Times*

# FORGING NEW FRONTIERS IN HEALTH INNOVATION

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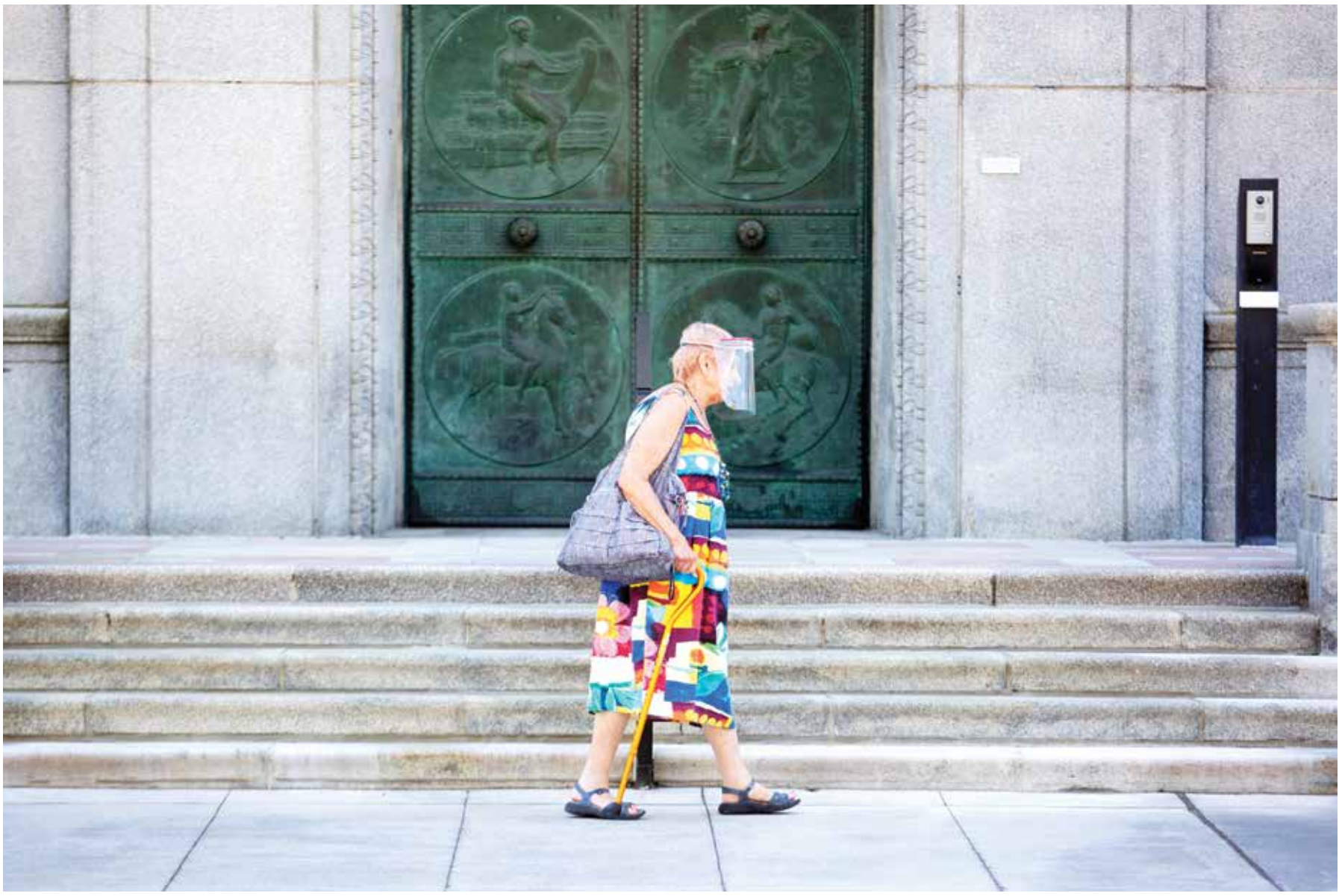

A woman, pictured July 20, 2020, walking down Wellington Street in Ottawa. Before COVID-19, industry had shown little interest in developing treatments against coronaviruses. This led many to suggest that we should rethink how we encourage biopharmaceutical innovation for public health emergencies. *The Hill Times photograph by Andrew Meade*

# A 'once-in-a-generation' chance to reset vaccine innovation in Canada

The experience of Connaught Labs offers lessons for Canada's new Sanofi deal to manufacture vaccines in Canada, and it doesn't appear the government has learned much from it.

**Matthew Herder and Srinivas Murthy**

*Opinion*

The $925-million public-private partnership to enhance the manufacturing capacity of Sanofi's influenza vaccine facility in Toronto is only the latest in a string of deals meant to protect Canada against this, if not future, pandemics. Occupying the grounds of what was once "Connaught Labs," Canada's famed, publicly controlled vaccine manufacturer, the transfer of $470-million in taxpayer money to a multinational corporation has increased debate about whether private industry's grip on biopharmaceutical production adequately serves the public good.

Before COVID-19, industry had shown little interest in developing treatments against coronaviruses. This led many to suggest that we should rethink how we encourage biopharmaceutical innovation for public health emergencies. And they pointed to Connaught as the alternative—a public supplier, which prioritized public health problems identified by provincial governments, and ensured that the resulting therapies were affordable not only to Canadians, but also populations in other parts of the world.

Connaught's history is, like most things, more complicated. While it was connected to the University of Toronto for most of its existence, the university seldom funded its operations. Instead, most of its resources derived from charitable donations, the occasional sum from the Ontario government, and funds from the sale of excess product which Connaught redirected back into research. Each provincial department of health was represented on Connaught's advisory committee. But the decisions about what diseases to focus on, or how to ensure that the products that Connaught produced were affordable, owe more to the ethics of Connaught's directors and affiliated scientists than government direction. The deal that Connaught, in coordination with U of T's Frederick Banting and Charles Best, struck with Eli Lilly to scale up production of insulin in the early 1920s is celebrated to this day because the people involved made sure that the insulin manufactured under the arrangement would be accessible to all those in need.

Connaught's achievements, in other words, don't simply follow from its university home. Rather, they are grounded in the efforts and ethics of individual people that infused the organization with a commitment to public good.

By the same token Connaught's unravelling did not happen overnight when it was privatized in the 1980s. On the contrary, Connaught had been in steady decline since the second world war when sales of its excess product declined, limiting Connaught's ability to maintain lab equipment and other infrastructure. The pharmaceutical sector was also growing through the 1950s and 1960s, creating competition. The historical record suggests that this may have pushed Connaught towards a for-profit approach even before it morphed into a Crown corporation in 1972, and long before the Mulroney government sanctioned its sale to what stands today as Sanofi's soon to be enhanced manufacturing plant in Toronto.

The point is that labels like 'public' and 'private' only tell us so much. What matters is whether the public good is clearly built into the institutional design and carefully maintained by an organization's leadership.

Too often that is not the case. Almost every drug and vaccine that has meaningfully improved public health in the last 50 years originally emerged from university and government labs. But the public sector's contributions, in terms of financing, risk, and scientific labour, are never reflected in the resulting treatment's price. Academic norms have also shifted substantially. Researchers and universities have internalized commercializing a discovery as their responsibility but, unlike Banting and Best, typically take a hands-off approach to questions of accessibility and affordability as the product moves toward patients.

We can't say whether the partnership with Sanofi will serve the public good because the terms of the deal are not in the open. But if Sanofi was given full control over which diseases to ultimately prioritize, how to evaluate new products in clinical trials, whether to share important information such as manufacturing know-how, and what price to charge for the plant's products, then the deal fails to protect the public good.

Contrary to many recent news headlines, Canada has always had some domestic vaccine manufacturing capacity in a number of public and private facilities. Rather, the fundamental problem that has been magnified by the pandemic is that Canada has–since Connaught's heyday—had virtually no say over when and how to produce a drug or vaccine. It appears that the Sanofi deal has done nothing to change that situation.

The government has dubbed the Sanofi deal a "once-in-a-generation" opportunity. We fear that opportunity has already been squandered. Rather than learning from the lessons of Connaught, taking advantage of a world-leading academic research community, and integrating commitments of transparency, affordability, and public governance into the partnership, our governments went with business-as-usual instead. That approach left us vulnerable to COVID-19, and it will not help us to be better prepared for the next pandemic.

*Matthew Herder is the director of Health Law Institute, Schulich School of Law, Dalhousie University. Srinivas Murthy is a clinical associate professor in the Department of Pediatrics, Faculty of Medicine, at theUniversity of British Columbia.*

*The Hill Times*

Policy Briefing **Health**

# Three lessons learned from the COVID-19 global pandemic and how we can prepare for the next one

Here in Atlantic Canada we have been successful in mitigating the impacts of COVID-19 because, for the most part, we have approached health guidelines and restrictions as an opportunity to care for one another, versus an infringement on individual rights.

**Brenda Merritt**

*Opinion*

As a health educator and academic leader at Dalhousie University, I have seen first-hand and contributed to the massive effort to adapt all of our systems of teaching and research over the past year to mitigate the impacts of the pandemic and ensure that the highest standards of health education are met within our faculty.

Along the way, I have spoken to students, staff, and faculty members as well as partner organizations about how the pandemic has been affecting them personally and professionally. This, combined with my own personal journey to maintain physical and mental stamina during this difficult year, has led me to several conclusions. Top of mind is the knowledge that self-care is not an indulgence; in times of great and ongoing stress it is a necessity. There is also a critical need for social connection to support health on an ongoing basis.

In addition, here in Atlantic Canada we have been successful in mitigating the impacts of COVID-19 because, for the most part, we have approached health guidelines and restrictions as an opportunity to care for one another, versus an infringement on individual rights.

The following are three additional lessons learned from the COVID-19 global pandemic, from an academic perspective. During the COVID-19 pandemic, we in the faculty of health at Dalhousie fully grasped the critical nexus that exists between the delivery of health care, public health policy, and scientific research. The pandemic was a perfect example of how scientists from across the health spectrum (from bench science to social science) mobilized to create collaborative teams to quickly and competently: investigate strategies of how to address imminent health concerns and deliver care to COVID-19 patients; develop rapid protocols for vaccine development; and better understand and address the existing, as well as the amplified health disparities that emerged during the pandemic for our Black, Indigenous, and persons of colour (BIPOC) communities.

With research teams engaged and delivering research evidence, public health was able to utilize this evidence to develop informed decisions and public health policies to mitigate the impact of the pandemic. The research and public health policies also advanced our health care delivery over the past year—from treating COVID patients, to offering telehealth services, and advancing policies and care delivery in long term care settings.

The pandemic has brought to the forefront the historic and systemic racism that our BIPOC communities face on a daily basis, and how this impacts well-being, safety, health, and wealth. There is a call to action for every Canadian to learn our histories, to understand white privilege, and to deeply reflect on our own biases, as well as how our institutional structures and colonial histories continue to marginalize and disadvantage our BIPOC community members. As an academic leader, I have a call to action to understand and remove the long-standing systemic barriers to post-secondary education and to meaningfully support our programs in diversifying their curricula so that the educational programs for health professionals and researchers effectively reflect the communities we serve.

The pandemic has also shown us that we can and we must work in different ways. We have seen the benefits of working from a collaborative and distributed leadership model and how efficiently we can work under this model versus top-down, hierarchical leadership. Also, we've proven that in many employment sectors that we do not need to be in office buildings 5 days a week. From a health care perspective, we now know that we can effectively deliver some aspects of health care through telehealth appointments and may have greater agility in efficiently working with and treating persons in rural and remote communities. The impact of operationalizing permanent hybrid workplace practices, where there is a mix of face-to-face work and telecommuting, will likely have significant positive impacts on the environment, work-life balance, productivity, and wellbeing going forward.

These lessons and many more will shape how we work going forward in many ways, hopefully providing us with preparation and insight if and when another global pandemic strikes.

*Dr. Brenda Merritt is dean of the Faculty of Health at Dalhousie University in Halifax. She is also an associate professor in the School of Occupational Therapy, with a cross appointment in International Development Studies.*

*The Hill Times*


The new vaccines are effective against the COVID virus in its current form, but as it continues mutating we will need others. We will certainly need next-generation vaccines to address the next pandemic and annual illnesses such as the flu. *Image courtesy of Pexels/torstensimon*

# The problem is pandemics and Canadian university research is the solution

Universities are uniquely positioned to steer us out of the COVID-19 crisis and the next pandemic.

**David Farrar**

*Opinion*

For more than a year now, the world has been on a crisis footing after the emergence of a frightening new virus for which there was no known prevention, treatment, or cure.

The pandemic's ravages—including illness, death, economic upheaval, and social isolation—have hit Canada hard, and other countries, with fewer resources, even harder.

Though the virus continues to shift its shape and evade human control, it appears we are closing in on effective prevention and treatment responses.

Since the virus responsible for the pandemic, SARS-CoV2, was first sequenced in January 2020, researchers around the world have mobilized with amazing effort and speed, developing multiple vaccines and finding ways to expedite the necessary trials to prove they are safe and effective.

None of this would have happened without massive infusions of public spending.

The new vaccines are effective against the COVID virus in its current form, but as it continues mutating we will need others. We will certainly need next-generation vaccines to address the next pandemic and annual illnesses such as the flu.

Universities are uniquely positioned to lead the way out of this crisis and to prepare for the ones that will come next.

The speed and degree of progress of research into this new and challenging enemy is impressive, but it is important to remember how it got its start.

It started from a foundation of knowledge that had already been developed through decades of research: knowledge about bats, viruses, other pandemics, vaccines, molecular engineering, diagnostic testing, PPE materials, off-label uses for existing drugs, and many more critical subjects.

The diagnostic tests we have are improving, but they need to be more reliable, faster, and more accessible. We need to know more about how viruses like this jump from animals to humans, how we can make personal protective equipment more effective, and how we can more effectively treat people who do become infected.

All of that work, and more, is happening now, and researchers are starting to make the world safer from COVID.

It's safe to say that without the momentum provided by these and countless other forms of research, many more people would have become sick or died, and that without the research now underway, we'd be in even deeper trouble.

Over the course of my time as a chemistry researcher, an academic leader at the University of Toronto and the University of British Columbia, and now as president of McMaster, the dynamics of health-related research have changed considerably.

Less than a generation ago, large and small companies had time and resources to do most of their own research and development. More recently, globalization and other forces have compelled businesses to run lean, forcing them to trim their in-house research.

Today, Canada's leading research universities, known as the U15, conduct about $8.5-billion worth of research every year, including more than four-fifths of all contracted private-sector research.

New knowledge—both abstract and practical—has always come from universities, but now their discoveries are more necessary than ever, especially with human survival at risk.

On our own campus in Hamilton, where COVID has kept us from holding in-person classes for more than a year, researchers have been working flat out to understand and control COVID and its consequences, and to position us for what comes next.

We have pooled and streamlined our McMaster resources into an all-out collaborative effort we call Canada's Global Nexus for Pandemics and Biological Threats. We are working not just on our own research but with partners at other universities, institutions and corporations.

Knowing that Canadian vaccines, tests, treatments, and equipment still need to be created, improved, validated, and brought quickly to market, we recently allied our efforts with those of our colleagues at the University of Saskatchewan's Vaccine and Infectious Disease Organization, whose strengths and facilities are complementary to our own.

The university research system was made for this moment.

University research is trustworthy, independent, and conducted in the public interest. It generates innovations that improve the quality of life and our understanding of the world. It creates jobs in the private and public sectors.

University researchers are constantly collaborating—within and between institutions, and with public and private partners. We must work even more closely with industry to speed commercialization—the process of converting discoveries into the products we need to be healthy and safe.

Canadians rely on universities to provide high quality education in tandem with top-level research, assuring that qualified experts are always available to solve known problems and to take on crises that emerge suddenly, as so many are doing now during this historic pandemic.

With mandates and resources from government partners, Canada's universities are answering the call.

Our role is to serve society, and this is a responsibility we are proud to take on.

*David Farrar is the president and vice-chancellor of McMaster University.*

*The Hill Times*

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# What a 'return to normalcy' in a post-COVID world means for children

We cannot simply go back to normal after the pandemic. Instead, we must strive to reconfigure the system to address existing inequities families face that have been highlighted by the COVID-19 global pandemic. Our children's future is at stake.

**Sarah Dow-Fleisner**

*Opinion*

It has been over a year since the COVID-19 pandemic changed the world. During that time, babies have been born, schools have been closed, loved ones have passed away, and our way of living has changed significantly.

However, as more and more Canadian adults roll up their sleeves and get vaccinated, the reality of a COVID-contained future with vaccine protected holiday gatherings, hugging of loved ones, and a return to in-person activities feels within reach. There seems to be a collective sigh of relief and a refrain of "now that things are returning to normal" among many adults.

But what about the children? While severe cases of COVID-19 infections among children have been limited, this pandemic has had major impacts on the developmental health and psychological well-being of children and youth. We must be aware of the unique impact the novel coronavirus has had on the children as we aim for a return to normalcy.

Children have grown up without the structure and routine afforded by regular attendance in childcare settings or school, have been raised by overly stressed parents, and have lacked the social connectedness that underlies optimal development. The pandemic has led to economic downturn, which has increased the risk of child maltreatment and family violence.

The pandemic has changed the way parents care for their children, with caregivers often lacking essential informal and formal social supports due to physical distancing and social isolation. Parents are under considerable stress, whether working from home and parenting simultaneously or having to work outside the home as an essential work and lacking childcare.

With that said, we cannot simply "go back" to normal, instead we must strive to reconfigure the system to address existing inequities families face that have been highlighted by the COVID-19 global pandemic. We must learn from the impacts of this pandemic to inform approaches to address inequalities in health care, education, and social welfare for children and families.

This includes developing a two-generation health-care approach that supports child health and caregiver health as one in the same, funding for school infrastructure and personnel, and providing income supports that enable families to build savings, while maintaining secure housing and access to food. As we move forward, we must also provide funding and training to ensure school personnel can support children as they re-engage in the learning process.

As children return to full-time schooling, teachers, social workers, and other school personnel will be supporting children who potentially have complex trauma as a result of family loss, maladaptive family functioning, and mental health concerns. We must remember that while adults revel in a vaccine protective tomorrow, the exact date for a child-safe vaccine is largely unknown. And after a year of unknowns, we should all be able to empathize with that unsettling position.

So, as we push towards a return to normalcy, we must consider that for young children growing up in a COVID world, the past year may have become their normal. To support children in the transition to a post-COVID world, we must listen to and validate their fears and anxieties about returning to school, childcare settings, or attending family gatherings.

Be patient with young children during family get-togethers (among fully vaccinated adults), as this may be a novel and overstimulating experiencing. Allow children a space to move away from the crowd when feeling overwhelmed. We must also ensure that children have body autonomy. Even if it is safe to hug their auntie, asking kids if they want a hug or kiss is essential. Forcing physical contact after months of physical distancing may lead to children feeling overwhelmed and anxious. Accept and listen to caregivers who still do not feel comfortable attending events with their unvaccinated children.

Finally, in the absence of an approved vaccine for children, adults must continue to do their part by adhering to public health guidelines around mask wearing, physical distancing, handwashing, and getting the vaccine. In doing so, we can halt the spread of COVID-19 and support a return to normalcy, whatever that means.

*Sarah Dow-Fleisner is an assistant professor at the School of Social Work at the University of British Columbia.*

*The Hill Times*

# Window of opportunity for feds to address health-care deficits

The COVID-19 pandemic has opened the door to something more.

**Sarah Watts-Rynard**

*Opinion*

Headlines across Canada and around the world continue to be filled with news of shutdowns, widespread economic chaos and the race to vaccinate. Where we once defaulted to small talk about the weather, conversation has turned to daily case counts, ICU beds, and vaccination statistics. Health has become a national obsession, with all signs suggesting it will remain so until the pandemic fades into memory.

That's why now is the right time to talk about—and invest in—the future of Canada's health-care system.

For many years, investing in health care was a matter of boosting federal transfers to the provinces. Not terribly exciting in terms of advancing national policies or programs but, rather, a way to buy short-term peace within the federation. The COVID-19 pandemic has opened the door to something more.

Lessons from the pandemic point to two structural issues that are well within the federal government's capacity to address: Canada's system of long-term care and challenges within the health-care talent pipeline. The current environment opens a window to fresh policy action and a renewed federal/provincial partnership on health care.

First, the pandemic has laid bare the fault lines in Canada's long-term care system. Staffing was inadequate to meet the needs of seniors in care when family access was restricted. By all accounts, personal protective equipment was insufficient and the need for it poorly understood. As a result, those with compromised immune systems and pre-existing health conditions—the very group long-term care is designed to support—died at alarming rates.

With a Canadian population that is living longer, eldercare is a reality with which the federal government must grapple. Now is the time to activate and empower the minister of seniors to set national standards of care and employee training for senior living facilities. These actions would be appropriate and well-timed, not to mention welcomed by countless families who were denied the ability to visit, advocate for, or support their loved ones over the past year.

If there were a federal will, there is no shortage of capacity. Polytechnic institutions, for example, have dedicated applied research expertise in eldercare and healthy aging. They are also the foremost education providers for a workforce that is well-trained and certified, rather than ad hoc and under-prepared.

While a number of the issues surrounding eldercare relate to training standards, the government needs to think bigger. Frontline workers across all health fields have been pushed to their limit for more than a year, with each subsequent wave of the pandemic accompanied by a host of new challenges.

Part of the solution lies in a much greater emphasis on professional development and upskilling. While the same can be said across sectors, the health-care field is a critical case in point. At Polytechnics Canada, we are hearing about micro-credentials to activate a vaccination workforce and upskilling for critical care nurses. Investments in upskilling and reskilling must be viewed as much a health issue as a workforce training priority. It isn't enough for the courses to exist—Canadian workers need to be encouraged, supported and navigated to high-quality continuing education.

Another important way to support the current health-care system is to enable the efficient entry of new graduates.

While late-stage students in many vital health fields made an accelerated entry into the health-care workforce last spring, the learners behind them have struggled to find the practicums and placements critical to earning their professional designations. Work-integrated learning opportunities didn't dry up for lack of work, but because of an overwhelmed system without the resources to offer hands-on experience to students.

Polytechnic institutions found creative ways to continue hands-on and applied learning in a largely remote environment, but investments in post-secondary digital infrastructure—simulators, augmented and virtual reality, high-tech labs and smart classrooms— will go a long way to ensuring new entrants are work-ready in high demand fields. In addition to providing teaching and learning solutions in the time of a pandemic, such investments lay the groundwork for a future that includes digital and remote healthcare.

While most Canadians will be grateful when the pandemic is over and behind us, we shouldn't lose sight of the opportunities to address deficiencies identified in the last year. Without a doubt, one of the most important is a reimagined federal/provincial partnership for the health and welfare of Canadians.

*Sarah Watts-Rynard is CEO of Polytechnics Canada.*

*The Hill Times*

# Canada will need 'intensive collaboration' between provinces, territories, and federal government for next pandemic, say experts

Ontario Premier Doug Ford and Prime Minister Justin Trudeau, pictured Nov. 21, 2019. Greater collaboration between the provinces, and between Ottawa and the provinces, is crucial to Canada's pandemic response. *The Hill Times photograph by Andrew Meade*

Continued from page 15

Just as lack of government coordination was highlighted in the 2003 Naylor Report, respecting how socioeconomic factors affect the course of an outbreak is a lesson that past pandemics have offered, said University of British Columbia professor Tom Koch, who specializes in medical history and medical geography and has written extensively on the topic, including *Cartographies of Disease: Maps, Mapping and Medicine*.

He pointed to two examples from the 19th century.

One was an 1842 report on cholera outbreaks in London, titled *Report on the Sanitary Condition of the Labouring Population of Great Britain*, that focused on how class affected the spread of the disease. Another report on typhus outbreaks in the poor region of Upper Silesia in 1848 by Rudolf Virchow (a historical region mostly in modern day Poland, with small parts in Germany and Czechia) also hit on these themes.

"Medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time," Virchow wrote.

The Virchow report "continues to set a standard for any attempt to understand and change the social conditions that produce illness," reads a 1984 article in the *International Journal of Health Services*.

"By and large what we're doing is not learning but relearning," Prof. Koch said. "The fault lines we're seeing here ... as it's related to poverty and racial inequality ... that's nothing new. We've seen it every time. And every time we see it, we write a report on it, and then we ignore it," he said.

Erin Strumpf, a professor of economics and epidemiology at McGill University, said the degree to which the pandemic and the policy response is a social problem has been undersold.

"We're treating this like a scientific challenge and a medical challenge, but it's a huge social challenge," she said.

"The idea that there's this virus that should be, in some sense, equal opportunity, but the impacts have been so vastly different. And the experiences of people, of both the virus itself and the policy responses, have been so vastly different" depending on socioeconomic factors, she said.

"The social factors have had a huge impact on people's experiences and the outcomes," she said. "If we don't learn those lessons and work to address some of the social factors that really impact people's ability to follow social distancing guidelines and take time off work, then we're just going to repeat this the next time around," she said.

"Epidemics are not random events that drop from the sky without warning," said Sandra Hyde, a professor of medical anthropology at McGill University. "Epidemic outbreaks follow the fault lines of society, where they begin to entrench more" along racial and economic disparities.

Prof. Hyde said Canada did implement some of these lessons on a national level by prioritizing Indigenous adults in the vaccine rollout, but not to the same extent on the local level through targeting hotspots in major cities.

Some provinces, like Ontario, recently tried to focus on hotspots by postal codes, but that effort has been hampered by a confusing vaccine rollout.

A focus on the social determinants of health will be crucial to getting ready for the next outbreak, Prof. Strumpf said, "it's not really obvious that we're going to be able to science our way out of the next pandemic."

*achamandy@hilltimes.com*
*The Hill Times*