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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 pandemic 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 a book titled This is Public Health: A Canadian History.

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 epidemic 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.

“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 interprovincial 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, and they tend to be faster in the Atlantic bubble,” he said.

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

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 medical 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

Continued on page 15
A quick, cost-effective way for the federal government to save lives

Time to implement front-of-pack nutrition labels

As we’ve learned from the pandemic, the best way to lessen the cost and impact of illness is to prevent it; hence masks, social distancing, working from home and the great hope for vaccines. We need to apply the same lessons to other serious health challenges. For example, eating ultra-processed packaged foods is linked to increased health risks including high blood pressure, heart disease and stroke, diabetes, obesity and cancer. In 2019, almost 26,000 deaths in Canada were attributed to unhealthy diets.

The packaged food industry has been thriving during the pandemic as we eat more comfort foods, snacks and find pleasure in the little things. Unfortunately, identifying healthy choices and comparing products in the grocery store is not an easy, straightforward task. We need simple nutritional information on the front of packaged foods. It’s one very important way we can help prevent the illness and deaths that come from unhealthy food choices.

Governments and the health system in general are rightfully focused on the pandemic. However, the federal government has the opportunity to decide whether we come out of this pandemic relatively healthier by acting on other health commitments, including nutrition labelling policies. And it won’t take much time or effort, or any money.

Healthy eating initiatives have been a pillar of this government’s public health agenda, a pillar Canadians support. Canadians recognize the importance of healthy eating policies even as the pandemic continues, with 80 per cent supporting action on nutrition policies in the next six months.[1] The federal government’s 2015 election platform, 2019 federal budget and several mandate letters from the Prime Minister to the Minister of Health committed to promoting healthy eating. Some of the promised measures have been implemented, including a ban on artificial trans fats and the introduction of a revised Food Guide. The Food Guide is a key achievement of the federal government that received much public praise. This demonstrates that nutrition measures are good policies!

However, one important outstanding commitment is requiring clear front-of-package nutrition labelling. Work on this has been underway since 2015 but Canadians have yet to see it implemented and reap the benefits. It is critical that the federal government implement the ready plans to mandate prominent nutrition labelling on packaged foods Canadians buy. It would be relatively easy and cost-effective for this government to implement as this measure has already undergone robust consultations, has received support from Canadians, and would be as simple as finishing the process for regulatory change by posting and adopting the final draft regulation.

Since Canada’s proposal was introduced in February 2018, several other countries have implemented mandatory front-of-package nutrition labelling, including one of our key trade partners, Mexico. A proposal for harmonized, mandatory front-of-package nutrition labelling is slated to launch in the European Union in 2022. If Canada does not move soon to adopt this regulation, we will fall behind other countries instead of being a leader.

This may seem like a small policy that is unimportant in the context of a global pandemic. But the costs are very high. Healthy Canadians mean a healthy economy. The economic burden of chronic diseases impacted by diet and other modifiable risk factors is $26 billion annually. Front-of-package labelling is an easy way to save $3.19 billion over 10 years in direct and indirect health costs.

So why hasn’t this regulation been finalized to support the health and well-being of Canadians? The government has faced significant pressure from the food and beverage lobby to set these regulations aside, claiming the burden of cost will be too great.

We know this isn’t true. The packaged food industry is seeing incredible profits right now as Canadians more than ever eat more of their products. But also more than ever, Canadians deserve to know and clearly understand what is in the food they purchase so they can make healthy choices for themselves and their children. This will save lives.

Doug Roth, CEO, Heart & Stroke

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[1] Heart & Stroke public opinion polling conducted by Pollara Strategic Insights with a random sample of 1,512 Canadians 18 years of age and over, conducted December 11 to 14, 2020 in an online survey. As a guideline, a probability sample of this size would yield results accurate to ±2.5%, 19 times out of 20 (95%). National data has been weighted by region, gender, and age, based on the most recent Census figures.
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.

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.

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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.

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

Ramy Elitzur

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.

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Delayed access to medical services can be life threatening.

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Scathing audit highlights PHAC failures

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

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.

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 14, 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 on March 22, 2020, 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 2018 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.

On 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.
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.

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.
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.

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

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 generally 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 research, developing 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.
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.
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 caring, 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
Health innovation is occurring at an increasingly rapid pace in Alberta and around the world, with technology leading the future of healthcare. Faced with the rising cost of acute healthcare, an aging population, and changing citizen expectations, policymakers, healthcare providers and taxpayers alike are seeking new ways to deliver services and achieve better outcomes.

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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

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 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 originated 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 the University of British Columbia.

The Hill Times
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 Merrill
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: invest in individual rights.

We have developed 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, 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 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 Merrill 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 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.

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, 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 it is a responsibility we are proud to take on. David Farrar is the president and vice-chancellor of McMaster University.

The Hill Times
We’ve changed the lives of millions of people around the world.

And now, we are about to do it again.

Nous avons changé la vie de millions de personnes dans le monde entier.

Et maintenant, nous sommes sur le point de le faire à nouveau.

Some of the world’s top scientists at Canadian Nuclear Laboratories are developing advanced life-saving treatments that harness the power of nuclear science to achieve unprecedented levels of precision in beating cancer.

Certains des meilleurs scientifiques du monde aux Laboratoires Nucléaires Canadiens développent des traitements avancés pour sauver des vies qui exploitent la puissance de la science nucléaire pour atteindre des niveaux sans précédent de précision dans la lutte contre le cancer.
What a ‘return to normalcy’ in a post-COVID world means for children

Sarah Dow-Fleisner
Opinion

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

There has been over a year since the COVID-19 pandemic changed the world. During this time, babies have been born, schools have closed, and some 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-containing future with vaccine protected holiday gatherings, hugging of loved ones, or programs that had been suspended 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 exposure to neglect, 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 at home and parenting simultaneously or having to work outside the home as an essential worker 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 access 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 conditions. 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 will all be able to reengage 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, child-care settings, or attending family gatherings.

While there is much focus on returning to normalcy, children will be supporting children who potentially have complex trauma as a result of family loss, mal-adaptive family functioning, and mental health conditions. 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 will all be able to reengage with that unsettling position.

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Window of opportunity for feds to address health-care deficits

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

That’s why now is the right time to think 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 national emergency 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: vaccine distribution, and 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 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.

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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 with which the federal government must grapple. Now is the time to activate and empower the health care workforce.

Part of the solution lies in a much greater emphasis on professional development and reskilling. 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 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.

Be patient with young children during family get-togethers (among vaccinated adults), as this may be a novel and overstimulating experience. 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 isolation may lead to children feeling overwhelmed and anxious. Accept and listen to the fears of kids who do not feel comfortable attending events with their unvaccinated classmates.

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, social distancing, handwashing, and getting the vaccine. In doing so, we can support children who are likely to possibly have some degree of immunity to the virus, and that immunity is likely to wane over time.

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

The Hill Times

Sarah Dow-Fleisner is CEO of Polytechnics Canada.

The Hill Times
Canada will need ‘intensive collaboration’ between provinces, territories, and federal government for next pandemic, say experts

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.

“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.”

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The Hill Times

Virtual Care in the Patient’s Medical Home

Virtual care connects patients with their family practices in key ways that complement in-person care and support continuity.

The College of Family Physicians of Canada calls on government leaders to:

- Enhance the integration of virtual services to strengthen primary care
- Improve access to high-speed Internet across Canada to make virtual care more available, particularly among marginalized and vulnerable populations
- Create virtual care standards and support provinces in maintaining them

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