Health

HEALTH POLICY IN THE 44TH PARLIAMENT

In-depth Policy Briefing compilation to some of the main issues of the 44th Parliament

HEALTH POLICY IN THE 44TH **PARLIAMENT**

MENTAL HEALTH

PHARMACARE

OPIOIDS

MEDICAL ASSISTANCE IN DYING

COVID & VACCINES

BIOTECH

THE HILL TIMES

Health Policy in the 44th Parliament

Health policy has topped the government's agenda in this 44th Parliament. From pharmacare to opioids, assisted dying, mental health, and biotech, you will find it all in *The Hill Times*' special ebook on health policy for this session of Parliament, featuring cross-party analysis, legislation, opinions from key decision-makers. This special ebook is a compilation of all our Health policy briefings from the past three years, and is your complete reference guide to the health policy options and political implications.

Designed by Naomi Wildeboer

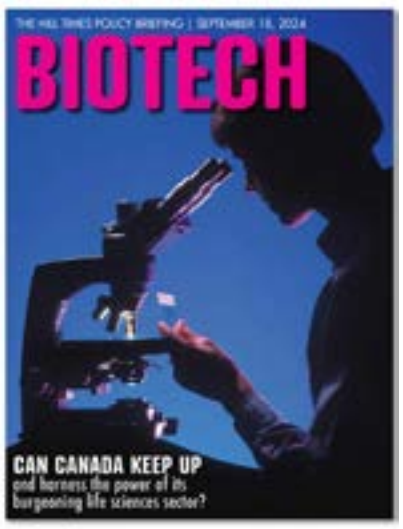

Table of Contents

MENTAL HEALTH

THE HILL TIMES
POLICY BRIEFING
OCTOBER 7, 2024

Linking affordability CRISIS AND MENTAL HEALTH REQUIRES 'TRANSFORMATIVE CHANGE' IN HEALTH CARE

Time for Canada TO TREAT MENTAL HEALTH LIKE PHYSICAL HEALTH

FEDS MUST REMOVE BARRIERS to improve access to mental health and substance use

THE KIDS are not ALRIGHT

CANADIANS' MENTAL HEALTH: LOOKING TO THE FUTURE

RAPID ACCESS TO EFFECTIVE MENTAL HEALTH CARE for youth should be national priority

PERINATAL mental health strategy CRITICAL STEP

Canada's federal Minister of Mental Health and Addictions Ya'ara Saks. *The Hill Times photograph by Andrew Meade*

Linking the affordability crisis and mental health requires 'transformative change' in health care, say critics and experts

The affordability crisis has exposed Canada's mental health-care system as being "behind a paywall," according to the Canadian Mental Health Association's Sarah Kennell.

BY JESSE CNOCKAERT

A wave of mental strain facing Canadians in response to affordability challenges—including housing and putting food on the table—requires an overhaul of the public health-care system to include mental health supports, according to the NDP mental health critic.

"Certainly, coming after COVID, it's obvious people are struggling just to make ends meet. Basic needs like food and shelter, which are creating stress for people and families, and the chronic stress that impacts people's mental health, especially young people," said NDP MP Gord Johns (Courtenay-Alberni, B.C.). "[The NDP are] going to be continuing to put pressure on the government, as we have been, but especially this fall we're going to ramp it up even more. We can't afford not to make transformative change to mental health-care in Canada, and the failure for the government to treat mental health equally to physical health under our current public health-care system has had enormous costs for Canadians."

Economic factors, such as the rising cost of living, are affecting Canadians' health, according to a report released by the Canadian Institute for Health Information on March 21, 2024. The report cited survey data gathered between Nov. 1 and Nov. 16, 2023, by Pollara Strategic Insights, which found that about 41 per cent of Canadians feel that their mental health has been negatively impacted by financial concerns.

Minister of Mental Health and Addictions Ya'ara Saks said that the 2024 federal budget's $500-million Youth Mental Health Fund will 'help fill gaps in our mental health support system and ensure young Canadians get the help they need to succeed, right in their communities,' in an April 9 press release. *The Hill TImes photograph by Andrew Meade*

NDP MP Gord Johns says he has been 'calling for the federal government repeatedly to create parity with mental and physical health.' *The Hill Times photograph by Andrew Meade*

Sarah Kennell, national director of public policy with the Canadian Mental Health Association, says the affordability crisis is creating 'a real strain on the ability of frontline community mental health and substance use health service providers to deliver on those social determinants of health.' *Photograph courtesy of the CMHA*

Allison Cowan, vice-president of external affairs and development with the Mental Health Commission of Canada, says 'as we've moved into this post-pandemic phase, not only do we have the ongoing mental health challenges persisting, but [we are] also facing increased costs of living, inflation, [and] soaring housing costs.' *Photograph courtesy of the MHCC*

Johns said that there are massive financial barriers for accessing mental health-care because mental health supports, such as counseling and psychotherapy, are excluded from this country's universal public health care system.

Canada doesn't have universal mental health care, which means some services—such as visits to registered psychotherapists or psychologists—must be paid for out of pocket.

Johns said it's long overdue for the government to bring mental health services into the public health-care system to remove the financial barriers.

Recent government-led efforts to support mental health in Canada include $500-million announced in the 2024 federal budget for a Youth Mental Health Fund so that community health groups can provide more care for youths.

Minister of Mental Health and Addictions Ya'ara Saks (York Centre, Ont.) called the fund "a once-in-a-generation investment in youth" in a Finance press release on April 9, 2024.

"This fund will help fill gaps in our mental health support system and ensure young Canadians get the help they need to succeed, right in their communities," said Saks in the press release.

Liberal MP Élisabeth Brière (Sherbrooke, Que.), Saks' parliamentary secretary, told *The Hill Times* in an emailed statement on Sept. 24 that Canadians are facing mental health challenges like never before because of the stressors of the pandemic and affordability challenges.

"We have transferred billions of dollars to the provinces and territories to support health care, including mental health care, overing coming years, through both an increase of the Canada Health Transfer, and the new ten-year bilateral agreements," said Brière in the emailed statement.

"Mental health is one of the four shared priorities in the new bilateral agreements and integrated into the other three. As a result, more than one-third of all spending in the bilateral agreements has gone to mental health and substance use services. This is in addition to the $5-billion provided to the provinces and territories, starting in 2017 to increase the availability of mental health care and substance use services."

To help address the costs of some mental health supports, the Canada Revenue Agency announced on July 15, 2024, that certain psychotherapists and counselling therapists would no longer be required to collect GST and HST on their services as of June 20, 2024.

"We'll keep working with all partners to ensure all Canadians get the mental health-care they need to thrive," said Brière in the emailed statement.

Canada is also currently facing an overdose crisis, with an average of 22 people losing their lives each day in 2023 to opioids, according to a June 28, 2024, press release from the Public Health Agency of Canada.

"There is no single solution to addressing this crisis and no organization or level of government can solve this crisis alone. Together with our partners, we must continue to look at every tool we have available to support both public health and public safety," said Saks in the press release.

Measures taken by the Liberal government have included commitment of $150-million announced in the 2024 federal budget for an Emergency Treatment Fund to help provide a rapid response to the overdose crisis.

When asked about Saks performance on the mental health portfolio, Johns referred to

Continued on page 26

Time for a shift: Canada must treat Alzheimer's like other progressive diseases

By Adam Morrison, Senior Director, Public Policy & Partnerships, **Alzheimer Society of Ontario**

Every day, more than 350 people in Canada will develop Alzheimer's disease or another form of dementia[1]. The Alzheimer Society of Canada's Landmark Study found that by the end of this decade, more than 1 million Canadians will live with this disease and by 2050, this number will surpass 1.7 million[2]. There is no denying that Alzheimer's disease is one of the most significant public health challenges of our time, but unlike other progressive conditions such as cancer, it lacks the urgency and comprehensive care it deserves.

There are many misconceptions and stereotypes that have become synonymous with Alzheimer's. When a disease this prevalent continues to be poorly understood, it creates an environment for false beliefs to spread and thrive. This means for those living with the disease, symptoms including cognitive decline and personality changes are regularly dismissed or met with uncertainty and fear – forming a culture where barriers to early diagnosis, treatment, and social support for those living with it are all too prevalent.

Through our work, we have seen firsthand how this narrative has lasting impacts on patients and their loved ones. Many feel ashamed, isolated, or hesitant to seek care until the disease has drastically progressed. Compare this with cancer, where early detection is praised, and patients from the beginning are regularly encouraged to pursue aggressive treatment options. If we want to improve the lives of those with Alzheimer's, we must actively dismantle these falsehoods, normalizing conversations about cognitive health and dementia.

Inequality in treatment approaches is evident in research funding. While Alzheimer's is the seventh-leading cause of death worldwide, it receives less than 1.5 per cent of health research funding[3]. Despite this, new and emerging treatments are shaping the future of the disease. Significant efforts by researchers and patients, including those in Canada, have led to full U.S. FDA approval of two disease modifying treatments that can slow the progression of Alzheimer's in the past year. These medications target individuals with mild cognitive impairment or mild dementia due to Alzheimer's to help slow decline[4].

With Health Canada's decision on the approval of these medications still to come, efforts to help shift the approach to Alzheimer's care must continue. This starts with ensuring that patients have equitable access to testing, community support services, and care partner support – no different than those facing other progressive conditions.

The approval of new treatments – the first in 20 years – is an important and welcomed first step in the fight against Alzheimer's. We share the excitement of hundreds of thousands of Canadians impacted by this disease as advancements help inspire hope about a new future. As these treatments move closer to approval, policymakers must take action now to prepare the health system. This includes improving access to screening and assessment in the community, diagnostic testing that includes biomarker and genetic tests, making more flexible use of existing imaging devices, and increasing the number of dementia specialists, such as neurologists and geriatricians.

Alzheimer's disease, like cancer, deserves to be treated with urgency, compassion, and comprehensive care. Changing the narrative surrounding the disease is crucial to normalizing early diagnosis and providing the resources and support necessary for both patients and care partners. We must invest more in Alzheimer's research, expand treatment options, and create healthcare models that address the full spectrum of patient needs—from early intervention to end-of-life care.

By rethinking Alzheimer's care in this way, we can give those impacted by this disease the chance to live out their life on their own accord.

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1 Alzheimer Society of Canada "Dementia numbers in Canada". Available at: https://alzheimer.ca/en/about-dementia/what-dementia/dementia-numbers-canada. Last accessed: September 2024.

2 Alzheimer Society of Canada "Navigating the Path Forward for Dementia in Canada: The Landmark Study Report #1". Available at: https://alzheimer.ca/en/research/reports-dementia/navigating-path-forward-landmark-report-1. Last accessed: September 2024.

3 World Health Organization "Launch of WHO's first blueprint for dementia research". Available at: https://www.who.int/news/item/04-10-2022-who-launches-a-blueprint-for-dementia-research. Last accessed: September 2024.

4 Alzheimer Society of Canada "Your questions, answered: what should Canadians know about lecanemab". Available at: https://alzheimer.ca/en/whats-happening/news/updated-your-questions-answered-what-should-canadians-know-about-lecanemab. Last accessed: September 2024.

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Alzheimer Society ONTARIO

Quick access to proper care for those who need it is the key to helping young people who are suffering now grow into more healthy and productive adults in the future, write Senator Stan Kutcher and Alexa Bagnell. *Image courtesy of Pixabay*

Rapid access to effective mental health care for youth should be a national priority

Instead of one-size-fits-all, we need many types of access points integrated with mental health services offering different levels of care.

ISG Senator Stanley Kutcher & Alexa Bagnell

Opinion

The mental health of young people can be categorized into one or more of four states at any point in time. These are: resting baseline; emotional distress; mental health problem; and mental disorder. The first two characterize normal everyday life with its expected existential challenges, joys and sorrows, disappointments, successes, and failures. Young people in these states do not require mental health care. They need to learn how to cope with uncertainty, fall and get up again, and how to differentiate normal negative emotions from states that may require additional assistance. The second two states are of greater concern.

For these, rapid access to effective mental health care can make all the difference for the lives of young people and their families.

Adverse life experiences such as the death of a parent or caregiver, violence in the home, bullying, serious physical illness, or the experience of a pandemic can create substantial emotional distress. These situations may challenge a young person's coping capacity. Young people may need additional personal supports—family and friends—to get through these times, but do not always require mental health care. Occasionally, care may be required if coping strategies are overcome, or social supports are inadequate. This may include mental health professionals such as counsellors, therapists, and psychologists.

Providing mental health care to those who do not require it interferes in the normal emotional, cognitive, and social development of young brains. It additionally plugs up the health-care system, increasing barriers to those who need mental health care.

Quick access to care must be available to young people whose coping capacity has been overwhelmed by mental health problems, and must be prioritized for those who have mental disorders. It is well recognized that young people may experience severe mental disorders. Over 75 per cent of these first present in youth (under 25 years of age). This includes: anorexia nervosa; bipolar disorder; schizophrenia; substance use disorder; and major depressive disorder.

Rapid access to effective treatments for youth with mental health problems depends on the availability of community-based care, such as Integrated Youth Service Hubs, or through community-based pediatricians and family physicians practicing with psychosocial support teams. But one size does not fit all. What's needed is different types of access points that are seamlessly integrated with mental health services that can provide more complex levels of care if required.

School-based care sites such as Youth Health Centers provide excellent and cost-effective access to care for youth with mental health problems who are attending school. School is where most young people can be found, and a youth health center can provide holistic health care that does not stigmatize those seeking help for a mental health problem. It's really health for all just down the hall.

Integrated youth service hubs can also provide a youth-centered community approach with walk-in access available for youth aged 12-25 years, and can help bridge the gap for culturally supportive and inclusive spaces for young people and their caregivers.

Mental disorders have a substantial negative personal, social, physical, and economic toll. Fortunately, early identification and rapid access to best available evidence-based treatments can mitigate their negative impact, improving the lives of young people and their families in both short and long terms. This is why rapid access to effective mental health care for young people is so important. In school settings, properly trained teachers can assist in early identification and referral to needed mental health care resources. Sadly, this type of support—though readily available through existing training programs—is not widely offered in Canadian schools.

Rapid access to care for youth with mental disorders must be a priority, for without that, illnesses that otherwise would have responded to treatment will not be effectively mitigated. Thus, all community access points must be seamlessly linked to specialty mental health services where providers with the necessary competencies—such as child and adolescent psychiatrists—are available.

To put it into a better-known medical context: everyone with chest pain does not need an intensive care unit, but those who do need it must be able to access it immediately.

We applaud the positive steps being made by the federal government in addressing the necessity for rapid access to mental health care for young people who require it. We support additional investments that will result in the creation of early identification capacity in the school system, and easily available access points based on need for care as well as smooth pathways to more intensive services for young people who need them.

Rapid access to effective care for those who need it is, after all, the key to helping young people who are suffering now grow into more healthy and productive adults in the future.

Stanley Kutcher is an Independent Senator representing Nova Scotia. Dr. Alexa Bagnell is the head of the child and adolescent psychiatry division at Dalhousie University, and is chief of psychiatry at IWK Health.

The Hill Times

The kids are not alright: Canada needs a youth mental health strategy

Evidence suggests the pandemic spurred a trend of declining child and youth mental health that began two decades ago, and is ongoing.

NDP MP
Gord Johns

Opinion

Since the beginning of the COVID-19 pandemic, conversations about child and youth mental health in Canada have grown louder. There is an urgent need to turn this attention into action that will improve outcomes for generations to come.

Young Canadians are growing up in challenging, uncertain times, and research paints a troubling picture of their mental wellbeing.

In 2020, nearly a quarter of hospitalizations of Canadians aged five to 24 years old were due to mental health problems, with alarming increases in hospitalizations for self-harm, eating disorders, and substance use. Evidence suggests the pandemic accelerated a trend of declining child and youth mental health in this country that began two decades prior, and remains ongoing.

Coming out of the pandemic, data show young Canadians are experiencing higher rates of depression and anxiety than adults, but are less likely to access supports. Up to 1.6 million Canadian children and youth are estimated to have a mental health disorder, while suicide and drug poisoning remain leading causes of death. The kids are not alright, and it's clear we must do more to confront the youth mental health crisis.

Some of the issues that have been identified as contributors to growing mental health challenges among young people include the lingering impacts of pandemic isolation and disruptions, increased parental stress, pervasive use of social media, the rising cost of living, climate anxiety, global conflict, and a loss of hope for their future. There is a pressing need to restore hope for Canadian youth, and ensure they have timely access to mental health supports.

During the last election campaign, the Liberals promised to ensure mental health care is treated as a full and equal part of our universal public health care system, but they have failed to deliver. Chronic underinvestment in mental health and the ongoing exclusion of community-based supports under the *Canada Health Act* have left families seeking help for their children facing limited services, long waitlists, and out of pocket costs.

Coming out of the pandemic, data show young Canadians are experiencing higher rates of depression and anxiety than adults, but are less likely to access supports, writes NDP MP Gord Johns. Image courtesy of Pixabay

As most mental health issues begin before age 18, childhood is a critical time for prevention and early intervention initiatives. While families struggle to access supports, opportunities to intervene before severe or persistent mental health issues develop are missed. The Conference Board of Canada estimates investments in children's mental health could produce $28-billion of annual savings.

While the federal government committed in the 2024 budget to invest $500-million in a new Youth Mental Health Fund, it remains to be seen if or when funding will get out the door and begin producing measurable results. The government's track record of fulfilling its commitments on mental health is concerning. For example, the government abandoned its previous promise to establish the Canada Mental Health Transfer while it spent three years developing a roadmap towards national standards for mental health and substance use services.

Further, there is a need for federal leadership that goes beyond funding. Canada needs a comprehensive plan to improve the mental health of children and youth across the country. Such a plan should be informed by the voices of young people, and include strategies to help communities deliver mental promotion initiatives, address threats to youth wellbeing, and dismantle persistent barriers and inequities in mental healthcare. A plan should also facilitate improved data collection to measure progress, ensure accountability, and guide the path forward.

Specific policy proposals that deserve the attention of policymakers this fall include calls to revisit the *Canada Health Act*'s exclusion of services like counselling and psychotherapy and efforts to make social media platforms safer for minors by design. Despite the charged political environment in Ottawa, I hope Members will find ways to work collaboratively and deliver positive change. Canadian youth and families are counting on us.

NDP MP Gord Johns (Courtenay-Alberni, B.C.) is his party's critic for mental health and harm reduction.

The Hill Times

Time for Canada to treat mental health like physical health

All of us know someone who has suffered mental health problems, and who had trouble finding help. We must do better. It's time to do it.

CSG Senator Sharon Burey

Opinion

In my decades as a practising pediatrician, I have seen a heart-breaking and frustrating scenario play out far too often: a frantic parent comes into my office with their child facing a mental health crisis. Perhaps it's anxiety, or severe depression. The young person may be contemplating suicide. But I saw first-hand the difference in access, wait-times, and available acute and community mental health care, and the sometimes-devastating impact on children and families.

If the child had a broken leg or a cancer diagnosis, they would get care immediately. That is what we rightly demand of our health system. Not so if it is a mental health issue, even if a life is at imminent risk.

We have come a long way in acknowledging the importance of mental health. But the stubborn fact remains: the outcomes that all of us desire—universal and equitable access to mental health and addiction services, evidence-based treatment and support in the community, and better recovery outcomes—are increasingly out of reach.

Canada is in desperate need of an attitude shift, a reorganization of priorities. It can start with a concept called "mental health parity" or "parity of esteem." Already adopted in various forms in the United States and the United Kingdom, it is a recognition that people who suffer from mental health problems—including substance abuse—should receive the same level of care as people with physical ailments.

Several mental health organizations have been advocating for years for parity of esteem. It is time that it get on the agenda of governments.

That's why I hosted a roundtable called "Mental Health, Substance Abuse and Addiction Parity Across the Lifespan" on Sept. 20 in Ottawa. I invited legislators and ministers, eminent medical professionals, mental health organizations and policy experts, but—most importantly—individuals with lived experience in mental health.

A report from the Mental Health Commission of Canada found that the annual direct and indirect costs associated with mental illness reached approximately $90-billion in 2021. Over the next 30 years, the cumulative economic impact of these costs is expected to exceed $2.53-trillion, writes Senator Sharon Burey, who is also a paediatrician. *Image courtesy of Pixabay*

They spoke passionately about the many challenges and barriers to accessing mental health care in Canada, and about the costs, both human and economic. And about the importance of seeking parity. Their comments and insights represent just the beginning. It is my intention to produce a paper summarizing the discussion and areas where there is agreement on actions to prioritize, and to act on them.

I have also given notice that I will use a Senate inquiry to call attention to this issue in the Red Chamber. An inquiry is a way of allowing Senators to exchange views about an issue, calling upon their considerable expertise in health care, policy design, the economy, legal affairs, and business to help develop a wholistic approach to the pursuit of mental health parity.

Ultimately, I hope to spark legislation that will make mental health parity a requirement. Recognizing that health-care delivery is largely within provincial and territorial jurisdiction, any federal legislation would have to do be done in consultation with provinces, territories, Indigenous governing bodies and build on the principles of shared priorities and agreements.

It will be difficult, but it is necessary. Our continued neglect of mental health care comes with a steep economic and human cost.

A report from the Mental Health Commission of Canada found that the annual direct and indirect costs associated with mental illness reached approximately $90-billion in 2021. Over the next 30 years, the cumulative economic impact of these costs is expected to exceed $2.53-trillion. Moreover, a submission by the Canadian Mental Health Association notes that "every dollar spent in mental health returns $4 to $10 to the economy."

Meanwhile, the number of people living with mental illness in Canada is expected to grow to almost nine million within a generation. By 2050, one in two Canadians will have had a mental health problem before their 40th birthday.

The federal government has recognized the need to act, but it has so far fallen short in delivering those funds they had pledged. The Youth Mental Health Fund announced in budget 2024 was a good start, but $500-million over five years isn't close to what is needed.

I hope the roundtable and Senate inquiry will start to develop a strong consensus on how to make mental health parity a reality.

All of us know someone who has suffered mental health problems and who had trouble finding help. We must do better. It's time to do it.

Ontario Senator Sharon Burey is a pediatrician who has dedicated her career to children's mental health, equity, and social justice. She is a member of the Canadian Senators Group.

The Hill Times

Mental Health Policy Briefing

National Summit on Indigenous Mental Wellness: moving beyond gestures to real action

If we're truly committed to advancing reconciliation, supporting Indigenous workers, and building a robust economy, reinstating Canadian Certified Counsellors in the NIHB program in unregulated provinces is key.

Anangkwe Charity Fleming

Opinion

I was honoured to attend the National Summit on Indigenous Mental Health in October 2023, hosted by Indigenous Services Minister Patty Hajdu, and Minister of Mental Health Minister Ya'ara Saks. However, a critical question lingers one year later: is this event a genuine effort to address Indigenous mental health needs, or merely another performative gesture that ultimately harms Indigenous Peoples?

Gathering with Indigenous leaders, workforce, elders, and youth to honour our heritage and discuss mental health needs across Turtle Island was enriching. Yet, after voicing our concerns, we are left wondering: will these needs be prioritized in federal policy and budgets? For Indigenous workforce members like me, the silence that follows such discussions can be deafening.

I am the Indigenous-relations lead of the Canadian Counselling and Psychotherapy Association (CCPA), which includes over 15,000 members and a strong Indigenous circle chapter. Our members provide grassroots, innovative, and Indigenous-specific mental health care nationwide.

For decades, Indigenous Peoples have shared lived experiences illustrating how historical trauma continues to burden our communities. The summit highlighted these persistent challenges: alarming rates of suicide, homicide, and overdoses, alongside mental health needs such as anxiety and depression, and hospitalization for acute mental illness that are twice the national average. These numbers reflect the ongoing suffering that perpetuates disparity.

My own family history reflects these deep-rooted traumas. My great uncle died shortly after escaping residential school, and the scars from my grandparents' experiences at McIntosh Residential School affect my family today. My mother and her siblings were part of the Sixties Scoop, and my auntie was a missing Indigenous woman who was later found dead. Mental health struggles, PTSD, addiction, and suicide have devastated my family and community.

Despite decades of calls for change, I wonder: should we embrace hopelessness just to cope?

While the summit inspired hope, it also evoked a sense of urgency. A key issue I raised was the critical need to reinstate Canadian Certified Counsellors (CCCs) under the Non-Insured Health Benefits (NIHB) program in unregulated provinces. Provinces that have yet to regulate the counselling/counselling therapy/psychotherapy professions include Alberta, Manitoba, Saskatchewan, and Newfoundland and Labrador.

In 2015, the NIHB program quietly delisted CCCs—qualified, master's degree-trained professionals, many of whom are Indigenous women serving their communities. The CCC designation certifies psychotherapists and counsellors, regardless of whether a province has regulatory legislation or a professional regulatory body, which is about half of the provinces across Canada. Ironically, this exclusion occurred as the Truth and Reconciliation Commission's Calls to Action were being released. This decision has contributed to workforce burnout, and has forced skilled professionals into lower-paying positions, despite their qualifications.

The exclusion seems particularly unjust considering the Public Service Health Care Plan and Veterans Affairs Canada include CCCs as approved providers. Additionally, British Columbia's First Nations Health Authority recognizes CCCs in its mental health program, previously part of NIHB. Why don't First Nations and Inuit under NIHB receive the same access to health care as non-Indigenous People across Canada and Indigenous Peoples in British Columbia? Have we made this issue visible enough?

The CCPA has long advocated for reform of the NIHB program. We presented to the House Indigenous and Northern Affairs Committee in May 2022, which lead to a recommendation for the "immediate reinstatement" of CCCs in INAN's December 2022 report. Our advocacy has continued at national summits and the Assembly of First Nations dialogue sessions, most recently in October 2023. The AFN made a formal recommendation in support of reinstating CCCs in their summary report. Influential voices, including Senator Mary Jane McCallum, echoed our call: CCCs must be reinstated in unregulated provinces without delay.

Reinstating CCCs is not just a health issue, it's also an economic one. Doing so could enable approximately 2,000 CCCs to serve an estimated 140,000 more Indigenous people annually, strengthening the Indigenous workforce, and fostering sustainable, community-driven solutions. This aligns with this year's Mental Illness Awareness Week theme—Access for All: Time for Action, Time for Change—providing a clear opportunity to promote both health equity and economic growth.

If we are truly committed to advancing reconciliation, supporting Indigenous workers, and building a robust economy, reinstating CCCs in the NIHB program in unregulated provinces is essential. I urge policymakers to act now—to reinstate CCCs in unregulated provinces to the list of NIHB approved service providers and take meaningful steps to improve health outcomes for Indigenous peoples across Canada.

Anangkwe Charity Fleming is Anishinaabe from Treaty 3, and CCPAs lead on Indigenous Relations. Anangkwe also co-owns five mental health clinics, and teaches Indigenous adapted mental health courses at both Wilfrid Laurier and McMaster universities.

The Hill Times

Looking to the future of Canadians' mental health

As meagre as funding has been for health research in general, the situation for research into mental health is much worse.

Hymie Anisman

Opinion

Mental illnesses have been a scourge that affects all segments of society with the incidence of various disorders increasing progressively over the past 30 years. Regrettably, treatments for these illnesses have been only moderately effective. The importance of dealing with these conditions not only stems from their devastating direct effects—undermining quality of life—but they may also presage physical illnesses, including Type 2 diabetes and heart disease that share several underlying processes.

Conditions such as depression, anxiety disorders, schizophrenia, and developmental disorders account for approximately 30 per cent of the non-fatal disease burden. The frequency of such disorders has typically been estimated to be about 20 per cent, but may be appreciably greater since many people fail to seek help owing to the stigma associated with being labeled as suffering 'mental problems', and consequently they remain in the shadows.

When they do look for help, affected individuals frequently encounter diverse problems. People with serious physical illnesses already experience long delays in obtaining therapies, and it is no better for patients seeking psychiatric help, who have to routinely wait for more than a year. Outside of hospitals, medications are often not part of our health care system, but hopefully, this will change. The passage of Bill C-64, the Pharmacare Act, may improve patients' ability to afford medications.

Compounding the problems in receiving adequate care, funds for research to determine the processes that underly mental illnesses, as well as prophylactic and therapeutic strategies to deal with them, have been woefully inadequate and have worsened over the past two decades. On a per capita basis, health-related research funding in Canada is far behind that of most of the G7 countries, as well as Israel, South Korea, and China.

Funding for research through the Canadian Institutes of Health Research has increased marginally since 2000, and success rates of grant applications has fallen from 31 per cent in 2005 to less than 15 per cent since 2018. Thus, many promising research programs go unsupported, and overall funding is far too low to sustain a vibrant and productive research environment. The Natural Science and Engineering Research Council has similarly become less generous to health-related research. Moreover, studentships and scholarships devoted to training new scientists have been inadequate, so there will be a dearth of next-generation researchers engaged in health-related issues.

As meagre as funding has been for health research in general, the situation for research related to mental health is considerably worse. Private foundations exist that support research for cancer, heart disease, Parkinson's and Alzheimer's disease, and varied immune-related disorders. In contrast, private funding for mental illnesses is not as readily available. It has been said that mental illness is the orphan of the medical establishment, and funding for research related to mental illnesses is the orphan's orphan.

As dismaying as the picture may be, it is even more disturbing among Indigenous Peoples. The history of abuse and neglect, the impact of poverty, and limited availability of medical care, access to healthy foods on Northern reserves, together with overcrowding and the presence of poor air quality in homes, as well as other stressors, have taken a toll on their physical and mental health. Moreover, there is a strong possibility that these impacts are transmitted across generations.

The Royal Society of Canada, together with several partners, provided a series of actionable recommendations that encompass governance/stewardship, financing, capacity building, as well as research, which could enhance Canada's health research system. These recommendations address many of the systemic shortcomings that were mentioned earlier. Importantly, tackling the ongoing health crisis requires increased spending so that enough health facilities are established, and a greater number of physicians and health researchers are available. It is often assumed that we're dealing with a zero-sum game in which increased spending on health research and health care means that cuts are necessary for other important endeavours. Yet, the World Health Organization has made the very salient point that for every dollar invested in scaling up treatments for mental illnesses, a fourfold return on investment is realized. Mental health is an issue that directly or indirectly affects most Canadians and it's time that a more proactive approach be adopted by federal and provincial governments.

Dr. Hymie Anisman is a professor in the department of neuroscience at Carleton University in Ottawa.

The Hill Times

Mental health funding must keep pace with the growing demand for accessible and inclusive mental health supports for youth

When we invest in youth, we are ensuring that that they can grow into the leaders of tomorrow, supported and empowered to thrive.

Liberal MP Élisabeth Brière

Opinion

The impact of the COVID-19 pandemic has also had a profound effect on youth mental health, writes Liberal MP Élisabeth Brière. *Image courtesy of Pixabay*

Young people today are facing new realities in a changing and complex world.

From the climate crisis, to the traumas of global conflicts and the stressors of a life where it is hard to disconnect, children and youth are facing increased mental health issues like never before.

The impact of the COVID-19 pandemic has also had a profound effect on youth mental health. We also know that teenage girls, in particular, are facing significant challenges, with one-third of girls aged 16 to 21 reporting a decline in their mental health since 2019. Many of us have seen first-hand the many challenges that our kids are confronting as they deal with shifting realities.

The need to overcome existing barriers to better mental health of youth must be one of our main priorities. As leaders, as parents, as communities, we must ensure our youth have the tools they need to thrive.

Mental health funding must keep pace with the growing demand for accessible and inclusive mental health supports for youth. We know that youth mental health is declining, and services are not as comprehensive as they should be. The time to act and meaningfully address these issues is now and is a top priority.

To meet the challenges of the moment, as well as a platform commitment in the last election, we announced a generational investment of $500-million to create a Youth Mental Health Fund.

Together, we can make sure young people can access the mental health care they need by the organizations and service providers they trust the most.

Investing in the mental health of young people is an investment in our collective future. It is not a choice but a necessity. And the time for action is now.

Accessing the health-care system can be stressful and confusing. This is one of the major challenges to care. A challenge we wanted to address head on.

In partnership with provinces and territories and community organizations we saw that providing a "one-stop-shop" would be the key to resolving this challenge. Through the Integrated Youth Services model, we can simplify access to care and streamline services through a hub that serves as community safe havens for youth.

Last year we also launched, 9-8-8, Canada's National Suicide Crisis Helpline. We made trauma-informed help readily available, 24/7, recognizing that in a moment of crisis people need to know where they can turn to.

These initiatives are not just investments to address the mental health of young people but are crucial in building the resilient communities of the future. When we invest in youth, we are ensuring that that they can grow into the leaders of tomorrow, supported and empowered to thrive.

While there is still more work to be done, with a dedicated focus, we can turn the tide on this crisis and ensure a brighter tomorrow for all young Canadians. The kids may not be alright—but if we all work together, they can be.

Liberal MP Élisabeth Brière, who represents Sherbrooke, Que., is the parliamentary secretary to the minister of mental health and addictions and to the minister of families, children and social development.

The Hill Times

Perinatal mental health strategy is a critical step

Let's commit to women's mental health, and invest in the future of Canadians.

Patricia Tomasi

Opinion

What's it like to experience postpartum psychosis? In my case, it was life altering.

I lost my house, my career, and my sanity. Not to mention what it did to my marriage and my kids. But I'm still here. I survived. Unfortunately, the same can't be said for other mothers across Canada, like Flora Babkhani.

Babkhani was a thriving single mom by choice who gave birth to Amber on Nov. 4, 2021, in a Toronto hospital. Just two months later, she was gone. Babkhani tragically lost her life due to a condition that's been studied since the 1800s, yet isn't recognized as a distinct disorder in the Diagnostic and Statistical Manual of Mental Disorders.

I only learned about Babkhani's story through a friend of a friend. In Canada, we don't keep track of mothers who have died due to perinatal mental illness even though worldwide statistics tell us that suicide is the fourth leading cause of maternal death.

Every year, hundreds of thousands of women give birth in Canada, and tens of thousands of those women—80,000 in fact—will develop a perinatal mental illness of which postpartum psychosis is the most severe. The rate is upwards of 20 per cent for depression and anxiety, and higher for BIPOC, disabled, and LGBTQ+ women, men, partners, and birthing persons.

Perinatal mental illness is the most common complication of pregnancy and postpartum. It's more common than gestational diabetes, and yet we still don't have a National Perinatal Mental Health Strategy to make sure every single Canadian woman and birthing person is properly screened.

If we're truly invested in solving the mental health crisis in Canada, we should be investing in perinatal mental health care. Because that's where the path to mental health well-being for all of us truly begins: before birth. Infants and children of parents with untreated perinatal mental illness are a higher risk of developing mental illness in adulthood.

Once the Health Canada-funded, Canadian Network for Mood and Anxiety Treatments 2024 Clinical Practice Guideline for the Treatment of Perinatal Mood, Anxiety and Related Disorders guidelines are released, we want the federal government to invest in a national strategy to ensure the guidelines are properly implemented and followed.

I co-founded the Canadian Perinatal Mental Health Collaborative in 2019. Along with countless advocates, we're working to improve perinatal mental health care across the country. Since then, we've had a meeting with Prime Minister Justin Trudeau where he promised to deliver timely access to perinatal mental health services in his mandate letter to the minister of mental health and addictions. We believe a national strategy is the best way to deliver on this promise.

We don't want what happened to Babkhani to ever happen again. Sadly, this past year, we learned about the death of Renée Ferguson in Regina who had been struggling with postpartum anxiety and depression.

The government has a chance to bring Canada on par with other countries such as the United Kingdom, Australia, and the United States, which all have adopted national legislation and a national perinatal mental health strategy, and invested millions of dollars in perinatal mental health care. Don't families deserve to have the same in Canada?

Let's commit to women's mental health, and invest in the future of Canadians. Let's see legislation committing to a National Perinatal Mental Health Strategy happen as soon as possible so we can start saving lives. Let's all work together to make sure what happened to Babkhani and Ferguson—and all the mothers we have yet to hear about through the grapevine—never happens again.

Patricia Tomasi is executive director of the Canadian Perinatal Mental Health Collaborative.

The Hill Times

Minister of Mental Health and Addictions Ya'ara Saks, pictured on July 26, 2023. Instead of funding a Canada Mental Health Transfer as was committed in the minister for mental health and addictions' mandate letter, the federal government negotiated 10-year bilateral deals with each province and territory, writes S.M. Leduc. *The Hill Times photograph by Andrew Meade*

Fact check: 2023 bilateral investments in mental health care less than half of what feds claim

Too often, governments use rote messaging about money as a cudgel to shut down innovations that the mental health sector can offer.

S.M. Leduc

Opinion

Attempting to understand federal funding for mental health care is a rather opaque exercise. Instead of funding a Canada Mental Health Transfer as was committed in the minister for mental health and addictions' mandate letter, the federal government negotiated 10-year bilateral deals with each province and territory last February towards meeting the mental health-care needs of Canadians.

The 2023 bilats add a level of budgeting bewilderment: they stir together existing expenditures alongside newly committed investments. This is clear as mud since the federal government claims, on average, that more than 30 per cent of bilateral funding is dedicated to mental health initiatives.

The 30 per cent figure could be considered misleading.

In a report released this week by the Canadian Mental Health Association, a deeper analysis of the bilats reveals that, in fact, the average percentage of new federal money going to mental health care is only 15 per cent, with Yukon spending approximately 66 per cent and acting as a significant outlier, raising the average. Manitoba, Prince Edward Island, and British Columbia are not using any new bilateral dollars for mental health services.

Therefore, the government is spending less than half of what it claims, at least in terms of new dollars.

This isn't a case of being pedantic about numbers. In the face of a mounting mental health and addictions crisis in our country, understanding the difference between repackaging existing expenditures versus making new investments matters. It's through these numbers that we can hold the government accountable for its commitments.

Let me clarify: The government had already gone down the road of signing health bilats back in 2017 with about $500-million annually for 10 years set aside for mental health. When the pandemic battered Canadians' mental health, the Liberals recognized a need to act, and during the 2021 election they promised—in addition to the existing 2017 bilat dollars—a new permanent funding transfer specifically for mental health care.

> "Bilateral agreements are not adequately serious mechanisms for confronting the urgency of an unrelenting toxic drug crisis, prolonged wait-times for mental health services, and the normalization of suicide in the North.

That promise, however, never materialized.

Amid mounting pressure from the premiers about cost-sharing for public health care, the federal government did an about-face on permanent funding in 2023. Instead, the premiers were offered the remainder of the 2017 bilat dollars and another 10-year funding pocket for mental health and other emerging health priority areas.

In the end, what should have been a permanent $2.5-billion annual investment for mental health and addictions health care turned into an annual spend of $901-million. When the 2017 bilats expire in three years, that annual amount is further reduced to a mere $301-million.

The government repackaged existing funding for mental health care, and did not clearly communicate how much funding was new. As a result, policy decision-makers—and the voting public—could not determine whether need was being sufficiently addressed.

Mental health sector stakeholders know that the government is failing Canadians, and they know why. It's because federal health legislation only funds the provinces and territories for medically necessary services, leaving many mental health services outside the scope. But when stakeholders tell this to the government, the response is a fixation on funding. And even that funding is being misrepresented.

Investments alone are not a solution to our mental health crisis. And yet, too often, governments use rote messaging about money as a cudgel to shut down innovations that the mental health sector can offer.

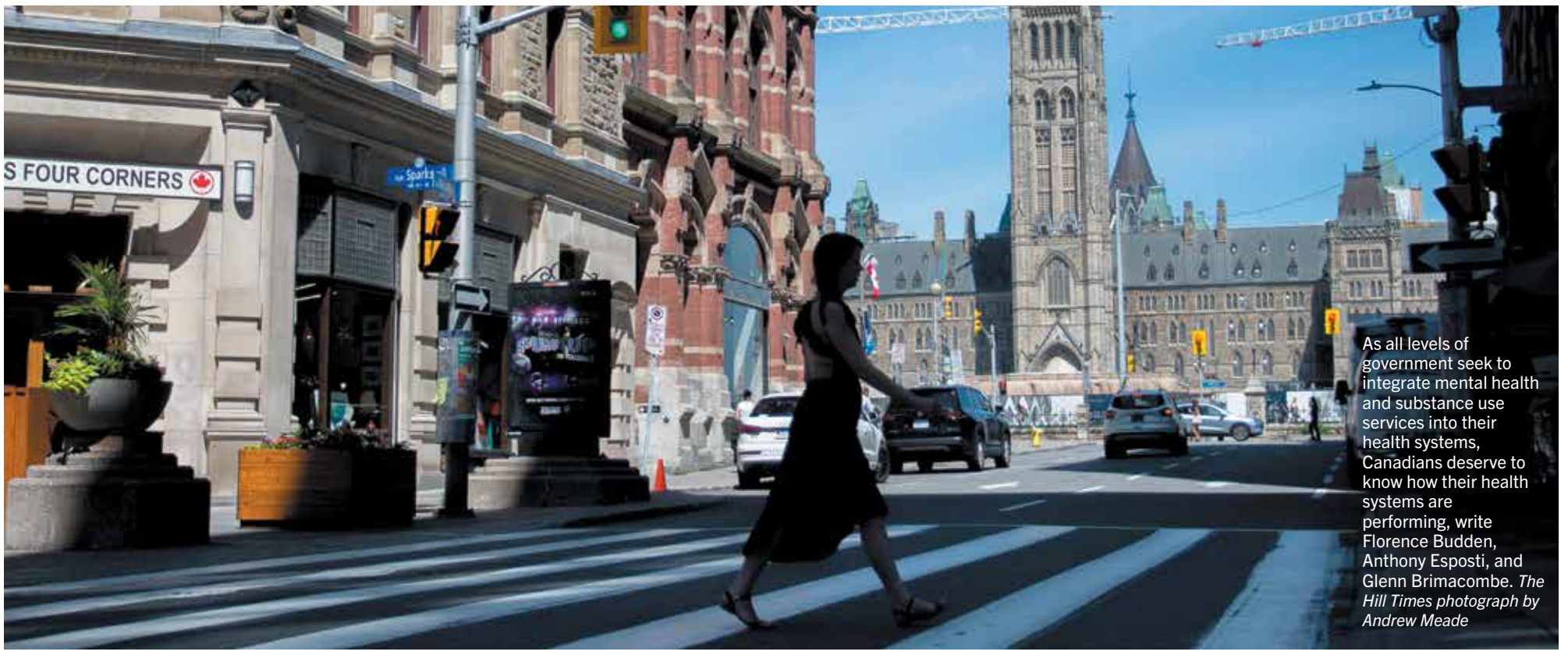
It is questionable whether bilateral agreements are an effective policy tool for meeting the mental healthcare needs of Canadians, so it's perplexing why the government keeps returning to them.

Bilateral agreements are not adequately serious mechanisms for confronting the urgency of an unrelenting toxic drug crisis, prolonged wait times for mental health services, and the normalization of suicide in the North. These agreements are vulnerable to political shifts because they are short term, and, therefore, contribute to the instability routinely encountered by the mental health sector.

The federal government must think differently about how it invests in mental health care. Instead of an approach that perpetuates pilot projects, the government needs to examine legislative levers—such as amending the Canada Health Act—that would sustain investments and the delivery of mental health care by the provinces. Because ultimately, while money may talk, it doesn't always tell the whole story.

S.M. Leduc is the national government relations adviser for the Canadian Mental Health Association, the most extensive frontline provider of community mental health services in Canada. She is the author of a new report titled Overpromised, Underdelivered: Analysis of Federal Mental Health Care Investments in the 2023 Working Together Health Bilateral Agreements.

The Hill Times



As all levels of government seek to integrate mental health and substance use services into their health systems, Canadians deserve to know how their health systems are performing, write Florence Budden, Anthony Esposti, and Glenn Brimacombe. *The Hill Times photograph by Andrew Meade*

Governments must remove barriers to improve access to mental health and substance use services

Now is the time to take action to support the mental and substance use health of Canadians.

Florence Budden, Anthony Esposti & Glenn Brimacombe

Opinion

Governments across Canada are falling short in their obligation to provide timely access to mental health and substance use services, leaving many Canadians without the care they desperately need.

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) has found that federal and provincial government efforts to address this longstanding issue are inadequate with both levels of government receiving failing grades in CAMIMH's second annual report card.

Mental health and substance use health issues affect one in five Canadians each year, yet access to timely and effective care remains a significant challenge. Despite the federal government's initiatives—including the $500-million Youth Mental Health Fund and the removal of GST from counselling and psychotherapy services—these measures have proven insufficient. The long-promised Canada Mental Health Transfer, valued at $4.6-billion over five years, has yet to be delivered, further exacerbating the crisis. Moreover, the federal government's decision to collapse the Wellness Together Canada portal, which provided crucial mental health supports during the pandemic, has left a void in the availability of accessible services.

Canadians overwhelmingly recognize the need for better access to mental health care. CAMIMH's findings reveal that 90 per cent of Canadians believe timely access to publicly funded mental health resources is important, and 83 per cent agree that provincial governments should hire more mental health care providers. Yet, despite this high degree of public consensus, these views have not translated into meaningful government action.

The patchwork approach currently adopted by governments is not only inadequate, but also harmful. Mental health care must be treated with the same urgency and priority as physical health care. CAMIMH and other organizations across Canada continue to advocate for a Mental Health and Substance Use Health Care For All Parity Act, proposed federal legislation that would enshrine the importance of timely, inclusive, and accessible mental health and substance use health care in law. This act would establish clear objectives and standards for provinces and territories, while ensuring that mental and substance use health care receives the sustained investment it requires.

The need for increased investment is clear. The federal government has allocated an additional $25-billion over the next 10 years to the provinces and territories to advance shared health priorities, including mental health and substance use health. However, only an average of 16 per cent of these new federal funds are being directed toward mental health and substance use services—a figure that falls far short of what is needed.

These low levels of investment are tangible evidence that mental health and substance use health care is not being treated with the seriousness it deserves by Canadian policymakers. Without significant, targeted funding, the gaps in mental health and substance use health services will continue to grow, leaving more Canadians without the support they need.

Transparency is another critical issue. As all levels of government seek to integrate mental health and substance use health programs into their health systems, Canadians deserve to know how their health systems are performing. The Canadian Institute for Health Information (CIHI) provides a publicly available database showing how health systems are managed, measured, and monitored. However, CIHI's mental health and substance use health indicators and expenditure data is currently limited; in the former, mostly coming from hospitals and physicians rather than the community, and in the latter, not accounting for the private sector or out-of-pocket payments. This lack of comprehensive data hinders Canadians' ability to understand how effectively their mental health systems are functioning.

To address this, CIHI needs the resources to collaborate with provincial and territorial governments to develop a national database that includes public, community-based, and private health expenditure data, along with comprehensive performance indicators. This would provide Canadians with the transparency they deserve, and hold governments accountable for the mental health and substance use health services they provide.

The urgency of the mental health crisis in this country cannot be overstated. Governments at all levels must take immediate action to remove the barriers to accessing mental health and substance use health services. Mental health and substance use health is health and treating it as anything less is not an option. The time for talk is over: Canadians need and deserve real, sustained action to ensure that mental health and substance use health care is accessible to all.

As a coalition of 18 groups representing individuals with lived and living experience, their families and caregivers, as well as health care providers, CAMIMH is committed to collaborating with all levels of government, employers, and other stakeholders to make meaningful progress on these issues.

Florence Budden is co-chair of CAMIMH, and represents the Canadian Federation of Mental Health Nurses. Anthony Esposti is co-chair of CAMIMH, and CEO of Community Addictions Peer Support Association. Glenn Brimacombe is the chair of CAMIMH's Public Affairs Committee, and is the director of policy and public affairs at the Canadian Psychological Association.

The Hill Times

Linking the affordability crisis and mental health requires 'transformative change' in health care, say critics and experts

Continued from page 16

Liberal government measures as a "piecemeal approach."

"I've been calling for the federal government repeatedly to create parity with mental and physical health," said Johns. "We've been calling on her to do that. I wouldn't just put it on her. I'd put it on the prime minister and the whole cabinet. They're not treating the mental health crisis or the toxic drug crisis like the emergency that it is."

Sarah Kennell, national director of public policy with the Canadian Mental Health Association (CMHA), told *The Hill Times* that social and economic status play a major role in determining health outcomes, even if the patient has access to the best of physical care and mental health supports. Non-medical factors—such as income, unemployment, and job security, food security, and housing—account for between 30 to 55 per cent of health outcomes, according to the World Health Organization.

"What we're seeing right now, in terms of the impact of the affordability crisis, is a real strain on the ability of front-line community mental health and substance use health service providers to deliver on those social determinants of health," said Kennell. "When we don't have access to housing supply, affordable rental units, [and] when income supports delivered through provincial and territorial sources are not keeping up with inflation, it really hampers the ability of our frontline staff to keep people well and get them towards a place of long-term recovery."

Kennell said that the current affordability crisis is placing strain on Canadians' mental health almost as high as what was experienced during the pandemic. To help address the demands placed on mental healthcare, Kennell argued the federal government should reopen the Canada Health Act "with a view to explicitly include community-delivered mental health and substance use health services." Besides counselling and psychotherapy, other services that fall outside of the Canada Health Act include eating disorder treatments and addiction treatments, she said.

"The current affordability crisis is really exposing, once again, the fact that our mental health system is behind a paywall," she said. "It's about really fundamentally changing the way we view mental health services and putting them on par with physical health services, which would go a long way to making them affordable and accessible for people as part of our public, universal healthcare system."

Kennell said that the CMHA is currently preparing a report on the state of mental health in Canada, which will look at factors such as poverty, employment, and housing. The report is expected to be released in November, she said.

Allison Cowan, vice-president of external affairs and development with the Mental Health Commission of Canada (MHCC), told *The Hill Times* that the link between mental health and financial health is undeniable, and "we're seeing this play out in real time across Canada."

"As we've moved into this post-pandemic phase, not only do we have the ongoing mental health challenges persisting, but [we are] also facing increased costs of living, inflation, [and] soaring housing costs. Really, underlying this reality is a financial strain that can chip away at our resilience," said Cowan. "It's truly a cycle—that financial stress can lead to mental health challenges, which in turn can really make it harder to maintain employment, manage finances effectively, and really have overall mental well-being."

The MHCC released a policy brief discussing mental health and high living costs on Feb. 13, 2024. The commission argued in the brief that high inflation has made it more difficult for many households to meet their financial needs, and poverty and low-income puts people at a greater risk for mental illness, worsen existing mental health concerns, and creates significant barriers to accessing services and supports. Food insecurity has also become a nationwide problem, with about 5.8 million Canadians across 10 provinces living in food-insecure households in 2021, according to the brief.

To address the mental challenges associated with affordability concerns, the MHCC recommendations in the brief include strengthening the full range of income and benefit supports for people living in Canada, monitoring their associated impacts on mental health, and providing new National Housing Strategy funding for Housing First and supportive housing programs for people living with mental health concerns.

"We need to tackle not just housing, not just food, not just poverty, [and] not just mental health. It's all connected, and everyone's experience is unique. Individual experiences are shaped by factors like race, gender, sexual orientation, physical health and disability. Solutions need to consider the whole person, and the policies and support systems need to work for everyone, especially those of who are vulnerable and facing multiple barriers due to who they are, [and] where they come from," said Cowan. "One of the areas that the Mental Health Commission is working to address gaps in the system is really advocating for more accessible and affordable mental health care options for everyone in Canada."

Nicole Racine, a clinical psychologist and assistant professor in the School of Psychology at the University of Ottawa, told *The Hill Times* that the current housing and affordability crisis will undoubtedly have implications for mental health.

"We know from other research we've done also that experiencing disruptions in income, and basically the stress that people experience when they can't afford simple things like housing [and] groceries … is a real catalyst for mental health concerns like anxiety, [and] like depression," she said. "Increases in pricing and decreasing in housing—when you're living below the poverty line—has an even more substantial impact to the point where there are families who are homeless and they can't engage in addiction services, addressing their trauma, [or] trying to promote child development if they're unhoused and if they actually can't feed their families."

Racine suggested this situation could be helped by the federal government "strengthening the full range of benefit supports" which includes housing paid for by the government.

"The percentage of individuals every night who can't even get shelter is jarring, and so, those are individuals who will certainly have mental health difficulties, and then those show up in our communities and in our emergency departments seeking services when so many of those things could be alleviated by stable housing and income support," she said.

The affordability crisis has only added to the strain on mental health that already existed because of the COVID-19 pandemic, according to Racine.

"I think we're seeing perhaps some gradual declines [in strains on mental health], but on the whole we haven't gone back to pre-pandemic levels," she said. "It just means that when we're faced with these additional stressors, we're already in a place that's more precarious than we were before. I think sometimes people forget that for children and youth mental health, we had a crisis on our hands before the pandemic happened. We already had wait lists that, in some places in Ontario, had an upward limit of two years, where only one in four kids who needed mental health support actually got it. And then we layered on the pandemic. We've layered on the affordability crisis."

During the pandemic, about 61.8 per cent of sexual and gender diverse (SGD) youths experienced clinically elevated levels of depression, 55.4 per cent had clinically elevated anxiety levels, and 50.9 per cent contemplated suicide, according to a study released on June 24, which was conducted by Racine in collaboration with Ian Colman, a professor in the School of Epidemiology and Public Health at the University of Ottawa, along with students and trainees.

These rates are nearly twice as high as those reported for non-SGD youth during the same period, according to the report.

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The Hill Times

Mental Health Statistics:

- In 2022, more than five million people in Canada met the diagnostic criteria for a mood, anxiety, or substance use disorder with the prevalence of mood and anxiety disorders increasing substantially over the previous 10 years
- The proportion of Canadians aged 15 years and older with a generalized anxiety disorder doubled from 2012 to 2022, from 2.6 per cent to 5.2 per cent. Similar increases were seen for the 12-month prevalence of major depressive episodes, up from 4.7 per cent in 2012 to 7.6 per cent in 2022, and of bipolar disorders, which went from 1.5 per cent to 2.1 per cent over the same period.
- According to the 2022 Mental Health and Access to Care Survey, among the 18.3 per cent of Canadians aged 15 years and older who met diagnostic criteria for a mood, anxiety or substance use disorder in the 12 months before the survey, about half (48.8 per cent) reported that they had talked to a health professional about their mental health in the past year.
- People who met diagnostic criteria for a mood, anxiety or substance use disorder were more likely to report having received counselling (43.8 per cent), than medication (36.5 per cent) or information (32 per cent) for their mental health.

Source: Mental Health of Canadians—it matters*, released by Statistics Canada on Oct. 10, 2023*

Housing affordability statistics

- The share of households living in unaffordable housing—defined as spending 30 per cent or more of their income on shelter costs—was 22 per cent in 2022, virtually the same as it was in 2018 (21.5 per cent), before the COVID-19 pandemic
- In 2022, renters (33 per cent) were more than twice as likely to spend 30 per cent or more of their income on shelter costs than owners (16.1 per cent), a gap that has persisted over time.
- From 2018 to 2022, shelter costs increased nationally by 20.6 per cent. Against this backdrop, a larger share of Canadians were dissatisfied with the affordability of their housing in 2022 than in 2018.
- In 2022, 14.5 per cent of households were dissatisfied with the affordability of their housing, marking a 3.4 percentage-point increase from 2018 (11.1 per cent). Renters (20.8 per cent) were more likely to be dissatisfied with the affordability of their housing than owners (11.2 per cent) in 2022, but the rates of both groups grew by more than 3.0 percentage points since 2018.
- Households felt the pressure on their overall household budget in 2022, because of an overall rise in shelter costs, as well as price increases for other items that make up the Consumer Price Index, such as gasoline (+34 per cent since 2018) and food (+22.7 per cent since 2018)

Source: Housing affordability in Canada, 2022, released by Statistics Canada on Sept. 10, 2024.

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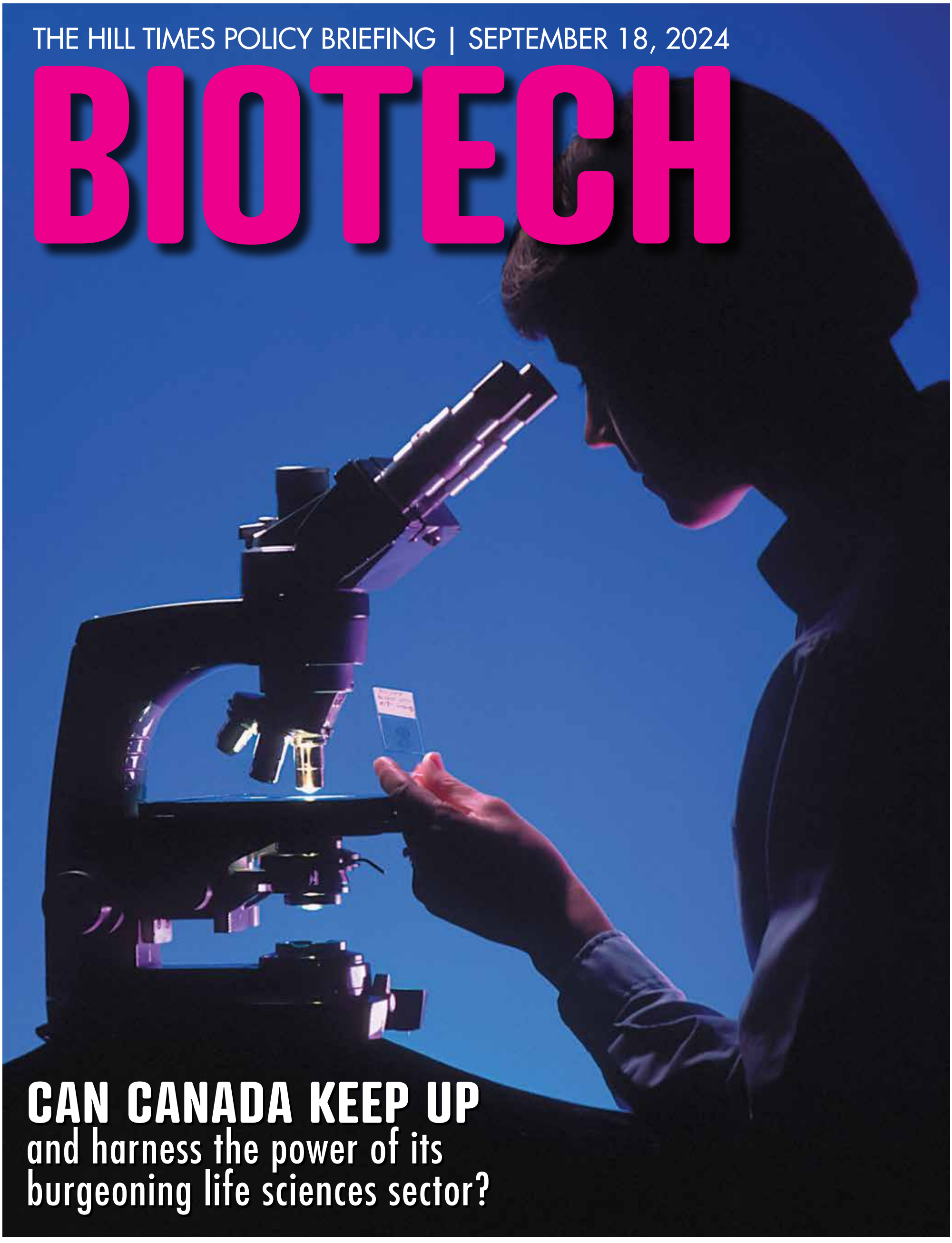
BIOTECH



CAN CANADA KEEP UP
and harness the power of its burgeoning life sciences sector?

Biotechnology momentum in Canada needs infusion of talent and anchor firms, say industry reps

Canada has several prominent life science firms, but none can be considered an anchor company, according to a report by the adMare Institute released in late 2023.

BY JESSE CNOCKAERT

Innovation Minister François-Philippe Champagne said the government is committed to supporting innovation in the life sciences sector to ensure Canadians have access to 'cutting-edge medical technologies to keep them safe,' in a July 9 press release. *The Hill Times photograph by Andrew Meade*

Capitalizing on momentum in Canada's biotechnology sector gained during the COVID-19 pandemic will require a strategy to draw and retain more talent, as well as "anchor companies" to help ensure long-term successes in the industry, according to the president and CEO of BioTalent Canada.

"The problem is you have a lot of bricks and mortar being invested in, and a lot of infrastructure being invested in, with no mandate for talent," said Rob Henderson. "The issue then is that you can't just build it, and hope they will come. There has to be a talent strategy behind it."

The pandemic resulted in an influx of investment capital and growth within Canada's biotechnology and life sciences sectors both from the federal government and the private sector, according to Henderson. However, the inadvertent consequence of greater investment is a shortage of talent to accommodate expanding labs and businesses, he said.

Canada's growing bioeconomy will require an additional 65,000 workers by 2029, according to a report released on Oct. 13, 2021, by BioTalent Canada.

"The talent crunch was made that much worse because now we have biomanufacturing facilities who are now already entering a very tight labour market, so unfortunately, you have a lot of biomanufacturers that are pilfering from each other … because there's only so many STEM grads and STEM expert out there for these companies," Henderson said. "You can throw as much money as you want on these things, but if there's not people there to do the work, you're not going to attain your goals."

As an example of federal government support, Henderson pointed to the $2.2-billion announced in the 2021 federal budget toward implementing a comprehensive strategy to build a strong domestic biomanufacturing and life sciences sector in Canada. The strategy is the responsibility of Innovation, Science and Economic Development (ISED).

Different federal government departments have a hand in Canada's bioeconomy, but they are "siloed," according to Henderson. Besides ISED and the life sciences strategy, there is also Health Canada, which handles the regulatory requirements for approval of new drugs; and Employment and Social Development Canada (ESDC), which is responsible for social programs, and the labour market at the federal level. ESDC has no mandate to preferentially support the Canadian life sciences industry, Henderson said.

"I think [the federal government] needs to take a more holistic approach. I think their job is also to position Canada as a leader around the world for this so that we can attract not only the investment, but also the talent that we require to foster these companies," he said.

Another challenge in building the bioeconomy over the long term is this country's lack of anchor companies, which Henderson described as firms large enough to attract investment capital and talent.

A report released by the adMare Institute on Nov. 21, 2023, argued that Canada has several prominent life science firms, but none at that time could be considered an anchor company.

Henderson said biotechnology firms in Canada never grow to the point where they become "truly behemoth companies across the world," because they are often sold to foreign entities before they reach that point.

As an example, he cited Biovectra, a biotechnology and pharmaceutical ingredient manufacturing company based in Prince Edward Island. Biovectra was sold to Agilent Technologies, a biopharma firm based in the United States, according to a July 22 Biovectra press release.

Obstacles holding back the establishment of anchor companies in Canada include a prolonged regulatory environment compared to other countries like the United States, according to Henderson.

"You can imagine how much capital you're burning through if it takes you two years to get a drug on the market," said Henderson. "We've got a regulatory environment that is conducive to having companies go elsewhere to commercialize. That's a big problem, and that rests directly with the federal government."

To help address a "critical labour shortage" in Ontario, BioTalent Canada launched an initiative on Aug. 22 intended to encourage more involvement from people with disabilities in the bioeconomy workforce. The organization said it will co-ordinate four events—one in Ottawa, one in the Greater Toronto Area, and two conducted virtually—intended to show potential employers how to attract and retain persons with disabilities. Conventional solutions such as relying on immigration and new graduates entering the field won't suffice, according to a BioTalent Canada press release. People with disabilities currently represent only one per cent of the bio-industry, according to the press release.

Michael May, president and CEO of the Centre for Commercialization of Regenerative Medicine, told *The Hill Times* that in order for momentum to continue in biotechnology, "we need to focus on access to capital," and Canada needs to put more funding into basic biotechnology research.

However, he added that there is no silver bullet for addressing challenges for growth in the biotechnology sector. He said Canada also needs to find a way to better leverage the Scientific Research and Experimental Development (SR&ED) Tax Incentive Program, which provides support in the form of tax credits and refunds to corporations, partnerships, or individuals who conduct scientific research or experimental development.

"If we want to be competitive, and improve our productivity in Canada, we need to invest more in R&D, but then we also need to—I think—take advantage of our SR&ED program a little bit more, and make it more available—particularly available to incentivizing foreign capital to come and do industry research and clinical translation in Canada," he said. "We need to make sure we focus on the early stage and then also on the scaling stage, but the bottom line as a whole [is] access to capital is a weak spot for Canada."

In terms of support for the biotechnology sector, Innovation Minister François-Philippe Champagne (Saint-Maurice–Champlain, Que.) announced the opening of a STEMCELL Technologies facility in Burnaby, B.C., on July 9. The facility has been supported through a $22.5-million investment by the federal government and matched by the B.C. provincial government.

The government is committed to supporting innovation in the life sciences sector to ensure Canadians have access to "cutting-edge medical technologies to keep them safe," Champagne said in a July 9 ISED press release.

"The opening of STEMCELL Technologies' state-of-the-art facility is another important milestone in achieving a robust domestic life sciences sector in Canada. Through investments such as this, we are securing domestic supply chains and ensuring new intellectual property remains in Canada, while supporting the creation of hundreds of great-paying jobs for Canadian workers," said Champagne in the press release.

May described Champagne as energetic and enthusiastic when it comes to the biotechnology file.

"He has been seen to be making investments. I think that he has been a champion for innovation, broadly. Of course, I'd love to see more in life sciences and biotech, but I think he's been very visible as a supporter for innovation in the sector," said May. "More R&D spending, leverage our existing tools like the SR&ED program, and make sure we're seeding access to capital, because … that will drive all the training and that's necessary to make a vibrant biotech industry."

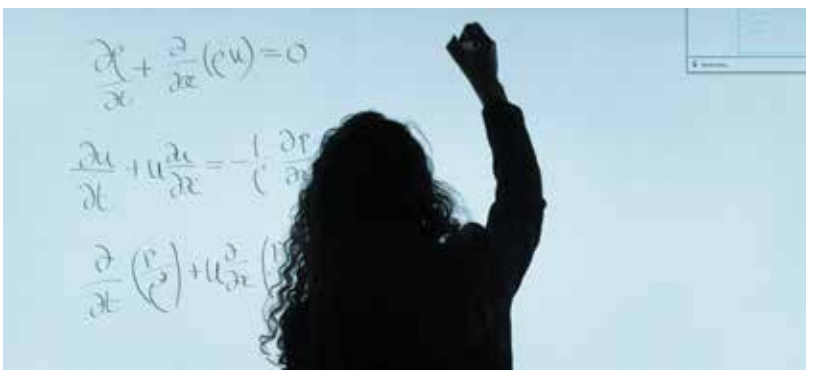
Henderson said Champagne has been a great champion of the bio-industry "within the confines of what they can achieve."

"The issue is the talent game hasn't been looked at for the long term; it's looking at being able to try to reskill a bunch of people within a very short mandate [of] one or two years, if at all, and not aligning priorities from other ministries," said Henderson. "As we look at the potential transition from one government to the next, this has to be not a political aim. This has to be long term."

Stefan Raos, the general manager of Moderna Canada, told *The Hill Times* that Moderna decided to invest in Canada in part because of a good "end-to-end ecosystem," from the study of vaccinations, through to clinical trials, and then vaccine manufacturing.

Continued on page 18

Canada needs to catch up in the biotech sector



Canada is well behind most developed nations in research investment, so we need to catch up in direct and indirect ways, writes Richard Cannings. *Photograph courtesy of Pexels*

Currently, our scientists have to look outside of the country to take their work to the next level, which means that Canada is not benefitting fully from Canadian ideas.

NDP MP Richard Cannings

Opinion

Countries around the world have long known that investments in research are the key to future prosperity, and one of the leading sectors in that drive is biotech. Unfortunately, Canada is well behind most developed nations in research investment, so we need to catch up, both in direct ways such as university and private sector grants, and indirect methods such as tax credits.

In Canada, direct instruments fall under business innovation and growth support programs, while the tax credit scheme is known as Scientific Research and Experimental Development (SR&ED).

We have to remember that at the heart of any research program are the researchers themselves. In last year's biotech briefing in *The Hill Times*, I wrote of the desperate need to increase scholarships for graduate students and post-doctoral fellowships, the amounts of which had remained stagnant for 20 years. Thankfully, after three years of effort by myself and many others, Budget 2024 contained increases to these amounts. These support levels must be maintained and tied to the cost of living.

Budget 2024 also contained a commitment to provide an additional $600-million for SR&ED over four years, and $150-million per year ongoing for future enhancements to the program. This past spring, the government conducted consultations as part of its work to improve the SR&ED program, and target this additional funding to boost research and innovation.

To claim SR&ED tax incentives, the work of businesses must meet two requirements:

- The work is conducted for the advancement of scientific knowledge, or for the purpose of achieving a technological advancement.
- The work is a systematic investigation or search that is carried out in a field of science or technology by means of experiment or analysis.

Eligible work may include basic research, applied research, and experimental development, including activities related to engineering, design, operations research, mathematical analysis, computer programming, data collection, testing, and psychological research.

The problem is that less than one per cent of Canadian businesses are investing in science, particularly for the process of taking basic research from a concept to a viable product. This lack of private sector investment means that Canada is not benefitting fully from Canadian ideas.

Simply put: our scientists have to look outside of Canada to take their work to the next level.

The biotech sector provides many examples where Canadian discoveries went on to be developed by foreign companies. For example, Derrick Rossi, the molecular biologist from Scarborough, Ont., whose work on stem cells at the University of Toronto was showing great promise. He couldn't find domestic support to put his knowledge into commercial production, so he went to the United States to co-found Moderna. Or, there was the announcement last March that British pharmaceutical giant AstraZeneca has an agreement to acquire Hamilton, Ont.'s Fusion Pharmaceuticals, which specializes in precision cancer drugs.

Continued on page 20

Biotechnology momentum in Canada needs infusion of talent and anchor firms, say industry reps

Continued from page 16

According to Raos, that ecosystem should include a strong system of surveillance in regard to COVID-19. However, he said he is concerned because COVID-19 surveillance in Canada has "diminished significantly" since the height of the pandemic.

"I always look at our biotech investment as an end-to-end investment, not just a manufacturing investment, and we do want to be an anchor company, and act like one, and attract more investment to Canada," he said. "But if there are areas of concern, for example, with a diminished interest in surveillance for COVID-19 and sharing of data, then that does concern me because I think we should keep that as a piece of the … value story for Canada."

Surveillance measures implemented by provincial and territorial governments during the pandemic include tracking the spread of COVID-19, as well as vaccine coverage. Raos said that if COVID-19 observation is reduced, a gap is created in public health defences.

"Surveillance is information. That information is used to address gaps in vaccine uptake rates. If there are certain regions that are lacking the appropriate vaccination rates for high-risk groups, then you would want to know that," he said. "I think just understanding where there are gaps and opportunities to improve the implementation of vaccine uptake is really important. That's where the data contributes to the actual implementation, and then ultimately the health of Canadians."

Raos said that other countries are surpassing Canada in terms of current COVID-19 surveillance, such as the United Kingdom.

"The U.K. may be a good example. They're continuing to invest in robust surveillance even in this phase of post-pandemic, and they're positioning themselves as leaders in public health preparedness, which I know is something that Canada is working very hard to do on many fronts, but on the surveillance piece itself, I think it's something we need to pay attention to," he said.

Bettina Hamelin, president of Innovative Medicines Canada, told *The Hill Times* that the federal government achieved great strides during the COVID-19 pandemic in supporting the life sciences ecosystem, but "we have lost some of the momentum, in terms of supporting the biotech sector in a co-ordinated way."

When asked how to maintain that momentum, Hamelin said Canada should have a co-ordinated strategy, governed by an independent body including representation by ISED, the Health Department, health system administrators, and academia.

"No. 2 is really supporting a 'life-cycle approach' to the discovery and development of new medicines, where there is co-ordination of funding for basic research with the subsequent development path that really happens in the health-care system," she said. "I think our health-care system has been underutilized for the development of life-changing innovations. And so [we should be] looking at the health-care system as a big participant and driver for innovation, and then accelerating commercialization and access to patients. We have a lengthy process of approvals."

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The Hill Times

Pharmaceutical sector research and development statistics

- In 2021, the R&D pharmaceutical sector contributed $16-billion to the Canadian economy in gross value added (GVA), an increase of 0.8 per cent from 2020. This followed a larger increase of 5.8 per cent reported from 2019 ($15-billion) to 2020 ($15.9-billion). Just more than half of the total—51.3 per cent, or $8.2-billion—was attributable to the direct impacts of the sector, which rose 3.5 per cent from the $7.9-billion generated in 2020.
- Indirect impacts accounted for 28.4 per cent of the total GVA in 2021, and increased 1.2 per cent to $4.6-billion, while induced impacts—which accounted for 20.3 per cent of total GVA—decreased 6.1 per cent to $3.3-billion.
- Overall, the R&D pharmaceutical sector accounted for 0.7 per cent of Canada's gross domestic product (GDP) at basic prices in 2021, a slight decrease from the 0.8 per cent in each of the two previous years.
- Nearly $13.7-billion (85.5 per cent) of the total GVA ($16-billion) contributed by the sector to the Canadian economy was generated in Ontario ($8.2-billion) and Quebec ($5.5-billion). Similarly, of the $9.3-billion in labour income, 85.8 per cent was attributed to these provinces, with $4.7-billion coming from Ontario, and $3.2-billion from Quebec.
- These two provinces further accounted for the majority (86.2 per cent) of full-time equivalent (FTE) jobs in the sector. Among the 102,717 FTEs in the sector, 49,623 FTEs were in Ontario, and 38,937 FTEs were in Quebec, while 14,157 FTEs were in the rest of Canada.
- In 2021, the output generated by the Canadian R&D pharmaceutical sector increased slightly by $10-million from the previous year to just less than $30-billion. This increase follows an upward year-over-year trend in total output since 2018.
- Overall employment in the Canadian R&D pharmaceutical sector decreased to 102,717 FTEs in 2021, down 4.9 per cent from the previous year, a loss of 5,256 FTEs. This decrease brought overall employment to levels seen in 2019, when there were 102,595 FTEs in this sector.
- While the overall number of FTEs decreased in 2021, this decline was more noticeable for those with an indirect or induced impact on the sector, compared with those with a direct impact. The number of FTEs with a direct impact on the sector, which supported 48,826 FTEs in 2021, saw a reduction of 578 FTEs from 2020.

Source: The Canadian Research and Development Pharmaceutical Sector, 2021, *released by Statistics Canada on June 10, 2024*

Biotechnology: an opportunity balanced on a knife's edge

We are observing an exodus of talent from our country towards greener pastures, and limited growth in a field of incredible strategic interest, writes Adam Damry. *Pexels photograph by Mike Chai*

To fully harness the benefits of a thriving biotechnology industry, it is critical we act to address the challenges that threaten it.

Adam Damry

Opinion

With the COVID-19 pandemic fresh in our memories, the impact of biotechnology has never been as apparent with the swift deployment and development of lifesaving mRNA vaccines showcasing the capacity of this field to contribute to global solutions. Continuing breakthroughs in gene editing and therapeutic technologies such as biosimilars and CAR-T cell treatments now offer hope to patients with previously untreatable conditions. Beyond health care, bioengineering advancements such as industrial enzymes and drought-resistant crops are further driving the development of environmentally friendly practices. And yet, despite its incredible transformative potential, the Canadian biotechnology industry is at risk.

Growth of the biotech sector in Canada has been slow, and we are losing our country's talent to more competitive markets. To fully harness the benefits of a thriving biotechnology industry, it is critical we act to address the challenges that threaten it.

The biggest of these hurdles is a lack of funding and support. According to data released by the Organisation for Economic Co-operation and Development, Canada allocated 1.7 per cent of its GDP to supporting local research and development; only half of the allocation of biotech hubs such as the United States (3.46 per cent), Germany (3.13 per cent), Switzerland (3.36 per cent), and South Korea (4.93 per cent).

Venture capital investment in Canada is also limited, creating a financial bottleneck that stifles innovation, as biotech startups are generally considered to be high-risk—but high-reward—ventures. This is due to long development timelines and high R&D costs; factors that come with existing at the cutting edge of science.

Programs such as the National Research Council's Industrial Research Assistance Program and the Strategic Innovation Fund represent recent government efforts to supplement R&D, enabling exploratory and transformative research. These, however, remain inadequate for the Canadian biotech sector to flourish amidst rising research costs.

Most critically, initiatives such as expanding R&D tax incentive programs, establishing new incubator hubs, and de-risking biotech startups to attract investment would substantially help to support early-stage biotech companies. Pre-commercial biotech firms are under especially high pressure as they seek to transition from research to commercialization; a particularly difficult step in the

Continued on page 23

Canada's biotech carpe diem

The Biomanufacturing and Life Sciences Strategy—jointly overseen by Innovation Minister François-Philippe Champagne and the health minister—is building from a position of strength, writes Andrew Casey. *The Hill Times photograph by Andrew Meade*

It's imperative Canada keep pace with other competing jurisdictions, and establish itself as a regulatory leader that rewards investment and talent.

Andrew Casey

Opinion

The pandemic's economic, social, and health impacts have effectively focused the attention of policymakers and the public on the strategic importance of building a competitive domestic life sciences industry and biomanufacturing capacity. Accordingly, nearly four years after the onset of the pandemic, all governments—including those in Canada—are prudently preparing for another pandemic or global health emergency. As a result, Canada's biotech sector is having a generational moment on which we must capitalize.

While it makes practical and strategic sense to prepare for another pandemic-like event, it is not possible to predict what or when the next challenge will be. It is, therefore, practically impossible to identify what types of technologies will be needed during the next crisis. Indeed, it is highly probable the technology we will need in 20 or 30 years has not yet been discovered. In this context, when considering how to prepare for the next crisis, the more strategic approach for Canada is to build our life sciences and biomanufacturing sector broadly so it can offer many potential solutions for the next crisis while also acting as an innovator and economic driver during non-crisis periods. Both objectives can be met by focusing on creating a competitive environment which generates ideas and attracts the investors, partners, and talent required to turn ideas into companies and scale them to become Canadian anchors.

With the implementation of the federal Biomanufacturing and Life Sciences Strategy, the federal government has signalled it recognizes the importance of building the nation's biotech sector. The strategy's corresponding investments are now accelerating the creation of companies, and the growth of Canada's biomanufacturing capacity and life sciences sector more broadly. Wisely, governments are avoiding the trap of betting on the horse they think will win the race. Instead, they are remaining technology agnostic, which will establish the conditions for a Canadian discovery or company being an essential component of the next solution when the time comes.

Importantly, the Biomanufacturing and Life Sciences Strategy is building from a position of strength. Indeed, Canada has a vibrant and diverse life sciences ecosystem which is founded on a global reputation for excellent scientific research. As a result, we're home to an ecosystem which includes hundreds of early-stage biotech companies, a strong global pharma presence, supporting a national clinical

Continued on page 21

Tax policy also plays an important role in encouraging businesses to take the risks necessary for innovation, and Finance Minister Chrystia Freeland's recent capital gains reforms discourage this, writes Frank Baylis. *The Hill Times photograph by Andrew Meade*

Biotechnology must factor into a broader Canadian industrial policy

Governments should focus on supporting basic research, helping startups, and funding the scale-up of growth companies.

Frank Baylis

Opinion

The 2024 Bloom Burton Awards underscore the strength of Canada's biotechnology and life sciences sectors. The award honours an individual who has made the greatest contribution to Canada's innovative health care industry. This year's finalists are Roberto Bellini of Bellus, Tom Frohlich of Chinook Therapeutics, and François Ravenelle of Inversago. Notably, all three work in the biotechnology and pharmaceutical industries. Each built businesses that have employed high-skilled workers including scientists, researchers, and technologists. Their innovations advanced medicine and contributed to the prosperity of our nation.

To build upon our economy for the future, governments—both federal and provincial—should focus on three areas: supporting basic research, helping startups, and funding the scale-up of growth companies.

Supporting basic research

Basic research is essential to innovation, providing the groundwork for future discoveries. Canada's universities—home to world-class research—require government support to continue leading in the biotechnology sector. Sadly, many universities are being financially squeezed at a time when they should be receiving increased investment to conduct research and educate the next generation of innovators. Properly funded, Canadian universities can compete at the highest level globally, fostering discoveries that lead to future technological advances.

For instance, the groundbreaking GLP-1 medications, which have made Novo Nordisk one of the top 20 most valuable companies in the world, are based on fundamental research by Canadian professor Daniel Drucker. Without strong government support for such research, these types of innovations do not come to fruition.

Helping startups

Once basic research produces new discoveries, it's up to startups to commercialize them. Supporting startups is critical to ensuring that promising ideas are turned into viable businesses. Canada already has the infrastructure to grow its biotechnology sector. Incubators like the Health Innovation Hub (H2i) at the University of Toronto play a vital role in this process. In just a decade, H2i has supported more than 200 startup companies. These firms have created high-paying jobs that contribute enormously to the Canadian economy. Governments should provide sufficient funding to incubators to ensure the next generation of biotech entrepreneurs has the support they need to thrive.

As H2i's co-founder and director stated, "Canada is a sleeping giant that has awoken." With the proper government support, Canada's biotechnology and life science sector can become a global powerhouse.

Funding the scale-up of growth companies

Of the many startups, only a few will emerge as winners capable of scaling their operations. Scaling up requires significant financial capital, and this is where governments can make smart investments. However, governments should not be in the business of directly picking winners because they do not have the expertise needed to identify which companies will succeed, and they tend to make decisions for political reasons rather than business reasons.

Instead, governments should work in partnership with venture capitalists (VCs) who specialize in assessing high-potential companies in the biotechnology sector. Governments can co-invest alongside VCs, requiring that the VCs contribute at least 50 per cent of the investment from their own resources. This way, government funding supports growth companies while leveraging the expertise and judgment of seasoned investors.

Tax policy also plays an important role in encouraging businesses to take the risks necessary for innovation. Unfortunately, the recent increase in capital gains tax discourages the very investments needed to scale up companies. BIOTECanada, the association representing the Canadian biotechnology industry, has clearly stated that the "capital gains tax changes are a setback for Canadian biotech competitiveness." To incentivize commercialization and risk-taking, governments should ensure that tax policies are structured to reward innovation and investment.

The efforts to support the biotechnology sector should be part of a broader Canadian industrial policy aimed at building homegrown industries. Our country has the potential to become a global leader in the biotechnology sector, but there is much to be done.

Governments must create an environment where innovation can flourish. Supporting basic research at universities, helping startups commercialize discoveries, partnering with venture capitalists to scale up businesses, and enacting constructive policies are all critical steps. With the right approach, Canada can lead in the development of life-saving medicines and breakthrough health-care solutions, ensuring long-term prosperity for our country.

Frank Baylis is the executive chairman of Baylis Medical Technologies, a medical device company focused in the areas of interventional radiology and neurology. From October 2015 to October 2019, Baylis was the Liberal Member of Parliament for the riding of Pierrefonds-Dollard, Que.

The Hill Times

Canada needs to catch up in the biotech sector

Continued from page 17

While foreign investment is welcome, the COVID-19 pandemic clearly showed the strategic value of having a strong Canadian biotech sector.

So how do we increase investment in Canadian science? The private sector in this country is perhaps disadvantaged to some extent in terms of the big investments needed to fully develop important discoveries because we simply have a smaller proportion of those big companies that can afford those investments. So, government has to step up to provide direct support, as well has the indirect funding we provide through SR&ED.

It will be important to examine the outcome the SR&ED review—what barriers to investment were identified, and how will they be addressed? However, there seems to be a need to address an inherent reluctance by Canadian financiers to take a risk on science. This culture of risk avoidance puts the brakes on prosperity here at home.

One counterintuitive solution might be to increase the corporate tax rate. As former U.S. president Dwight Eisenhower observed, businesses are more likely to look for investment opportunities for their profits if they avoid paying higher tax amounts. Further, increased revenue from higher corporate taxes could also be directed towards direct government investments in the biotech sector and other areas of science.

Canada has a long history of successes in the biotech sector. In addition to the well-known invention of insulin, Canadians developed the first Ebola vaccine, and discovered the genes that cause ALS and cystic fibrosis. We pioneered the field of regenerative medicine through the discovery of stem cells, while work by the University of British Columbia's Dr. Pieter Cullis developed the lipid nanoparticle technology that is a key component of the mRNA COVID vaccines.

What we need is more investment to both create more future discoveries like these, and to turn those discoveries into real products that will make the world a better, healthier place and bring prosperity to Canada.

NDP MP Richard Cannings represents the riding of South Okanagan–West Kootenay, B.C. He is his party's deputy critic for innovation, science, and industry.

The Hill Times

A flourishing biotech sector starts by innovating education

Innovating graduate education to support a wider variety of career paths will be key to creating the talent we need to have a vibrant biotechnology ecosystem.

Valerie Ward, Marc Aucoin & Hector Budman

Opinion

Academia provides an ideal environment to de-risk entrepreneurial ventures, write Valerie Ward, Marc Aucoin, and Hector Budman. *Photograph courtesy of Unsplash*

The site of the Connaught Medical Research Laboratories in Toronto can be thought as the longest-standing host to biopharmaceutical manufacturing in Canada. With more than 100 years of history, it's surprising that more Canadians aren't aware of it. Now owned and operated by Sanofi, it continues to be a major vaccine producer for Canadians, and people around the world. However, the disruption of the COVID-19 pandemic revealed the weaknesses of the Canadian biotechnology and pharmaceutical manufacturing industry. As the world leveraged the amazing innovations of the past decade to produce testing, research, and medical treatments at a previously unprecedented pace, Canada struggled to keep up after decades of bleeding talent to more vibrant biotech ecosystems abroad.

The Government of Canada's Biomanufacturing and Life Sciences strategy is a good beginning towards fixing these problems, but focuses too closely on building a pipeline of talent and infrastructure for manufacturing vaccines and therapeutics. To reduce costs, manufacturing facilities are usually dedicated to a single product, but these facilities cannot—and should not—sit idly waiting to make vaccines for a pandemic. Furthermore, this sector does not have the capacity to absorb the number of highly qualified individuals needed in high demand times—i.e. pandemics—during years of regular operation.

We need a thriving Canadian ecosystem that allows growth, movement, and has the capacity to absorb and supply that talent. The enabling technologies and underlying skills needed in the biotechnology sector are highly transferrable between different biotechnology fields. The tools used to purify a protein for degrading plastics do not differ from those used to make an antibody treatment. Greater support for the spectrum of biotechnologies is needed for Canada to stay economically competitive and ready to pivot. And it's not just smart pandemic preparedness.

The United States White House issued a report in 2023 on the state of the field that said, "The world is on the cusp of an industrial revolution fuelled by biotechnology and biomanufacturing." This is because the technologies that make it possible to manufacture a vaccine in a year are also driving innovation in environmental, industrial, and agricultural biotechnology. Along with the report, the U.S. has committed more than US$3.5-billion in new funding initiatives through all levels of government dedicated to biotechnology and biomanufacturing projects. This additional funding is just to ensure the U.S. retains the title of world leader in biotech. Major biotech companies are increasingly relying on startups or academic labs to conduct much of the basic and applied research needed to invent new technologies. Once the technology has been validated, they prefer to collaborate with or acquire the startup or tech, which is a less risky and more cost-effective approach than developing their own technologies in-house. Consequently, the biotech sector heavily depends on universities and their startup ecosystems, and there is no assurance that Canadians will have access to technologies or therapies developed abroad. Canada has lot of catching up to do, and a more comprehensive strategy encompassing other types of biotechnology is needed.

But there are many signs of hope. Canadian companies like AbCellera and Acuitas—both of which are based around technologies that were invented in Canadian academic labs by interdisciplinary scientists—played major roles in responding to the pandemic. Academia provides an ideal environment to de-risk entrepreneurial ventures. Not only do university labs have the infrastructure to develop and support small enterprises, but they also have the long-term subject-matter expertise and experience to facilitate and propel these ventures to the next level.

As chemical engineering professors, we see more students creating innovative biotech solutions for complex global challenges. However, upon graduation, these students face significant challenges in accessing the support they need to commercialize these inventions.

For this reason, we are pioneering a new type of interdisciplinary PhD program at the University of Waterloo to put biotech entrepreneurs in academic labs, and give them the scientific and engineering support they need to develop their technologies and create value for Canadians. Innovating graduate education to support a wider variety of career paths—like entrepreneurship—will be key to creating the talent we need to have a vibrant biotechnology ecosystem, and creating a greater variety of companies will ensure our talent has career growth opportunities at home.

Drs. Valerie Ward, Marc Aucoin, and Hector Budman are members of the interdisciplinary biotech collective Waterloo Bioworks, and are professors in chemical engineering at the University of Waterloo researching topics at the interface between engineering and biology.

The Hill Times

Canada's biotech carpe diem

Continued from page 19

trial network, which, in turn, provides investors and partners for Canadian biotech companies. The sector's strategic competencies include regenerative medicine, artificial intelligence, vaccines, clinical trial expertise, and genomics.

The sector's strengths are central to Canada's biotech industry experiencing a generational moment with more than $26-billion in investment deals flowing through the sector over the past five years. Highlights of this investment flow include major exits and deals involving companies such as BELLUS, Inversago Pharma, and Fusion Pharmaceuticals; global pharma investments in and partnerships with Canadian biotechs; and exciting growth evident in companies like AbCellera, Aspect Biosystems, Repare Therapeutics, and BIOVECTRA; and significant investments into the ecosystem by global pharma and biotech companies. Combined, all underscore a confidence in our capacity for generating innovation and dynamic biotech companies.

All told, a globally recognized and valued life sciences and biomanufacturing sector in Canada is already in place. Now is the time to capitalize on this momentum by investing more in enhancing this foundation, which will not only help address the preparedness objective, but—if done strategically and for the long-term—it will also generate and support the creation and scaling-up of companies in Canada.

As our country looks to build its domestic biotech sector, we do so with the knowledge that every other leading economic jurisdiction in the world is also investing heavily into their domestic life sciences sectors as they too understand the vital role biotechnology innovation is playing globally. As a result, the competition globally for biotech ideas, companies, talent, and investment has never been more intense. Accordingly, to establish the environment for company creation and growth, and ultimately retain what we have, it is imperative that Canada keep pace with other competing jurisdictions, and establish ourselves as a regulatory leader and jurisdiction that rewards investment and talent. This is essential to establishing the right hosting conditions that will attract the firms, talent, and investment required to build competitive national biotech ecosystem.

Canada has clearly demonstrated its ability for scientific discovery, entrepreneurship, and company creation. However, we have yet to truly capitalize on this strength by creating and retaining a home grown, globally commercial biotech company. Ultimately, the most effective way to grow and strengthen our biomanufacturing capacity and life sciences sector is to translate the global moment before us to create globally commercial companies that can anchor biotech clusters across Canada.

Andrew Casey became president and CEO of BIOTECanada in August 2012. As the head of BIOTECanada, he is the lead spokesperson for Canada's biotechnology industry communicating on the industry's behalf with government, regulators, international bodies, media, and the Canadian public.

The Hill Times

Harnessing the power of Canada's growing biotechnology industry: a perspective from the West

Government investment and policy can help ensure groundbreaking technologies remain in Canada when companies scale up their production especially for international distribution.

Stephanie Willerth

Opinion

The COVID-19 pandemic highlighted the need for both public and private support for the biomanufacturing industry in Canada as well as showcased some of the internationally recognized technologies developed here in British Columbia.

AbCellera demonstrated its antibody platform generated treatments for this disease, while the Victoria-based Starfish Medical worked to produce made-in-Canada ventilators. B.C. has also produced world-class nanotechnology companies such as Acuitas Therapeutics, which provide the lipid nanoparticle technology used by Pfizer for delivering the COVID-19 vaccine. In the cases of AbCellera and Acuitas, along with Canada's largest biotechnology company STEMCELL Technologies, these biotechnology tools were first developed in research labs at the University of British Columbia before becoming commercialized.

The role of government investment and policy can help ensure such groundbreaking technologies remain in Canada when companies scale up their production especially for international distribution. For this reason, our province under the guidance of Brenda Bailey—the minister of jobs, economic development, and innovation—has developed a comprehensive biomanufacturing strategy to help support this growing industry. Retaining these technologies in province will also create highly skilled jobs to retain the talent being trained in the province through programs like the undergraduate and graduate biomedical engineering degrees offered at the University of Victoria, as well as the undergraduate and graduate students being trained at the School of Biomedical Engineering at the University of British Columbia.

Dr. Peter Zandstra, who directs the UBC School of Biomedical Engineering, elaborates: "The success of Canada's biotech sector depends on building an ecosystem that fosters innovation. At UBC's School of Biomedical Engineering, we've shown how academic-industry partnerships and access to state-of-the-art wet lab spaces accelerate the transition from research to real-world impact. Government and private support have been essential to these efforts. Continued investment is crucial not only for developing the infrastructure and talent needed to advance Canada's biotech industry, but also for educating the next generation of leaders who will drive innovation and improve health outcomes."

Their school is home to the new BioDevice Foundry, which is a cutting-edge facility for designing, prototyping, fabricating, and testing biodevices that will accelerate biomedical innovation and advance the life sciences industry locally and globally with financial support from PacifiCan and the Conconi Family Foundation. It also houses the biotechnology incubator SBME Innovates, which provides essential wet lab space to startups. They are further expanding the capability of the province with the creation of a new Advanced Therapeutics Manufacturing Facility on UBC's Vancouver Campus—the first facility of its kind in Western Canada—being created with support from Immuno-Engineering and Biomanufacturing Hub hosted at UBC. Equipped with state-of-the-art bioreactors and quality control labs, the 25,000-square-foot facility will enable academic researchers and biotech startups to develop innovative cell- and gene-based therapies, and bring them into clinical trials for Canadians. Such cell-based therapies also include bioprinted tissues being generated by companies like Aspect Biosystems, Axolotl Biosciences, and Voxcell Innovations—all located in B.C.

Similarly, the University of Victoria hosts a Health Core facility that biotechnology companies can rent as a way to access the necessary wet-lab space, and the Vancouver Island Life Sciences group is currently building a scale-up facility located in Victoria to provide a home for biotechnology firms that are looking to scale up their production, led by Rebecca Hof. All of these initiatives would benefit from further investment from both the federal and provincial governments along with support from the private sector, including venture capital funds and organizations like in B.C.

As a founder of an academic spin-off company focused on 3D bioprinting, I feel it is essential to support such companies as we take our technology out of the laboratory through providing access to wet-lab space and equipment given that these facilities require significant resources to establish. The combination of affordable access to the specialized facilities necessary to perform biological sample manipulation along with easier access to capital investment would help encourage more effective and efficient technology transfer from academic settings to industrial applications.

Dr. Stephanie Willerth is a full professor of biomedical engineering at the University of Victoria, and also holds an appointment in the School of Biomedical Engineering at the University of British Columbia. She is the CEO of the award-winning biotechnology startup Axolotl Biosciences.

The Hill Times

Unlocking Canada's greatest economic potential: life sciences

The time has come for us to commit to life sciences as a driver for Canada's economy with the knowledge that this sector can help solve some of our biggest societal challenges.

Alison Symington & Jason Field

Opinion

Why do we believe life sciences is Canada's greatest untapped economic resource? You don't have to look far to find the answer.

The three top biotechnology outfits listed on the NASDAQ are Amgen, Regeneron, and Vertex with a combined market capitalization of US$429-billion. Compare this to the combined market cap of the 129 companies listed on the TSX/TSXV that constitute the Canadian oil and gas sector, valued at US$312-billion. In fact, Novo Nordisk's market value recently exceeded that of the entire Danish economy. The irony that this company is founded on the Canadian discovery of insulin is not lost on us.

Since the COVID-19 pandemic, the life sciences sector has been in the spotlight as a strategic economic and national security priority for Canada. We have seen the launch of the national Biomanufacturing and Life Sciences Strategy, as well as several regional initiatives. Our view is that although these strategies are a good starting point, much more is needed to create an environment that will support the sustained level of success to which we aspire. For this short discussion, we focus on three areas, recognizing this is not a comprehensive list. Ultimate success will require a co-ordinated effort across the discovery to commercialization pipeline.

Let's start with the perennial issue at the forefront of these discussions: access to capital. Life sciences, particularly therapeutics, is a high-risk/high-reward type of investment. As such, government policy is best focused at stimulating investment from a diversity of sources using a variety of policy levers. Many programs have focused on stimulating venture capital, but there are other sources of capital that have been underutilized in life sciences, including angel investment, public capital markets, and even pension funds. Frustratingly, even great performance has not been enough to stimulate these investments, as observed in a recent report from the Business Development Bank of Canada: "[the] life sciences sector returns continue to outperform ECT and ICT, despite being relatively underfunded."The same study also shows the most severe gap in life sciences funding occurs at the pre-seed/seed stage—typically in the $2-million to $10-million range—of investment. "This limits both pipeline development as well the emergence of Canadian champions." In short, we need a pool of investment capital that is not only deeper, but wider as well.

Next: technology adoption. This is where public policy has a strategic role given our publicly funded health system. The speed at which we can assess, value, reimburse, and deploy innovative technologies is a critical component in our overall competitiveness. To be clear, we are not suggesting sacrificing safety or efficacy standards. During the pandemic, we saw the impact of innovative mRNA technologies that allowed the development of effective vaccines at an unprecedented speed. Importantly, our regulators were equally innovative in assessing and approving these products in record time. Yes, these were exceptional circumstances, but it demonstrated the art of the possible. Recently, we saw the newly formed Canada's Drug Agency adopt a rolling review process reducing the time for reimbursement recommendations. This is the type of policy and regulatory innovation that Canada needs not only to accelerate the growth of our home-grown innovators, but also to attract global investments throughout the Canadian life sciences ecosystem.

Finally, there's been much discussion in the small and medium-sized enterprises community about the need for wetlab space. In particular, the lack of graduation space for startups that are beginning to scale. Other jurisdictions—such as Massachusetts—made significant investments in infrastructure and wetlabs that helped both expand their home-grown life sciences companies, and provided an environment that attracted companies from other jurisdictions including Canada. Having the necessary infrastructure is essential to keeping successful companies at home.

To conclude, Canada has made significant investments that support the production of world-class science from our world-class institutions. However, our economic policies have continued to be rooted in natural resources and traditional manufacturing while this "national intellectual resource" is ready and able to prime the 21st century economy. The time has come for us to commit to life sciences as a driver for Canada's economy with the knowledge that this sector can help solve some of our biggest societal challenges: an aging population, food security, climate change, health equity, prosperity, pandemic preparedness, and so much more. It's time to unlock the potential of Canada's life sciences.

Dr. Alison Symington is the current chair of the board of Life Sciences Ontario (LSO). She owns her own consultancy leveraging more than three decades of experience in drug development in both the private and not for profit sectors. Dr. Jason Field is president and CEO of LSO. Field has more than two decades of professional experience that spans the private, public, and the not-for-profit sectors.

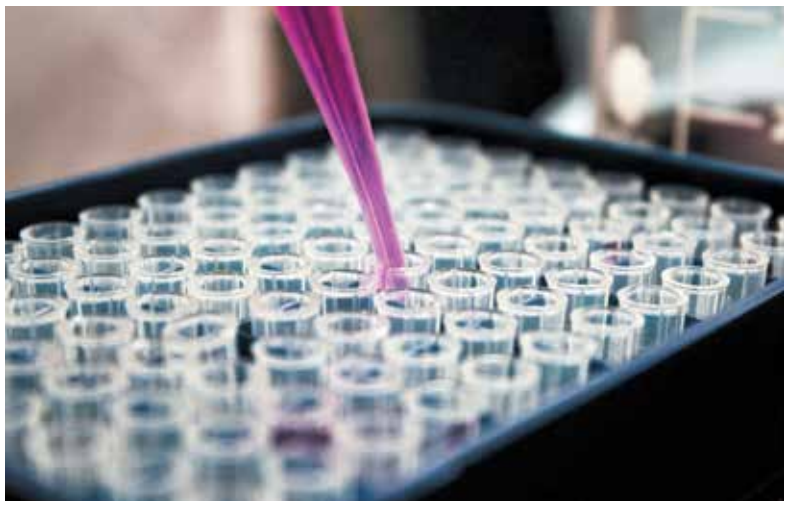
The Hill Times

From crisis to catalyst: Canada's opportunity to drive global health and research innovation

By creating an environment that fuels scientific advancement, Canada can face future crises with confidence, ensuring both its prosperity and global influence.

Pamela Shaver-Walker & Edward Short

Opinion



The country's readiness to respond to emerging health threats depends on robust research infrastructure, write Pamela Shaver-Walker and Edward Short. *Unsplash photograph by Louis Reed*

In a time of transformative health-care innovations, particularly within the biotechnology sector, Canada stands at a critical juncture. The COVID-19 pandemic, along with geopolitical and economic challenges, has highlighted the urgent need to strengthen the country's domestic research capabilities. With a strong scientific legacy, Canada has the potential to lead this global shift.

As the federal government plans for the future, it's crucial to learn from past decisions where research investment was often neglected. The country's readiness to respond to emerging health threats, including infectious disease, mental health, and chronic cardiovascular and respiratory conditions, depends on robust research infrastructure. While it is not possible to predict the next global health crisis, preparedness is essential.

Charles River Laboratories (Charles River) is a leading global biopharmaceutical research organization. With four facilities located in Quebec that employ more than 2,500 innovators, we certainly recognize just how much potential Canada holds. From entry-level laboratory technicians to PhD scientists, and more than 500 staff with advanced degrees in various biology and chemistry disciplines, Charles River's workforce has some of the brightest minds and talent responsible for delivering scientific breakthroughs.

Canada holds the potential to lead in key research areas, such as cell and gene therapies, rare disease treatments, vaccine development, and novel treatment development for chronic disease. However, delivering on this potential requires access to a greater pipeline of talent, attractive investment opportunities for biotech organizations, greater collaborations between private sector and all levels of government, and the capability for experimental development. Canada needs thoughtful policies that facilitate strategic investments, harnessing the nation's vast research potential.

While the federal Biomanufacturing and Life Sciences Strategy marked a pivotal moment in acknowledging the sector's immense potential for growth, significant work remains to address several critical barriers to growing Canada's biomanufacturing and life sciences sector. Specifically, a decreasing pipeline of talent, and a lack of much-needed laboratory space for drug discovery activities are two key factors to achieving long-term success.

Labour market research from BioTalent Canada shows that more than 65,000 new biotech workers will be needed in the country by the end of this decade. This, coupled with the fact that major Canadian cities lack available laboratory space, is preventing the biotech sector from thriving and driving innovation out of the country.

Investing in "accelerators" like vivarium laboratory spaces where biotech organizations can collaborate with necessary resources including expertise, equipment, and instrumentation, or contract their research out can alleviate pressures both from infrastructure demands, and costs associated with staffing. These "pop-up" lab spaces will not only spur innovation and discovery, but can also maximize regional economic development for surrounding communities. Moreover, partnerships with academic institutions should be a cornerstone of Canada's strategy. Charles River has seen great success through its collaborations on curriculum design, lab standards, and research, ensuring that the next generation of scientists is well prepared to lead the charge.

In addition, advancements in predictive toxicology, and responsible AI-driven decision support with regard to drug development are important to reduce the upfront investment required in the discovery and progression of compounds to first-in-human trials. Using the data from both successful molecules as well as those that fail helps to better explain and predict the toxicity and efficacy of molecules, which is invaluable to Canada's positioning as a leader in drug discovery.

Lastly, this country can harness its potential by paving the way when it comes to developing innovative research practices by actively embracing new approach methodologies. Through initiatives like Charles River's Virtual Control Groups in nonclinical toxicology, we are reducing animal usage by replacing selected control group animals with matched virtual counterparts developed from retrospective datasets. By advancing responsible and innovative scientific practices, Charles River is championing methods that reflect our commitment to ethical research, patient safety, and cutting-edge technology.

As Canada navigates the uncertainties of a post-pandemic world, we can't afford to fall behind in research. Investing in the country's domestic research infrastructure is crucial not only for protecting our communities and strengthening our economy, but also for asserting Canada's leadership in global health innovation. By creating an environment that fuels scientific advancement, Canada can face future crises with confidence, ensuring both its prosperity and global influence.

Most importantly, investing in research is about creating healthier lives—here at home, and around the world.

Pamela Shaver-Walker is the corporate vice-president, global head of operations for Safety Assessment at Charles River Laboratories. Shaver-Walker is responsible for global operations across more than 20 sites in seven countries and partners with senior leaders across safety assessment to drive initiatives related to harmonization and alignment in areas that converge across operations. Edward Short is the corporate vice-president, human resources at Charles River Laboratories. He has served as a member of BioTalent Canada's board of directors since 2017, where he currently chairs the Governance and Nominations Committee.

The Hill Times

Biotechnology: an opportunity balanced on a knife's edge

Continued from page 18

biotechnology field given lengthy and exigent regulatory approval processes.

Funding difficulties also rear their heads on the Canadian academic stage. Our population is amongst the most educated in the world with a public that understands the role of science in shaping and bettering our societies. Canadian scientists themselves are highly regarded internationally, punching above their weight due to a high level of rigor and quality in academic programs at all levels of education—especially in post-graduate programs. These factors give us the necessary drive and brilliance to excel not only in biotechnology, but also across R&D fields.

Retaining this talent is critical, and many Canadian professionals are being lured to more lucrative opportunities abroad. This brain drain often begins at the graduate level, with Canadian post-graduate studies becoming harder to access as the cost of living rises.

Notably, the scholarships offered to top Canadian graduate students have stagnated since 2004 despite an increase in living costs during this period of 50 per cent or more. As a result, today, the unfortunate choice faced by many Canadian STEM graduates is to face four to six years of poverty in a graduate program that pays far below minimum wage—as low as $21,000 per year—or to follow better opportunities outside of Canada.

Not everything is doom and gloom. Last April, the federal government announced plans to substantially expand R&D funding in a new five-year plan, joining key international research initiatives such as the Horizons Europe program, and pledging to increase graduate and postdoctoral scholarships. These initiatives will help to retain Canadian talent, and restore our competitiveness in biotechnological R&D. They are excellent blueprints to follow in future funding efforts.

Without further expansion to these and other R&D-driving programs, however, Canada's support for home-grown science will continue to lag behind that of international biotech hub countries. Today, we are observing an exodus of talent from our country towards greener pastures, and limited growth in a field of incredible strategic interest. Science is the lifeblood of progress, and we must pledge to safeguard and accelerate the momentum that we have only just begun to build. Otherwise, Canada will be left behind in the ongoing biotechnology revolution.

Adam Damry is an assistant professor at the University of Ottawa, and a Canada Research Chair in Synthetic Biology. He runs a research group that develops medical diagnostic platforms, and engineers enzymes to fight plastic pollution.

The Hill Times

HEALTH

The Hill Times
Policy Briefing
April 29, 2024

NEXT STEP IN UNIVERSAL DRUG COVERAGE SHOULD PRIORITIZE 'ESSENTIAL MEDICINES,' BY JESSE CNOCKAERT

JANE PHILPOTT talks about her new book, by Peter Mazereeuw

PATIENT INVOLVEMENT *in pharmacare critical*

PROTECTING PUBLIC HEALTH CARE has never been more important

MENTAL HEALTH, ILLNESSES are a population health issue

Need a reset on NATURAL HEALTH PRODUCT OVER-REGULATION

Health-care system's HIDDEN BACKBONE

Feds must expand PHARMACARE

All hands on deck for the FUTURE OF HEALTH CARE

EMBRACING REGULATORY AMBITION to shape Canada's future

Answering a call for help CAN SAVE A LIFE

Moving beyond Band-Aid solutions to deliver health care for kids

Next step in universal drug coverage should prioritize 'essential medicines,' says pharmacare expert

Focusing on a list of the most commonly prescribed clinically-important drugs could save billions of dollars, both directly in terms of drug budget, and indirectly in terms of improvements in health care, says Steve Morgan, a professor of health policy at the University of British Columbia.

BY JESSE CNOCKAERT

A next step in phasing in a national pharmacare program should begin with a list of "essential medicines," according to Steve Morgan, a professor of health policy at the University of British Columbia, who described the choice of covering contraception and diabetes treatments in the first phase as practical, but also political.

"What are the essential treatments for the widest possible categories of needs that we can fund as a country? And that's the idea behind essential medicines," said Morgan. "If you're going to ask what the next stage is, it's [to] focus on essential medicines as a human rights issue."

Canada's federal Health Minister Mark Holland (Ajax, Ont.) introduced Bill C-64, the Pharmacare Act, on Feb. 29, which proposes the foundational principles for the first phase of national universal pharmacare in Canada to help manage the costs of prescription drugs. If the bill is passed, Holland will begin negotiations with the provinces and territories for a funding commitment to provide universal, single-payer coverage for some diabetes medications and contraception.

Health Minister Mark Holland introduced Bill C-64, the Pharmacare Act, on Feb. 29, which proposes the foundational principles for the first phase of national universal pharmacare in Canada. *The Hill Times photograph by Andrew Meade*

Steve Morgan, a professor of health policy at the University of British Columbia, says 'What we should be saying is: what are the essential treatments for the widest possible categories of needs that we can fund as a country? And that's the idea behind essential medicines.' *Photograph courtesy of Steve Morgan*

Steven Staples, national director of policy advocacy for the Canadian Health Coalition, says 'We want to make sure that there's enough money there so that when Minister Holland goes out and begins to negotiate with provinces, the provinces know that there's sufficient funding.' *Photograph courtesy of Steven Staples*

Joelle Walker, vice-president of public affairs for the Canadian Pharmacists Association, says some of the provinces have signaled that 'they have some systems that they feel currently work and they want help supplementing that for people who don't have coverage or not enough coverage.' *Photograph courtesy of Joelle Walker*

Morgan told *The Hill Times* that he regards the choice of covering diabetes treatments and birth control as pragmatic, but also containing important symbolism.

"Birth control in particular is framing Canada's approach to pharmacare, in part at least, as a women's issue and a human rights issue, which is extremely powerful stuff," he said. "It does speak to just how important it is to ensure that people have access to the treatments that they need, including treatments to control their reproductive lives, and that is going into a 2025 federal election."

The selection of diabetes treatments may be seen as symbolic, because insulin is a Canadian invention, according to Morgan. Insulin was discovered by Frederick Banting, Charles Best, and John J.R. Macleod at the University of Toronto in 1921, and it was purified by James Collip. In 1923, Banting and Macleod received a Nobel Prize in medicine.

"The Canadian inventors of that invention dedicated the patents to the public good. They didn't actually choose that they and the University of Toronto would become uber-billionaires by having exclusive rights to the technology. They felt that the innovation was to be made available to everyone to save as many lives as possible," said Morgan. "The irony of that being [insulin is] a Canadian invention, and yet Canadians cannot universally afford … insulins or other diabetes treatments."

When considering the next possible phase towards universal pharmacare, Morgan argued the federal government should begin with a list of "essential medicines," or the most commonly prescribed clinically-important drugs.

"What we should be saying is: what are the essential treatments for the widest possible categories of needs that we can fund as a country? And that's the idea behind essential medicines," he said. "It says, 'Look, we're not going to fund 11 different treatments for high cholesterol and high blood pressure. We're going to fund six treatments in those categories because that will cover the vast majority of our needs. And the reason for focusing in that way is that means we can address more different needs."

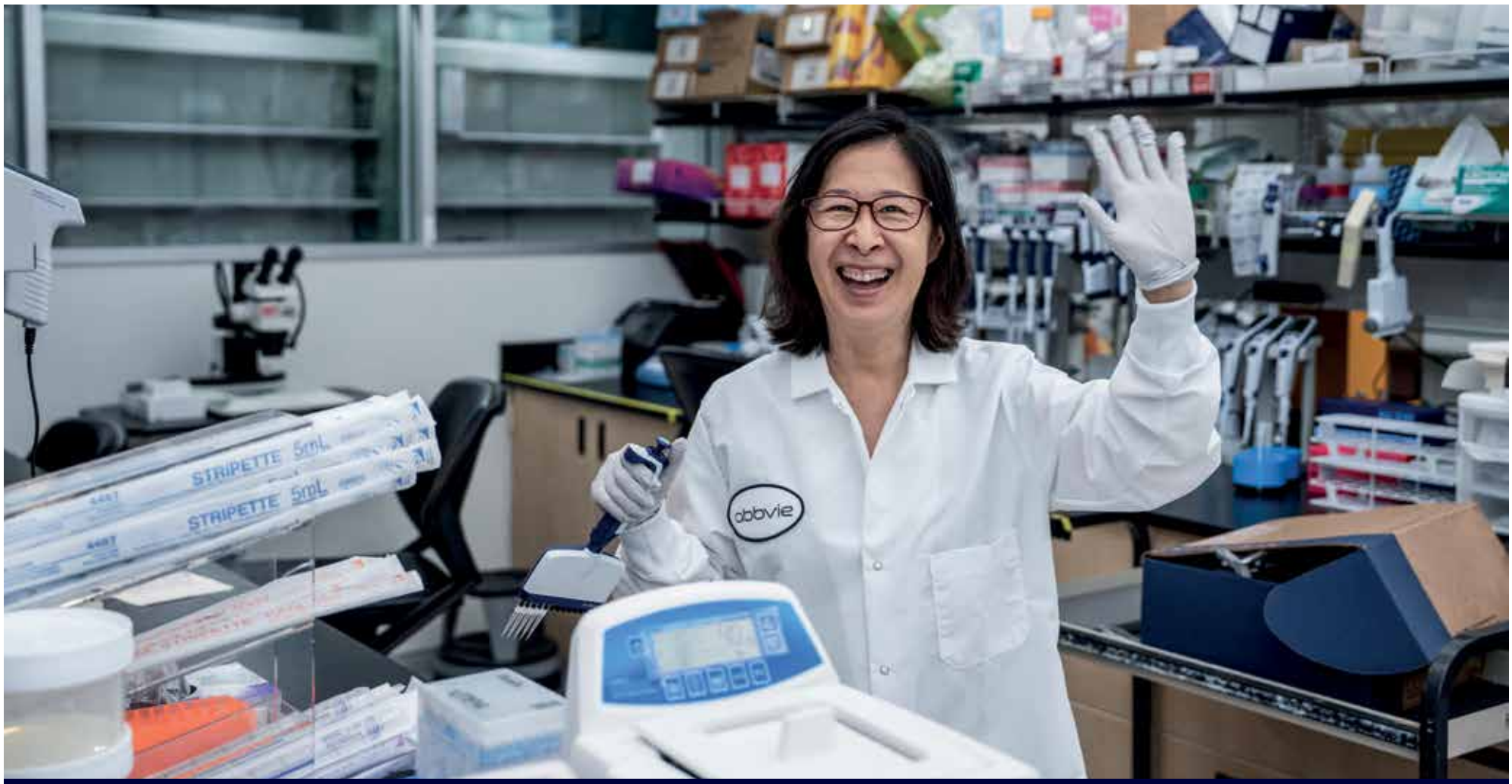
In February 2017, Morgan, along with Nav Persaud, assistant professor at the Department of Family and Community Medicine at the University of Toronto, and medical residents Winny Li of the University of Toronto, and Brandon Yau of the University of British Columbia released a study on the cost and benefits of covering essential medicines. The study focused on 117 drugs available and sold as prescription-only medicines in Canada, which were part of the CLEAN Meds list, an adaptation of the World Health Organization (WHO) model list of essential medicines for primary health care in Canada.

The study concluded that the 117 essential medicines spanned more than 40 different therapeutic categories, and could be used for 77 per cent of all prescriptions written in Canada, including the majority of prescriptions for insulins, antibotics, antidepressants, dementia treatments, and thyroid treatments.

Morgan argued there is a perception that it would be hard somehow for Canada implement a national pharmacare program, but that doesn't have to be the case.

"What a program needs to do—particularly just starting with those essential medicines—is develop a clear and transparent and publicly accountable means of arriving at that list of medicines that is going to be covered, and then apply global best practices with iron-clad supply contracts with manufacturers of the medicines that are chosen," he said. "And in so doing, as our research

Continued on page 30



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All hands on deck for the future of health care

One major gap that health providers have identified in testimony before the Standing Committee on Health has been the lack of high-quality, comparable data across provinces and territories.

Liberal MP
Sean Casey

Opinion

In my view, there is no better example of the disconnect between the Ottawa bubble and the electorate than the dearth of thoughtful urgent debate on the state of health care in Canada. It is consistently the No. 1 concern at doorsteps in my home province of Prince Edward Island, as it is across Canada, and rightfully so. Voters are acutely aware of the challenges facing the health workforce, and don't really care which level of government meets them.

As I write this opinion piece, one of the unions representing health-care workers on Prince Edward Island is moving to conciliation to negotiate a new collective agreement with the province. Prince Edward Island currently ranks last in access to health care among the provinces, largely due to workforce shortages to meet the need of Islanders. Health workers play a vital role in our communities, and we have an obligation to lean in and understand the challenges they face as they support us with care and compassion.

This workforce, which includes everyone from physicians and nurses to orderlies and pharmacists is currently facing a high volume of demands on care. This, alongside the doubling of the number of vacancies from the start of the pandemic to 120,140 in 2022-23, has dramatically increased the workload and burnout in the sector. To further exacerbate matters, many have reported feeling unsafe as they carry out their duties.

As decision-makers, it is our responsibility to listen to the concerns of these workers, and to develop solutions with them, not for them.

One major gap that health providers have identified in testimony before the House Health Committee has been the lack of high-quality, comparable data across provinces and territories. The lack of information means that we do not have a pan-Canadian snapshot of the situation on the ground, and are thus unable to develop solutions that work in every jurisdiction.

Last year, the federal government launched its *Working Together to Improve Health Care for Canadians* plan, committing $200-billion over 10 years in federal funding. The goal is to expand access to family health services, support health workers, reduce backlogs, improve access to mental health and addictions supports, and modernize the health-care system with standardized tools. As part of this plan, we signed bilateral agreements with every single province and territory, which include provisions for data collection and sharing between provincial, territorial, and federal governments.

This is essential to the development of the Pan-Canadian Health Data Strategy, which aims to modernize public health data, expand access to health services, and support health workers.

This strategy will, in turn, inform the work of Health Workforce Canada, an independent organization set up by Health Canada bringing health workforce experts and other health workers to strengthen health workforce data and planning in this country.

The work being done by these three initiatives is essential in both addressing the most pressing health workforce challenges and long-term planning.

While the federal government is uniquely situated for large-scale, sustainable planning and strategizing for health care, provinces and territories have an essential role to play, which is reflected in the bilateral agreements.

Indeed, as the governments with the jurisdiction over health-care delivery and workforce management, provincial and territorial governments must identify opportunities for improvements within their regions. From optimizing the education and training of future health workers, to streamlining the recognition of foreign credentials of health workers and revamping administrative processes, they can—and must—alleviate the pressures on the health-care delivery system.

In February 2023, during a meeting with Canada's premiers, Prime Minister Justin Trudeau announced an approximately $200-billion health-care plan, the Working Together to Improve Health Care for Canadians plan. *The Hill Times photograph by Andrew Meade*

Legislative frameworks and policies can be amended to reduce bottlenecks, and ensure that the health-care system is evolving to meet the challenges and opportunities of a changing society. This includes optimizing scopes of work, providing digital and administrative tools, and supporting a holistic model of care delivery.

An example of such good practice can be found in Atlantic Canada. In 2023, the four Atlantic provinces created an Atlantic physician registry, allowing doctors to work anywhere in the region without additional licensing requirements. This increased the mobility of physicians in the region with minimal paperwork, enhancing residents' access to care. Such innovation must be encouraged and expanded.

In my previous op-ed, I stressed the importance of a comprehensive, collaborative, and thoughtful approach to resolve the complex challenges within healthcare. This has been our government's approach so far, and we will continue to favour solutions over slogans to meet the needs of Canadians.

Liberal MP Sean Casey, who represents Charlottetown, P.E.I., is chair of the House Health Committee, and a member of the House Veterans Affairs Committee.

The Hill Times

Protecting public health care has never been more important

National pharmacare will be extended to 3.7 million Canadians with diabetes and nine million Canadians of reproductive age.

Liberal MP
Yasir Naqvi

Opinion

We are at a turning point in Canadian health care—a time of both challenges and opportunities. We need bold solutions to meet today's challenges and to harness tomorrow's opportunities. It is time for all parliamentarians to support our government's ambitious efforts to ensure that Canada's public health-care system moves into the 21st century, and remains a source of pride and a reflection of who we are as Canadians.

Access to quality health care is of paramount importance. However, with the difficulties facing the health sector, the industry's workforce has been significantly impacted, and access to health practitioners has become more challenging. As an MP and parliamentary secretary to the minister of health, I have spoken with many health professionals, and they have told me the same thing: "We need more staff."

Our government is taking action on this front. We have provided funding to provinces and territories to invest in key shared health priorities, including the health workforce, through the Working Together agreements, and have partnered with the provinces and territories on commitments to streamline the foreign credential recognition process. Budget 2024 includes $77.1-million over four years to help effectively integrate internationally educated health-care professionals into this country's health workforce. It also commits to an expansion of the Canada Student Loan Forgiveness program to encourage new graduates to set up practices in rural Canada. This has the potential to have an enormous impact on our rural communities.

Another significant obstacle that we have seen is the cost of essential medication. We have an important opportunity to make a real difference by passing Bill C-64, An Act Respecting Pharmacare. The bill proposes the foundational principles for the first phase of national universal pharmacare in Canada, and outlines collaboration with provinces, territories, Indigenous Peoples, and stakeholders to develop universal, single-payer coverage for a range of contraception and diabetes medications.

The cost of birth control is a significant barrier for women and gender-diverse Canadians. Passing Bill C-64 will mean that nine million Canadians of reproductive age will have greater access to reproductive autonomy. At a time when our neighbours to the south are seeing a political effort to remove their right to bodily autonomy, we must remain firm in our support of the right to choose. Eliminating barriers to accessing contraceptives is a necessary step forward.

Similarly, I believe that improving access to diabetes medications should be common sense as it will help improve the health of 3.7 million Canadians. One in four Canadians with diabetes have reported not following their treatment plan because it is too expensive. This is dangerous, and can lead to

Continued on page 31

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Feds must expand pharmacare to include essential drugs for our deadliest diseases: cancer, heart conditions, and stroke

An expanded pharmacare framework offers a lifeline for millions of people in Canada. It is time for federal, provincial, and territorial governments to deliver it.

Andrea Seale & Doug Roth

Opinion

The federal government's new pharmacare legislation is a historic step forward on the path to national, universal drug coverage. Through important collaboration between the NDP and the federal government, we've finally received a legislative framework intended to give everyone in Canada with a health card access to prescription drugs for diabetes and contraception.

Additionally, the infusion of $1.5-billion over five years in the recent federal budget is a welcome first step in terms of funding.

But it is not time to celebrate yet.

Not only must the legislative framework win the support of Parliament and the provinces and territories, but the federal government must also act quickly to close the gaps in the framework that leave out essential medicines to treat our deadliest diseases: cancer, heart conditions, and stroke.

Millions of people in Canada live with cancer and heart disease, and rely on prescription medicines to help keep them alive. Many cannot afford them.

A 2024 Leger poll commissioned by the Canadian Cancer Society and the Heart and Stroke Foundation revealed that one in four people in this country either do not have prescription drug insurance, or do not have enough insurance to cover their prescription medicines, leading many people to skip doses or split pills, or decide not to renew or fill their prescriptions due to cost.

This is not acceptable. We live in the only country in the world with a medicare system that does not include prescription medications. Without a national program to help reduce the cost of prescription medications, too many Canadians end up taking on this financial burden on their own. These costs are getting harder to manage as the cost of living crisis continues across the country.

This policy gap places a heavier burden on those struggling with complex diseases like cancer and heart disease—people like Robin McGee and Heather Evans.

McGee, from Nova Scotia, has late-stage colorectal cancer. While seeking treatment, she learned there were promising drugs that could help prolong her life. But the province's public health plan did not cover them. Neither did her private insurance.

To access the treatment she needed in Canada, McGee had to pay thousands of dollars out of her own pocket. She ended up buying the prescription medicine from a pharmacy in Bangladesh where it was more affordable, but still costly.

Evans, from Alberta, lives with heart disease and other health conditions. At times, her life-saving prescription medicines cost her up to $1,000 a month. She is currently taking a medication that would cost $46,000 a year if she had to pay for it out of pocket.

Fortunately, Evans has a job with health insurance coverage. But she wasn't always so lucky. Before she had coverage, she was forced to skimp on groceries for her family to afford her medication, and had to rely on free drug samples from her local medical clinic.

McGee's and Evans' stories are not unique. The Leger poll showed that more than one-quarter of respondents have had to cut back on groceries; delay rent, mortgage, or utility bills; or incur debt to pay for their prescription medicines.

A cancer or heart disease diagnosis is daunting enough without also having to face financial hardships to pay for necessary medications.

Beyond affordability for patients, an expanded pharmacare framework that includes prescriptions for cancer and heart disease can also reduce pressure on and save costs to the health-care system.

When we polled people about their prescriptions, one in 10 said they have gone to a hospital because they could not afford prescription drugs for their chronic condition. Universal coverage of essential drugs can prevent these unexpected and costly visits, saving the health-care system an average of $1,488 per patient per year.

Time is of the essence, and we have four critical asks.

Our first is that Parliament makes it a priority to pass the pharmacare legislation before it adjourns for the summer.

Second, we ask all provincial and territorial governments to sign on to new bilateral agreements with Ottawa before the end of the year. The pharmacare legislation enables the creation of these new agreements through which federal funding would flow to expand prescription coverage.

Third, the federal government must immediately appoint a committee of experts—including those from the cancer and cardiovascular diseases communities—to build the pharmacare program.

Fourth, we need the expansion of pharmacare to cover prescriptions for cardiovascular and cancer drugs.

An expanded pharmacare framework offers a lifeline for millions of people in Canada. It is time for federal, provincial, and territorial governments to deliver it.

Andrea Seale is CEO of the Canadian Cancer Society. Doug Roth is CEO at Heart & Stroke.

The Hill Times

Past time for health minister to hit reset button on Natural Health Product over-regulation

Health Canada's changes reflect neither the reality of the industry, nor the values around freedom of choice for the over 80 per cent of Canadians who choose natural to maintain their health and wellness.

Aaron Skelton

Opinion

In the spring of 2023, the Canadian Health Food Association officially launched the Save Our Supplements campaign. This campaign, which began as a response to Health Canada's many regulatory changes to the natural health products industry, remains one of the most active grassroots campaigns with the highest number of engaged Canadians in recent history.

But, despite public outcry and concern raised by many MPs from across the country, the federal government has remained perplexingly and stubbornly headstrong in pushing its agenda.

One of these changes is the new proposed fees for natural health products (cost recovery). As the minister of health stays silent on an exaggerated proposal under his authority, Health Canada keeps changing its stance on the justification and reasoning behind the changes. Cited initially as a response to its failed auditor general report, the department has now cancelled most of the program's modernizations and efficiencies. During an illuminating House Health Committee testimony last fall, the Natural and Non-prescription Health Products Directorate stated the need to increase regulation to protect Canadian health and safety. However, a 2023 Deloitte study analyzing Health Canada's databases, amongst other relevant sources, affirmed the safety of natural health products. These products have been a trusted choice for Canadians seeking alternative health solutions for decades. Yet, Health Canada has failed to adequately analyze the many impacts on Canadians.

Unfortunately, lack of analysis remains a running theme. The original cost recovery proposal (published in *Canada Gazette I*, May 2023) aimed to recoup $100-million a year from the sector. Industry response was overwhelming, as a lack of cost-benefit analysis left businesses to do the math on whether they could afford to stay afloat—which many small to medium-sized companies realized would be near impossible.

The current proposal (updated March 2023) has attempted to reduce the rates charged to industry. Still, it threatens to bleed Canadian businesses dry, demanding hundreds to hundreds-of-thousands of dollars to be compliant while foreign, unregulated competitors do not have to pay as they operate beyond Health Canada's regulatory oversight. Health Canada is worsening the already uneven playing field by increasing the regulatory burden on compliant Canadian companies, and essentially taxing domestic brands out of the market. The onslaught of costly changes being forced on Canadian small and medium-sized businesses appears conflicting to the message of protecting health and safety, as they will only result in Canadians losing access to safe, compliant products in local stores, driving consumers to online, international marketplaces.

The domestic market cannot afford to shoulder this financial burden: Canada's natural health products industry—a $5.5-billion industry that generates $2.8-billion in taxable revenue, and supports more than 54,000 jobs—will be left behind from what is a global, thriving industry set to see unprecedented growth in the next few years. The sector's innovation, research, and science will fall to shameful levels where this country was once a global leader.

Health Canada's changes reflect neither the reality of the industry, nor the values around freedom of choice for the more than 80 per cent of Canadians who choose natural to maintain their health and wellness.

We've said it before, and we're repeating it now: it is time for Health Canada to hit reset and do something about the uneven playing field it has created for Canadian businesses.

When we all do well, Canadians live well.

Aaron Skelton is president and CEO of the Canadian Health Food Association.

The Hill Times


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Mental health and illnesses are a population health issue

The government has heeded the call for pharmacare and dental care, which fall outside the Canada Health Act. Mental health care is the obvious third leg of the stool.

Louise Bradley

Opinion

The first iteration of Wellness Together Canada, funded through emergency federal dollars, ceased on April 3, 2024, yet the urgent need it filled remains, writes Louise Bradley, board chair of Stepped Care Solutions. *Photograph courtesy of Pixabay.com*

In the eye of the COVID storm, with the population's mental health in free-fall, the federal government acted with unprecedented foresight to sponsor a virtual, truly universal, mental health safety net made up of Canada's leading mental-health innovators.

Wellness Together Canada was a one-stop shop, providing services for a range of mental health concerns, free to *everyone* in Canada, regardless of postal code. This jaw-dropping achievement was unlike anything I'd seen in my three decades of mental health advocacy.

As though shaken from complacent slumber, Canadian leaders woke up to the reality that mental health problems and illnesses are a population health issue—full stop.

The federal government has heeded the call for pharmacare and dental care, which fall outside the Canada Health Act. Mental health care is the obvious third leg of the stool.

Our need for these services may ebb and flow, but it never recedes. If one in five Canadians experiences a mental health problem in any given year, and one in two by the age of 40, then the demand will grow as Canada's population ages.

We can meet the rising tide by building on the foundation laid by Wellness Together Canada, which was so much greater than the sum of its parts.

By uniting 15 expert providers—ranging from self-guided programs and peer support, to counselling and crisis intervention—the access and reach of each was expanded. People who might have otherwise fallen outside certain service areas were able to access timely help. Add to this lesser-known applications, such as an overdose prevention tool, and you have a comprehensive suite of services for a broad range of mental health and substance use concerns.

The program, designed to serve the needs of every individual—from new Canadians, to overwhelmed working moms, to trans kids in isolated communities, to residential school survivors—ushered in an era of unprecedented equity. Twenty-four hours a day, 365 days a year, Wellness Together Canada was there—and more than half the time, people sought help outside business hours.

From overtaxed nurses in the Northwest Territories, to once-skeptical psychologists in the heart of downtown Toronto, health-care providers of all stripes became ambassadors, safe in the knowledge those in need would find quality care at the tips of their fingers. The high level of satisfaction reported by visitors bore that out.

The first iteration of Wellness Together Canada, funded through emergency federal dollars, ceased to be available on April 3, 2024.

Yet the urgent need it filled remains.

It was founded on the pioneering Stepped Care 2.0 model, which eases system log-jams, slashes wait-times, and offers people choice. Among my proudest achievements as then-president and CEO of the Mental Health Commission of Canada was our work to scale up Stepped Care 2.0, initially at select sites across the country, and ultimately, as the bedrock of Wellness Together Canada.

As the name suggests, Stepped Care 2.0, a refined version of an earlier approach, recognizes that people move along a mental health continuum, from healthy and well to injured or ill, with few of us requiring the specialized care at the most intensive level, or "top step." In fact, evidence supports the extraordinary findings that a self-guided online program, or a single counselling session with a social worker, is often enough to help someone who may be struggling to course correct.

Wellness Together Canada has been lauded internationally for subtracting stumbling blocks from the help-seeking equation. Unlocking accessibility required nothing more than an internet connection or a telephone—a game-changer when six million Canadians are without a family doctor, and referrals are prohibitive. 'Convenience' and 'choice' were watchwords of Wellness Together Canada, offering people a selection of reputable resources from the comfort of their own homes with the added security of privacy safeguards.

Since its launch four years ago, there were over four million visitors to the service, averaging 100,000 people each month. This redirected patients from emergency rooms and freed up physician visits, while providing services to many who would have otherwise been left out in the cold. If an ounce of prevention is worth a pound of cure, then a re-upped Wellness Together Canada would be a bang-for-your-buck investment.

With increased advertising, greater public awareness, and continued health care provider referrals, a similar offering could become an even greater, more efficient resource, costing each Canadian taxpayer less than a cup of coffee—*per year*.

Wellness Together Canada was truly a port in a storm. If there was a silver lining to COVID, it is the invaluable lessons learned through Wellness Together Canada. Imagine the possibilities waiting for us in version 2.0.

Louise Bradley is board chair of Stepped Care Solutions, and is former president and CEO of the Mental Health Commission of Canada.

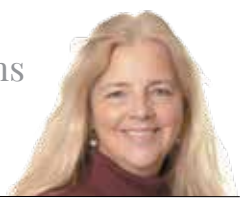
The Hill Times

The health-care system's hidden backbone: workplace supports for economic sustainability

Whether it be providing long- or short-term care, unpaid carers reduce strain on the healthcare system by taking care of their loved ones either in the home or the community.

Allison Williams

Opinion



The sustainability of our healthcare system and workforce depends on the readiness of our workplaces to support and accommodate carer-employees to better manage their dual role, writes McMaster University professor Dr. Allison Williams. *Photograph by Matthias Zomer, Pexels.com*

As Canada approaches National Caregiving Month in May, people across the country recognize the difficult and important work of unpaid carers in supporting health-care systems.

Unpaid care work is the backbone of the health-care system in Canada. Unpaid carers are individuals of all ages—youth, older adults, and those in the prime of their careers—providing care to loved ones that could include spouses, parents, in-laws, family members, friends, or neighbours. Carers directly impact our country's economic health, specifically contributing to sustainable health-care infrastructure. In Canada, 75 per cent of care is provided by unpaid carers, saving our health-care systems billions of dollars, averaging about $24-billion to $31-billion in unpaid care work each year. Whether it be providing long- or short-term care, unpaid carers reduce strain on the health-care system by taking care of their loved one(s) either in the home or the community.

The impacts of COVID-19 are still being realized across health-care systems today, ranging from nursing shortages to the realities of underfunded long-term care; these weaknesses are placing additional strain on unpaid carers.

Some carers are simultaneously balancing their unpaid care work with paid employment; these folks are known as

Continued on page 31

CANADIAN PARTNERSHIP AGAINST CANCER

Transforming cancer care through the Pan-Canadian Cancer Data Strategy

Imagine a world in which a cancer patient's health data follows them across the whole healthcare system, from their first appointment with their family doctor, through radiation and surgery, to post-treatment care. Every step of the way, high-quality and up-to-date information about their health would be available to them and all the professionals involved in their case, allowing for better, more timely and more equitable decision-making and care. This would also provide decision-makers with a more complete picture of the processes and outcomes of care to inform policy.

This kind of approach to data is on the horizon in Canada: in May 2022, the *Pan-Canadian Health Data Strategy* laid out high-level requirements for improving point-of-care data access throughout the healthcare system. In July 2023, the Canadian Partnership Against Cancer (the Partnership) and the Canadian Cancer Society (CCS), working with partners throughout the Canadian health and data systems, launched the *Pan-Canadian Cancer Data Strategy*.

Building on strong foundations

The Cancer Data Strategy complements the Pan-Canadian Health Data Strategy which aims to modernize the health system by improving how health information is collected, shared, used and reported to people in Canada.

The Cancer Data Strategy also aligns with the goals of the Shared Pan-Canadian Interoperability Roadmap to help ensure different digital health systems can interact with one another so a patient's health information can move with them throughout the system. This is paramount for cancer patients who interact with different parts of the healthcare system throughout their journey, from screening to treatment to follow-up and beyond.

Investing in a cancer-specific data strategy is critical, not just because of the prevalence of the disease – two out of every five people in Canada will be diagnosed with cancer in their lifetime – but also because there are unique data systems such as cancer registries and radiation treatment files in the cancer data ecosystem. Additionally, the relatively good organization of cancer data makes cancer an ideal test case for initiatives under the broader health data strategy. The Cancer Data Strategy will help tackle the urgent need to close gaps in cancer data in Canada, leading to improvements in cancer prevention and care while also helping to address the needs of those who survive it. Additionally, the strategy will support better planning, evaluation and research to ensure that Canada's cancer system remains strong and effective.

The strategy includes three priorities for action and investment:

- Improve the efficiency, timeliness and quality of data capture and access.
- Enhance interoperability and linkages to current data.
- Fill gaps in current data collection and availability.

Achieving these priorities while centring the needs of equity-deserving groups, and supporting and upholding First Nations, Inuit and Métis data sovereignty, will ensure that all people in Canada have access to patient-centric, innovative and high-quality cancer care.

Collaborating to achieve the goals of the cancer data strategy

The work underway at the federal level toward the Pan-Canadian Health Data Strategy has created the supportive environment needed to achieve the priorities of the Cancer Data Strategy. In turn, the Cancer Data Strategy operationalizes many of the goals of the Health Data Strategy.

To achieve the goals of the Cancer Data Strategy, it is crucial that health administrators, researchers and academic institutions, First Nations, Inuit and Métis partners, as well as federal, provincial and territorial policymakers continue to invest in building a more cohesive cancer data ecosystem.

Together with provincial and territorial partners, the Partnership and CCS are pushing ahead with innovations in cancer data. We urge everyone with a stake in the healthcare system – and particularly government and healthcare leaders – to lend their support so we can move quickly to establish a comprehensive cancer data system that benefits all people in Canada, today and in the future.

Learn more at partnershipagainstcancer.ca

As the steward of the Canadian Strategy for Cancer Control, the Partnership works with Canada's cancer community to take action to ensure fewer people get cancer, more people survive cancer, and those living with the disease have a better quality of life and all people in Canada have equitable access to quality cancer care. The Partnership is funded by Health Canada.

This article was produced through a financial contribution from Health Canada through the Canadian Partnership Against Cancer. The views expressed represent those of the Partnership.

Close to 20 per cent of Canadians have inadequate or no drug coverage at all, forcing some to skip or cut doses of medicine, or forgo other necessities, such as food or heat, to be able to afford those medicines. *Image courtesy of Pexels*

Patient involvement in pharmacare is critical to its success

Pharmacare is the most innovative and important health policy legislation in decades. To get it right, the federal government must directly engage with patients.

Louise Binder & Filomena Servidio-Italiano

Opinion

Canada is on the verge of a new era in access to affordable prescription drugs. The federal government's long-awaited pharmacare bill promises to lay the foundation for a national, universal pharmacare plan.

It could be a game changer for the one in five Canadians who struggle to afford the cost of prescription drugs. The federal government and the NDP deserve praise for developing a framework for the most ground-breaking health policy initiative in decades.

Yet, an essential element for success is missing from the legislation: input from patients who rely on prescription medications to treat their illness or disease. Their experience is vital in ensuring that pharmacare makes prescription drugs more affordable while not limiting access to essential medicines.

The federal government must avoid a mistake that governments too often make when implementing health policy. It must directly involve patients in building pharmacare.

Governments often tout the importance of patient-centred care in decision-making, only to leave patients out of the loop when it comes to developing policies that affect them. This cannot happen with pharmacare. The stakes are too high.

Close to 20 per cent of Canadians have inadequate or no drug coverage at all, forcing some to skip or cut doses of medicine—leading to potentially catastrophic outcomes—or forgo other necessities, such as food or heat, to be able to afford those medicines.

So, how can the federal government directly engage patients in developing pharmacare?

First, it must include the patient voice on the expert committee that will make recommendations on operating and financing pharmacare. The legislation requires the government to set up the committee within 30 days after the bill passes.

However, the legislation makes no reference to patient representatives being among those experts. This is a mistake. Who knows better than patients—especially those with no or insufficient drug insurance—where the real gaps are in current public drug plans and how to fill them?

Second, the government must give patients a seat at the table when it comes to determining which prescription drugs to cover.

The government's commitment to provide first-dollar coverage for contraceptives and diabetes drugs and devices through provincial agreements is a good first start, but the list cannot end there.

Currently, it is up to each province to decide which prescription drugs to cover under their public health plan and under what conditions—including deductibles and co-payments. This results in unequal, inequitable coverage for and access to timely prescription drugs.

Drugs not covered publicly are only available to those fortunate enough to have a private drug plan covering them. Otherwise, people must pay for drugs out of their own pockets. This can be unaffordable for many, especially those in marginalized communities.

The federal government must work with the provinces, and consult with patients to expand the list of pharmacare-covered drugs to include prescribed treatments for life-threatening illnesses including cancer.

Governments must also include patients in discussions about how innovative drugs fit into pharmacare. Research advances have led to an explosion of new treatments in recent years, particularly for cancer.

These innovations can help patients live longer with a better quality of life. Yet, many innovative drugs are not covered under provincial public health plans, and are costly out of pocket expenses, limiting access for those who need them. Patients' insights can give governments a more comprehensive picture when determining how these treatments fit into pharmacare.

Third, the government must give patients a voice in the recently created Canadian Drug Agency. The legislation provides details on the agency's role—including in the areas of developing a list of essential prescription drugs, creating a national prescription drug purchasing strategy, and developing recommendations for doctors and patients about the appropriate use of drugs—yet it is silent on patient involvement.

Patients should be part of decision making not only about which essential medicines to cover, but also around an issue as important as the appropriate use of prescription drugs and related products. Patients' lived experience with medications is an invaluable asset in making evidence-informed decisions about their care.

Pharmacare is the most innovative and important health policy legislation in decades. To get it right, the federal government must directly engage with patients. Their expertise is crucial to pharmacare's success.

Louise Binder is the health policy consultant for Save Your Skin Foundation. Filomena Servidio-Italiano is the president and CEO of the Colorectal Cancer Resource and Action Network.

The Hill Times

Embracing regulatory ambition to shape Canada's future in health-care innovation

At this pivotal moment, Canada has the ability not only to redefine its healthcare landscape, but also to lead globally in the sector.

Andrew Casey

Opinion

As a result of game-changing innovations emerging from the biotechnology sector globally, health care is undergoing a truly transformational phase. With its long history of science, research, and health-related biotech innovation, Canada is well-positioned to be a leading force in this transformation which will benefit Canadian patients and millions of others globally.

The origins of this country's diverse and national biotech ecosystem can be traced back to the discovery of insulin and the development of the polio vaccine. Since that time, Canadian scientists have played central roles in developing remarkable breakthroughs in stem cell research, regenerative medicine, and vaccines. This legacy is augmented by a dynamic ecosystem characterized by collaboration across academia, industry, and government, which establishes the foundation for the next frontier of health-care advancements including next-generation vaccines to prevent cancer, gene-editing tools such as CRISPR, and advances in tissue engineering which all hold the potential to address previously untreatable diseases and genetic disorders.

Importantly, the rapid application of artificial intelligence (AI), another field in which Canada is developing recognized expertise, is now transforming the biotech industry by enhancing R&D, accelerating and streamlining new drug discovery and development. AI's capacity to swiftly analyze complex data sets enables companies to push the pace of innovation, promising rapid development of novel therapies. As a result, there are remarkable new technologies available now, with many others on the not-so-distant horizon. Accordingly, Canada needs to be ready to adopt and drive the development of health-care innovation and technology.

Building on the history and success of the established biotech ecosystem and the imperative of preparing for future pandemic-like challenges, the government has identified the biotech sector as a strategic priority. Importantly, just as Canada has, other countries are also moving aggressively to invest in and drive their domestic biotech sectors. In this context, the global arena is now a highly competitive space as countries compete for limited companies, investment, and talent. To remain competitive, Canada must establish a globally ambitious public policy and regulatory environment which supports and drives innovation forward. At a minimum, our nation must be on par with other like jurisdictions around the world if it aspires to attract innovation and grow its domestic life sciences sector. Following the pandemic, Canada has taken some meaningful steps to modernize and improve its regulatory capacity. Continuing to build on these initial steps will enhance domestic competitiveness and attract innovation. Embracing AI, developing technical expertise in emerging fields, regulatory cooperation, and alignment with other similar regulatory jurisdictions are some of the potential steps Canada should take to advance its regulatory capacity.

An efficient and agile regulatory framework is crucial for the success of our biotech sector and for the attraction of new technologies and therapeutics for Canadians. Canada has traditionally been viewed as a strong, science-based regulator for new drugs and technologies. An aspirational approach to modernizing this country's regulatory capacity will ensure it is ready to adopt the remarkable emerging technologies. Moreover, an ambitious approach to regulatory modernization sends a strong signal that Canada is serious about playing a leadership role in adopting and developing the new technologies. This will support the creation and scaling up of businesses, and will attract global pharma and biotech companies who will bring innovation, clinical trials, and investment to Canada.

At this pivotal moment, this country has the ability not only to redefine its healthcare landscape, but also to lead globally in the sector. By drawing on our strong tradition of innovation and fully embracing AI and biotechnology, we are well-equipped to navigate the complexities ahead and maintain our position as a leader in global healthcare.

Andrew Casey became president and CEO of BIOTECanada in August 2012. As the head of BIOTECanada, he is the lead spokesperson for Canada's biotechnology industry communicating on the industry's behalf with government, regulators, international bodies, media, and the Canadian public.

The Hill Times

Moving beyond Band-Aid solutions to deliver health care fit for kids

The Conference Board of Canada estimates the annual costs to treat anxiety and depression in young people to be $4-billion, which balloons to nearly $1-trillion over a lifetime without timely interventions.

Emily Gruenwoldt

Opinion

The vibrancy and wellbeing of children and youth serve as an important barometer of a nation's commitment to its future. In the Canadian context, we find ourselves at a critical crossroads, facing a crisis in child and youth health that demands our collective attention, and compels transformative action.

From coast to coast to coast, children and youth are struggling. From long waitlists for essential health-care interventions to a shortage of primary care providers, cracks in our health-care systems threaten to undermine the potential of our youngest generations, and indeed the future of our country.

Delays in access to care come at both a human and financial cost. The Conference Board of Canada estimates the annual costs to treat anxiety and depression amongst children and youth to be $4-billion; a figure that balloons to nearly one-trillion dollars over a lifetime without timely interventions for these common mental health diagnoses. Delayed pediatric scoliosis surgeries—based on children currently waiting beyond the recommended time frame—are estimated to cost our healthcare systems $44.6-million, and lead to caregiver productivity loss of $1.4-million. While children wait for services, they may experience physical or emotional pain, fall behind in school, miss out on social activities, and often their conditions worsen—in some cases, irreversibly. As a society, we cannot afford to ignore the mounting evidence of the profound impacts of inaction.

Canada has an unprecedented opportunity to reimagine its future by setting up children, youth, and families for success. The path forward requires a fundamental shift in how we conceptualize and prioritize investments and policies to support children and youth. A path that speaks both to a moral imperative and an economic one. We must recognize that investing in the health and wellbeing of our youngest citizens is an investment in the future prosperity and resilience of our nation as a whole. If we improve the health of children, we improve the health of Canada.

At the heart of this commitment must be the opportunity to "right-size" health-care systems tailored specifically to the unique needs of children and youth. Children are not tiny adults. They require specialized physical and mental healthcare services that span the continuum of care. From primary care to community settings, acute care, and rehabilitation, our health-care systems must be accessible, equitable, and purpose-built to meet the diverse needs of our youngest population.

Central to this vision is the concept of integration—of seamlessly connecting physical and mental healthcare services, of fostering partnerships between healthcare providers and families, and of ensuring continuity of care across the lifespan. Only through a holistic and interconnected approach can we hope to address the multifaceted needs of children and youth effectively.

Achieving this vision will require more than just lofty rhetoric. It demands concrete actions and unwavering commitments from all levels of government, advocacy groups, healthcare delivery organizations, and beyond. It requires dedicated funding envelopes for children's health systems, publicly accessible child health data, and a highly specialized health workforce trained to meet the unique needs of our youngest patients.

Fortunately, the groundwork has already been laid. Through extensive consultation and collaboration, organizations like Children's Healthcare Canada have developed a shared vision for high-functioning children's health-care systems. The report, *Beyond Bandaids: Delivering Healthcare Fit for Kids*, recommends collective and coordinated action to immediately begin maximizing results for children and youth. Now, it is incumbent upon us all to turn this vision into reality.

As we look to the future, let us not forget the profound impact that our actions—or inaction—will have on the lives of our children and youth. Every day matters in the life of a child, and it is incumbent upon us all to ensure that every child has access to the quality health care they deserve. Together, we can move beyond Band-Aid solutions, and build health-care systems truly fit for kids to deliver a brighter, healthier future for all Canadians.

Emily Gruenwoldt is a trusted voice and passionate champion for Canada's eight million kids, and advances a vision for vibrant, healthy children and youth in her role as president and CEO of Children's Healthcare Canada, a national, non-profit association representing more than 40 health-care delivery organizations serving children, youth and families. She is also executive director of the Pediatric Chairs of Canada.

The Hill Times

Answering a call for help can save a life, but what comes next is just as critical

With 12 Canadians dying by suicide every day, the government has set up a national three-digit helpline. But a compassionate response can't end there. It demands the availability of real help for Canadians in mental distress, before and after they hang up the phone.

Margaret Eaton

Opinion

For Canadians experiencing suicidal thoughts, dialling 988 could be the hardest call they'll ever make. For others experiencing distress, they wonder if their symptoms are "serious enough."

Some will reach out to the new 24/7 helpline for suicide crisis, made available nationwide last fall, during their own mental health crises. Others will make the call because a friend or family member needs help. For those who take this leap —and for the people who love them, their communities, and the responders on the other end of the phone — it's essential that the right help be available, when they need it, to alleviate the suffering that prompted the outreach in the first place. But right now, that's far from guaranteed.

The theme for the Canadian Mental Health Association's 73rd Mental Health Week (May 6-12) is "healing through compassion". Compassion goes beyond empathy in that it includes an authentic desire to alleviate suffering and is followed by genuine effort to do so. Providing adequate care in response to a mental health crisis is the compassionate thing to do.

Canadians are struggling. So much so that 12 people die by suicide each day in this country, on average, and 60 are hospitalized for self-harm. It was concern about this suffering, and compassion across party lines, that led to the establishment of a dedicated national helpline to provide immediate support to those thinking about suicide, and to de-escalate situations of acute emotional distress. It is an important first step, but additional federal leadership is essential to both prevent these crises in the first place, and to ensure that those reaching out for help actually get the support they need.

If connecting with a helpline responder isn't enough—and for many of those who call 988, it won't be—we know that too often, people in mental health crisis have nowhere to turn for care but a police car or emergency room. Where appropriate mental health care is available in the community, services are delivered by non-profits and charities whose current resources can't always meet demand. Otherwise, people with the ability to pay can use private providers.

The bilateral health agreements signed in 2023 with provinces, as well as the April 16 federal budget, fail to adequately invest in crisis services delivered by community-based organizations outside of hospitals and doctors' offices. This is a missed opportunity. According to polling commissioned by CMHA for Mental Health Week, 78 per cent of Canadians think this country could be more compassionate by doing more to help those in need, through social support programs and better laws/policies.

For Canada to be considered a truly compassionate nation we need to see dedicated investments in community resources to reduce instances of mental health distress and prevalence of suicide, and make sure that a call for help is the beginning of someone's journey towards mental wellness.

What would a compassionate response look like? Imagine hearing from a crisis line responder that a peer support worker, who has navigated a suicide crisis of their own, could be dispatched to make a home visit. Imagine being told you were going to get access to free, ongoing counselling for the mental illness that had brought you to a crisis point after going untreated for years. Or imagine that your child's school was implementing a skills-building emotional and social learning program to assist our youth grappling with the pressures of academics, social media, and other stressors.

Community-based services like these can be life-saving—where they exist—and access to them needs to be expanded. It's an investment that would address pressures on the public institutions, like hospitals and police departments, that are not equipped to bear the responsibility of comprehensive mental health care. It's also the compassionate thing to do.

By tangibly supporting evidence-backed, community-based care for people in mental health distress, federal leadership would have a rapid and significant positive impact on individual lives across the country. It would also uplift families, workplaces, and communities who suffer when their people suffer, and can thrive when they get the care they deserve.

Margaret Eaton is the national CEO of the Canadian Mental Health Association, the most established and extensive community mental health organization in Canada.

The Hill Times

Canada is grappling with overlapping crises in mental health and overdoses that are outpacing the capacity of the mental health and substance use health system to respond, write Kathleen Leslie and Jelena Atanackovic. *Image courtesy of Pexels*

Canada needs a workforce action plan to tackle overlapping crises in mental health and overdose deaths

With the ongoing mental health and overdose crises, Canada needs a MHSUH workforce action plan now so that Canadians can have timely and equitable access to these critical services. Federal, provincial and territorial governments must make this a priority.

Kathleen Leslie & Jelena Atanackovic

Opinion

Canada is grappling with overlapping crises in mental health and overdoses that are outpacing the capacity of the mental health and substance use health system to respond.

While governments across the country are taking steps to increase access to mental health and substance use health (MHSUH) services— including a recent federal government announcement of $500-million to support community-based youth mental health organizations—these measures often overlook the MHSUH workforce itself, the psychologists and social workers, counselling therapists and addiction counsellors, peer support and harm reduction workers, nurses and physicians, occupational therapists and other practitioners who are the backbone of the system.

Canada cannot close the gap in access to MHSUH services unless we develop a MHSUH workforce action plan to co-ordinate planning across jurisdictions, provider types and the public and private sectors.

Although the mental health and overdose crises pre-dated COVID-19, they were exacerbated by the pandemic. Fears of infection, financial stress, shutdowns, isolation, and interruptions in work, education, family, social and healthcare routines in the early stages of the pandemic led to an alarming increase in mental health and substance use concerns.

One in three people reported moderate-to-severe mental health concerns, and one in four Canadians who used alcohol or cannabis said their use was problematic.

Staffing shortages, restrictions on in-person visits, and the need to move to virtual care challenged the capacity of the MHSUH system to respond to growing population needs. The pandemic also further burdened the MHSUH workforce—especially those working in substance use health and addiction—who were already dealing with difficult working conditions, low pay, stigma, stress, and burnout.

While some MHSUH providers—particularly those in the private sector—increased their capacity to provide services during the pandemic, overall MHSUH workforce capacity decreased, widening the gap in access.

There have been some recent improvements reported in overall population mental health; however, the number of people reporting symptoms of depression, anxiety and post-traumatic stress disorder has not declined.

The toxic drug supply that is fueling the overdose crisis is compounding the pandemic's lingering MHSUH impacts, putting further strain on the capacity of the MHSUH system and its workforce to provide timely access to needed services and supports.

To strike at the heart of these issues, Canada must develop a MHSUH workforce action plan. Other countries—including the United States, the United Kingdom, Australia and New Zealand—have already adopted plans to tackle issues such as workforce planning, recruitment, and training.

It is time for Canada to do the same.

The federal government needs to work with the provinces and territories to develop an action plan that focuses on priority areas for the MHSUH workforce, including hiring more workers, diversifying the workforce, and implementing measures—including fair remuneration and support for well-being—to improve retention. The recent expansion of the Canada Student Loan forgiveness to social workers and psychologists working in rural and remote communities is a step in the right direction.

The plan must also prioritize better data collection.

Despite the vital work of the MHSUH workforce, significant data gaps exist—especially for psychotherapists and counselling therapists, addiction counsellors, and peer support workers—that hinder workforce planning. Without robust data on all occupations providing MHSUH services across the country, decision-makers do not have a clear picture of gaps in service delivery, or how to close them. The new federally funded Health Workforce Canada could play an important role in bridging these gaps.

The action plan must also include regulatory changes that develop and expand roles, scopes of practice, and the skill mix of MHSUH workers throughout Canada—including a flexible approach to quality assurance for some currently unregulated provider groups.

It must also address inequities in access, and the need for more public funding of MHSUH services. There are often long wait lists for publicly funded MHSUH services, leaving people to either wait longer for the support they need, or turn to the private system if they have employer-provided insurance or the financial means to pay out of pocket.

Education, training, and ongoing development must also be important components of the plan as must integrated team-based care so that mental health, substance use, primary care and other health sectors work together collaboratively.

Finally, given the shift to virtual care, it is also essential that the plan include funding to ensure that MHSUH workers have the digital infrastructure and training to provide virtual care in an equitable way.

With the mental health and overdose crises showing no signs of abating, Canada needs a MHSUH workforce action plan now more than ever so that Canadians can have timely and equitable access to these critical services. Federal, provincial and territorial governments must make this a priority.

Dr. Kathleen Leslie is an associate professor in the faculty of health disciplines at Athabasca University. Dr. Jelena Atanackovic is a senior research associate at the University of Ottawa.

The Hill Times

Getting everyone a 'front door into the health system': Jane Philpott weighs in on fixing health care, and her future in politics

'I feel that it is a fundamental responsibility of anyone who is an elected official... to collaborate with other orders of government to be able to make sure that health care works,' says the former health minister.

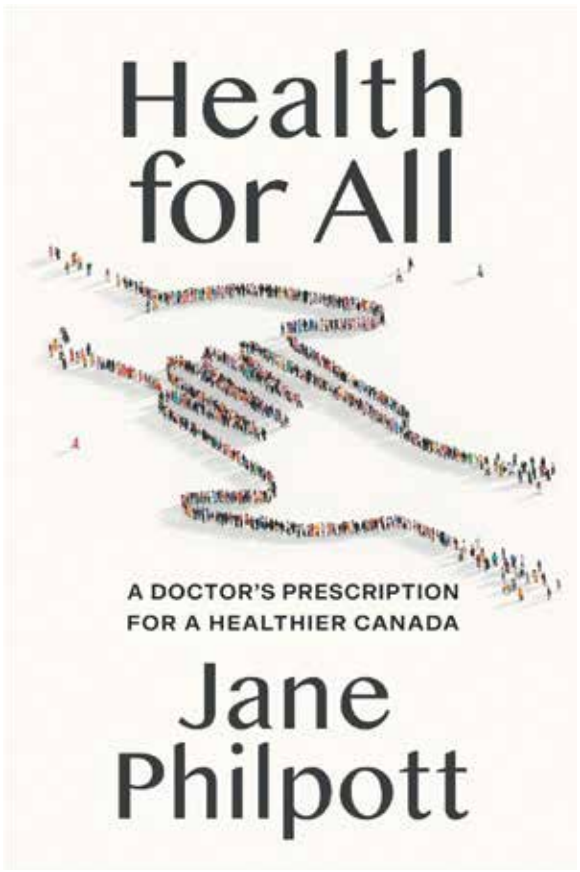
BY PETER MAZEREEUW

Former federal health minister Jane Philpott has written a book about how to solve Canada's family medicine problem. Titled, *Health for All: A Doctor's Prescription for a Healthier Canada*, the work is Philpott's call to arms to Canadians who are fed up with kitchen-table conversations about the impossibility of finding a family doctor, or negotiating hospital emergency rooms that have been overwhelmed in part by patients with nowhere else to turn.

The physician and former Liberal cabinet minister lays out her solution: a new model for providing family medicine in Canada, and renewed efforts to tempt medical students into the field.

Philpott joined *The Hill Times*' *Hot Room* podcast to talk about her ideas last week, the challenges of collaborating with provincial and territorial governments, and whether she plans to run for office again. The following interview has been edited for clarity.

You've written a book on how to overhaul Canada's health systems. And what I love about this book is it doesn't just talk about the problems or shortcomings in our systems. And it doesn't just talk about how important it is to fix those problems. You actually make some specific suggestions about how we could rebuild our model for delivering primary health care using the elementary school system as a kind of template. Can you walk us through how it would work?



"Yes, it's actually a pretty straightforward metaphor that I use. And I'm not the first person who's used this, but I'm perhaps the first person who's published a book describing this approach. Because, as people are feeling overwhelmed about health care and the huge challenges, the real problems with lack of access to primary care in particular—where we know that at least six and a half, and probably more like seven million Canadians don't have a family doctor or any other primary care provider—it feels a bit overwhelming. And everyone, I think, begins to despair that it's unfixable.

"And so I share this example of the fact that in Canada, for as long as any of us can remember, we have been able to have systems across the country where we know that every child has access to a publicly-funded education for elementary school and secondary school. It's wonderful. And you know, it's so reliable that you don't worry when you move to another town whether you'll be able to find a school for your child. But you sure do worry right now if you move to another town whether you'll be able to find a family doctor. So we need to design a system where everyone has access to a primary care team. And it's doable because many other countries have done this."

So why is this model—a sort of health centre in every community—why would that work better than what we have now?

"Well, what we have now is pretty ad hoc, right?

"I'm a family doctor. And when I wanted to start a practice, I could pick wherever I wanted to start. I didn't have to do it based on where there was need. But I did have to work with my group to lease a space, to hire our staff, to buy the computers that we needed, and essentially run the business. And so that has been the model that has existed in Canada, for the most part.

"There have been these facilities called Community Health Centres, which run under a slightly different model. But again, it's a little bit ad hoc as to which community gets a Community Health Centre. And so what we need to do is get organized, and figure out where the gaps are, and then build facilities that will have a primary care team, not just a family doctor, but primary care nurse practitioners, and nurses, and dietitians, because that's actually the most affordable way to get care. It's the most patient-centred or person-centred way to get care, so that everyone has a front door into the health system, because for seven million Canadians, they don't have anything like that. And their only choice when they get sick is to go to the emergency department. And often they don't go soon enough, because they've been waiting and waiting to get care. So we've left ourselves with a system that costs a lot more than it needs to, and people are not getting the care they need."

Not all family doctors will want to practice in a family health centre, and work with and through all these other staff members. Some of them like the current model. What happens to them if the powers that be decide to implement your model?

"That's a really interesting question. Of course, you know, physicians do enjoy a lot of autonomy, which is great, and there would be no likelihood that you could make people move out of the system that they're happy with. But actually, what we are hearing, especially from young doctors, is that they are really interested in looking at these new models. They're very interested in working with a salary-based approach, as opposed to the current models, which are often fee-for-service. And they very, very much want to work in teams. In fact, that's one of the problems that happens when family doctors finish their training. We train them in these beautiful team-centred clinics, where they're used to working alongside nurses and others, but then they get out to practice, and there's no public support for that except in very few cases. And so we know that that's one of the reasons why they decide not to open up a practice; they end up going to work in hospitals or emergency departments or other areas, but they don't do this comprehensive family practice with a team because the model doesn't exist."

The benefit of working through a team like this—I think the way you phrased it in your book— is, everyone is 'working at the top of their practice.' In other words, no one is spending time doing work that they're overqualified to do, it's very efficient. Is that right?

"Exactly. I mean, I don't think I'd go so far as to say that you never do something that you know someone else could possibly do, but you ideally have everyone working as close as possible to what we would call the top of their scope. So if it's something that, you know, only a doctor is qualified to do, then obviously the doctor does that. But there are lots of things that doctors end up doing that another person could easily do. You know, giving

Jane Philpott, speaking at the Canadian Museum of History in June 2018, says there is a 'lack of political will' to change Canada's health-care system. *The Hill Times photograph by Andrew Meade*

Jane Philpott, the former federal health minister and current dean of health sciences at Queen's University, spoke to *The Hill Times* about how to fix Canada's ailing family health systems. *The Hill Times photograph by Andrew Meade*

injections is an easy example, or suturing a wound, providing dietary counselling. There are so many things that other people on the team can do just as well, or sometimes even better. And so working together as a team is a way to make sure that we use our health workforce in the most efficient and effective way, because we know that we depend on that health workforce, and there are simply not enough family doctors to go around."

And right now, the reason we don't see more of this is because doctors have to pay out of pocket for anyone on their team if you're in family medicine, right?

"Exactly. There was, for a little while—in Ontario, for example—funding for family health teams. So about a quarter of the people in Ontario are attached to a team-based care model. That's fantastic where it exists. But apart from a few other isolated examples like that, doctors are paid in most parts of the country under a fee-for-service model. And if they want to have a nurse or someone else on their team, they pay for it themselves.

"One can certainly argue that that would be a good use of their resources, and many doctors do choose to do that. But it's less likely used, because it's not part of the plan, and the intentional design."

Your book presumes that a majority of Canadians want major change to the way primary health care is delivered. And that would seem obvious given how difficult it is for people to get a family doctor. Yet 10 Canadian provinces have had decades of opportunity to read all of these op-eds, and white papers, and books that have been written about this, and overhaul the system. And none of them have really done it. Why not?

"It's an excellent question. And I make the case in the book that it's largely because of the lack of political will. You know, I think there are other reasons around that: in part, there aren't always a lot of people in either the political side of government, or even the public service side of government, that have had experience on the frontlines of health care. And it's a really complex environment. And I think they get a bit overwhelmed, and aren't sure how they can actually do this.

"I'm hoping that having written the book and sharing this model and this idea with people across the country, that it will will take a little bit of the mystery out of it, and help Canadians in general to put the pressure on politicians to grow that political will to say, 'yes, we need to figure this out.' We aren't going to be able to do it overnight. But we can absolutely design an approach like this. We are doing a model like this now in Kingston: we've been funded for a portion of the population who have not got attachment to primary care. And with a little bit more funding, we could roll it out so that everyone in the city of Kingston would have access to primary care. And as we start to show what the models look like, then it becomes much more palpable and easier for the political decision-makers to imagine that they could actually do this for the whole country."

Speaking of political decision-makers, will you be putting your name on a ballot again?

"Well, at the moment, I'm working at Queen's University and loving my job there. I loved politics, too. I would, you know—I think you should never say never. I'm really interested in this work on primary care, and if an opportunity ever came up that there would be the right path to be able to think about politics again, it's not impossible. But it's certainly not in my immediate plans."

You imagine a central role for the federal government in getting all the provinces in line and rowing together, using legislation and cash transfers. You also have seen firsthand how much of a fuss the provinces put up when a federal health minister tries to give them cash to fix health care with a few strings attached. In some provinces, it seems the prevailing wisdom is to oppose, on principle, anything that's led by Ottawa.

So how do you make the politics work?

"I will agree with you that politics, and particularly federal-provincial-territorial relationships, can be challenging. But when this country has done well on big social issues, like health care and other social services, it has happened when the federal government and the provinces and territories have sat down together, agreed upon what they want to do for their people, and collaborated to make it happen.

"It doesn't happen as often as it ought to, and probably less and less over time. But this is something that matters so much to Canadians. I feel that it is a fundamental responsibility of anyone who is an elected official: whether they are in the federal government or a provincial government, they have a responsibility to collaborate with other orders of government to be able to make sure that health care works. Because if Canadians don't have health care, then it leaves us with an unsustainable quality of life. And it's something that we simply need to expect our politicians to do better, and to sit down and meet together and agree upon a plan."

I sometimes find myself wondering whether the federal government's involvement might actually be doing more harm than good. We see this every few years: there are arguments over, 'Well, the health care systems aren't doing well enough.' And then the premiers will get together and say, 'it's the federal government's fault. They're not giving us enough money.' And then the federal government gives them more money, nothing changes, rinse and repeat. Is it possible Canadians are confused about who is actually responsible, accountable for fixing health care— and that means no one's being held accountable?

"Well, it's an interesting hypothesis. We have a long history of finger-pointing and blaming somebody else when things aren't going well. And I think Canadians are really frustrated with that. Different orders of government like to claim that it's their responsibility at different times. And the fact of the matter is that health is a shared jurisdiction; that there's a role for all orders of government in different ways to work together.

"But you know, when things have gone well for us in this country, and we've done some really great things on health care, we have seen that both the provinces and the federal government have had a role to play in it. And of course, the classic example of that is when hospital insurance was first introduced, and doctor insurance was first introduced. It was Saskatchewan that led the way and ensured that everybody in their province had hospital insurance, and then doctor insurance, and then it was eventually adopted across the rest of the country a few years later.

"So who knows who will be the first to jump on this model of primary care for all? I would love to see it happen at a national level, eventually. It's quite possible that a province may decide to do this. And I can tell you I've already heard from provincial officials in parts of the country who have wanted to talk about it. So I'm excited about that. I think that there's a real opportunity for a province to take on this task, to be leaders, and then, hopefully, to be able to see that kind of model adopted across the country."

You wrote a little bit about the value of expanding medical schools, taking more students. It's become extremely difficult for even top students to get admitted to medical school, and I've often wondered, why don't they just admit more students, train more doctors? Where has the resistance to doing that come from? Is it from the medical schools themselves, or from the provinces?

"It's not from the medical schools themselves. And I can tell you that things are changing quite rapidly right now. So medical education, like other forms of education, does depend upon public support, as well as the tuition fees that students pay. But medical school is something that's regulated by provinces in terms of the size of the schools, and so we need provincial support to be able to grow the schools.

"The good news is that almost every province is growing its medical schools. In Ontario, there are two new medical schools coming on board, and every other school is actually in expansion mode. So that's great. We're seeing in places like B.C., where Simon Fraser [University] is launching a medical school; P.E.I. is going to have a medical school. So there's a lot happening in the country. I think it's now widely recognized that we have undertrained the health workforce, both in doctors and nurses and others. But it takes time, you know, for that to have an impact. And hopefully a few years from now we'll have a much more robust workforce. What we need to do, though, is make sure that we do the work to improve the conditions of work for primary care so that our medical students will want to become family doctors. Because right now, that's certainly part of our challenge as well."

Health for All: A Doctor's Prescription for a Healthier Canada, by Jane Philpott, Signal, 296 pp., $26.21

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Jane Philpott, centre, between Liberal MPs Yvonne Jones, left, and Carolyn Bennett in 2018. *The Hill Times photograph by Cynthia Münster*

Next step in universal drug coverage should prioritize 'essential medicines,' says pharmacare expert

Liberal MP Yasir Naqvi says 'I think it is best that we hear from experts as to what those next medications should be … as opposed to us politicians making that determination.' *The Hill Times photograph by Andrew Meade*

Continued from page 16

has shown, you will serve an extraordinary share of Canadians' needs and you will save billions of dollars more, both directly in terms of drug budget, but indirectly in terms of improvements in health care, then it will cost the government to run such a program."

Implementing a national formulary starting with essential medicines was also recommended in a study released in June 2019, which was led by Dr. Eric Hoskins, a former Ontario Liberal health minister. The study, commissioned by the Liberal government, estimated a cost of $3.5-billion to implement pharmacare if the program launched in 2022, reaching $15.3-billion by 2027.

Steven Staples, national director of policy advocacy for the Canadian Health Coalition, told *The Hill Times* that there is a clear need for national pharmacare, which he described as the missing piece out of Canada's medicare system. He said Bill C-64 is a positive first step, but there is still a lot more work to do.

"We're encouraged by Minister Holland's comments that he's willing to start talking to provinces now while the legislation is still going through its process. That's encouraging—that there's a sense of urgency to get some agreements in place and start rolling it out," said Staples. "Then eventually … what we'd want to see is the list of medications covered under the program to become more comprehensive to include other areas because there's other patient groups and other diseases that require the same attention as these, and I'm thinking particularly heart diseases, stroke [and] cancer."

The 2024 federal budget, released on April 16, addressed pharmacare by proposing $1.5-billion over five years to ensure an effective roll-out of the program, and to also provide immediate support by covering certain diabetes medications and contraceptives.

Staples described the budget announcement as an important milestone for pharmacare, but also said he isn't clear if that funding will be sufficient.

"Maybe the federal government has data to explain this, but we want to make sure that there's enough money there so that when Minister Holland goes out and begins to negotiate with provinces, the provinces know that there's sufficient funding," he said. "We want to make sure that the single-payer nature of the program continues. Right now, it's only stipulated for these two classes of drugs as it's mentioned in C-64. But as we expand, we want that framework to continue with new classes of drugs as they're added. That's something that's very important for us going ahead."

Liberal MP Yasir Naqvi (Ottawa Centre, Ont.), who is Holland's parliamentary secretary, told *The Hill Times* that there is "a patchwork within the provinces and territories," in terms of how pharmacare is currently delivered, and Ottawa wants to ensure that no Canadian is ever in a position where they are not able to afford prescription drugs.

"We're taking a very methodical and careful approach in building our pharmacare system," said Naqvi. "Of course, we're starting with contraception and diabetes because we think these are important medications that Canadians deserve, but in addition to that, doing the policy work that is required for Bill C-64."

In terms of the direction pharmacare is heading, Naqvi said he would leave that to the experts.

"Part of the legislation is the creation of an expert committee that will actually look at various models, do the evaluation, look at the costing, [and] look at what a national formulary looks like so that, again, they can give the government appropriate advice that could be acted upon," said Naqvi. "I think it is best that we hear from experts as to what those next medications should be … as opposed to us politicians making that determination."

Naqvi said that the federal government will develop pharmacare in part by considering what the government has learned from a pilot project in Prince Edward Island.

In August 2021, an agreement was announced to provide $35-million in federal funding to P.E.I. over four years to add new drugs to its list of covered drugs, and to lower out of pocket costs for drugs covered under existing public plans for Island residents.

When asked about the future of national pharmacare, and whether a universal program covering all drugs for health card holders will one day finally be a reality, Naqvi said that answer involves speculation.

"What I can tell you is that we are working towards making sure that Canadians never have to make a decision between choosing a medication that they need for their well-being or not," he said. "We really strongly believe that Canadians should have access to critical medication that is important for their own well-being and their health, and that's why we're building a national pharmacare framework. That's why we are going to be making insulin and contraception available to all Canadians. That is why we're investing in what P.E.I. is doing, so that we can develop a more fulsome program down the road, once we know what works best for Canadians."

Joelle Walker, vice-president of public affairs for the Canadian Pharmacists Association, said that her organization has advocated for a pharmacare model that builds on the public and private system. For a second phase, the federal government should look at Canadians who don't have coverage, and then extend coverage to as many medications as possible, rather than moving people with private coverage onto a public system, according to Walker.

"I think that's what the some of the provinces have signaled, as well, is that they have some systems that they feel currently work and they want help supplementing that for people who don't have coverage or not enough coverage. And that can vary considerably between provinces," she said.

When asked about a future phase of pharmacare focusing on essential medicines, Walker said there is already a fairly broad level of drug access in Canada, and the list of essential medicines by the WHO "would not do it justice."

She said that the federal government should think about a broad formulary that both public and private insurance needs to cover, "and think really about targeting those individuals."

For an example, Walker said that she spent three years of searching to find her current birth control medication, which is not on the federal government's list of covered contraception.

"Now I'm wondering—and I think my colleagues in pharmacy are wondering—are employers going to now no longer cover birth control because they think the federal government will cover it, which means that I might not have access to the drug that I'm currently covered for? Or will employers continue to supplement those coverages?" she said. "We can definitely achieve a full universal pharmacare, but I think we can achieve it through a mix of public and private, which would mean ultimately that everybody has coverage for drugs, but it's not all done through the federal government or a single payer. I think that's the nuance there."

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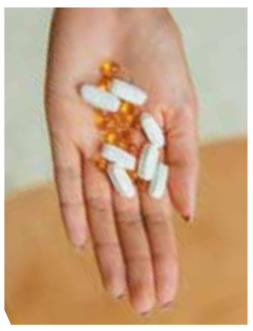
Canada prescription medications statistics



- About 22 per cent of Canadians have reported splitting pills, skipping doses, or deciding not to fill or renew a prescription due to cost.
- About 10 per cent of Canadians with chronic conditions have ended up in the emergency room due to worsening health because they were unable to afford prescription medications.
- One in five people in Canada don't have enough coverage (16 per cent), with more than one in four (27 per cent) finding it difficult to afford the cost of prescriptions.
- More than one in four (28 per cent) of Canadians have had to make difficult choices to afford prescription drugs such as cutting back groceries, delaying rent, mortgage, or utility bills and incurring debt.
- Eight in 10 Canadians (82 per cent) agree the federal government has a responsibility to ensure there is prescription drug coverage for all people living in Canada.

Source: A national poll commissioned by Heart & Stroke and the Canadian Cancer Society, conducted by Leger, and released on Feb. 14, 2024. The online survey of 2,048 Canadians, age 18 years or older, was conducted between Jan. 24-29, 2024.

Bill C-64, the Pharmacare Act, info

- Health Minister Mark Holland introduced Bill C-64, an Act respecting pharmacare (Pharmacare Act), on Feb. 29, 2024, which proposes the foundational principles for the first phase of national universal pharmacare in Canada, and describes the Ottawa's intent to work with provinces and territories to provide universal, single-payer coverage for a number of contraception and diabetes medications.
- Coverage for contraceptives will mean that nine million Canadians of reproductive age will have better access to contraception
- One in four Canadians with diabetes have reported not following their treatment plan due to cost. Improving access to diabetes medications will help improve the health of 3.7 million Canadians living with diabetes.
- Bill C-64 also provides that the new Canadian Drug Agency work towards the development of a national formulary, develop a national bulk purchasing strategy, and support the publication of a pan-Canadian strategy regarding the appropriate use of prescription medications.

Source: Health Canada press release, issued Feb. 29, 2024

Protecting public health care has never been more important

Continued from page 18

serious health complications like blindness or amputations.

Voting in favour of Bill C-64 is the right thing to do. Yet we have already heard the opposition use words like "terrifying" and "fantasy land" to describe the bill. Canadians do not want their uninsured neighbours to ration their insulin, or be more likely to face unwanted pregnancies. Spreading falsehoods on life-changing legislation like Bill C-64 is not only damaging to our public health system, but it also sends a terrible message to Canadians whose lives depend on it.

Finally, modernizing our health-care system means investing in innovations that will increase the safety and quality of the care that Canadians receive. We are committed to working collaboratively with provinces and territories to improve healthcare services. With the recent completion of all 13 Working Together Bilateral Agreements, we are on the right path. Provinces and territories will receive nearly $200-billion over the next 10 years to improve healthcare across Canada. Through our partnerships, we will also achieve advancement in digital health through the Joint Action Plan on Health Data and Digital Health and the Pan-Canadian Health Data Charter. Further, the Canadian Institute for Health Information and other federal partners will receive $505-million over five years to contribute to a world-class health data and digital health system. These investments will make a difference in the lives of our constituents.

Health Minister Mark Holland said 'each and every Canadian should have access to the prescription drugs they need,' when he announced Bill C-64, the Pharmacare Act, on Feb. 29, 2024. *The Hill Times photograph by Andrew Meade*

As a father, I want to be confident that our public healthcare system will be ready to support the next generation of Canadians. I want my children to grow up and be able to readily access their own electronic health records and be active participants in their care. I also want them to continue to use their health card—not their credit card—when they visit their doctor's office.

The bold and relentless actions our government is taking makes me hopeful for the advancement of public healthcare in Canada. Through these initiatives, our government is working to both improve access to and quality of healthcare and working conditions for health professionals. National pharmacare will be extended to 3.7 million Canadians with diabetes and nine million Canadians of reproductive age. All provinces and territories have signed on to a 10-year deal to receive $200-billion from the Government of Canada for healthcare services. There's always more to do, but our government is pushing for progress and sustainable solutions to keep our public healthcare system running smoothly.

We are on a path to change millions of lives and members of Parliament of all stripes should be working to strengthen public health care—not diminish it.

Liberal MP Yasir Naqvi was first elected as the Member of Parliament for Ottawa Centre in 2021. He previously served as parliamentary secretary to the president of the King's Privy Council for Canada and minister of emergency preparedness.

The Hill Times

The health-care system's hidden backbone: workplace supports for economic sustainability

Continued from page 22

carer-employees. In Canada, 67 per cent of unpaid carers are carer-employees, balancing their full-time or part-time employment with their unpaid care responsibilities. This translates into one in four affected Canadians.

Carer-employees make up 35 per cent of our workforce, and with an aging population, this percentage is expected to increase. In the future, more Canadians will be juggling their paid employment with caring for loved one(s) who maybe sick, disabled, or dying, further impacting healthcare systems, the workforce, and the country's overall economic development.

This balancing act leads many carer-employees to experience a range of negative health outcomes associated with their physical and mental health. This includes burnout, fatigue, depressive symptoms, stress and anxiety. In order to meet the demands of their unpaid care role, many carer-employees have to reduce their hours of work, turn down job opportunities such as promotions, and even leave employment all together.

The sustainability of our healthcare system and workforce depends on the readiness of our workplaces to support and accommodate carer-employees to better manage their dual role.

Workplace supports for carer-employees offers the needed accommodations to continue providing unpaid care while working in paid employment.

Over 50 per cent of carer-employees are between the ages of 40-59 years old, representing the most experienced workforce. It is in the best interest of employers to support these folks, as doing so reduces turnover rates and increases productivity.

A lack of supports and accommodation for carer-employees in the workplace can lead to negative impacts on the organization. Recruitment, retention, absenteeism, employee health and wellbeing, and productivity suffer when carer-employees do not have their needs met in the workplace.

Most employers in Canada do not offer supports or accommodations for carer-employees in the workplace, and this country receives a failing grade when compared to the rest of the Western world.

How can Canadian businesses and employers support carer-employees to improve work-life balance and sustain the economy?

Published in 2017 by the Canadian Standards Association, the *B701:17 (R2021) Carer-inclusive and accommodating organizations standard* (Carer Standard) and accompanying handbook, the *B701HB-18 Helping worker-carers in your organization* (Carer Handbook) was developed to provide a framework for organizations of all sizes and sectors to use as a foundation for building carer-friendly workplaces.

The Carer Standard is designed to be easily implemented into legislation and public policy.

Based on the research of the *CIHR/SSHRC Healthy Productive Work Partnership Grant, Mobilizing a Caregiver-Friendly Workplace Standard: A Partnership Approach* (McMaster University), the Carer Standard can be used by management or human resources to create and implement workplace policies and processes that are carer-friendly—specific to their employees needs. Addressing eight United Nations Sustainable Development Goals, the made-in-Canada Carer Standard was used to create the International Organization for Standardization's standard.

To help guide organizations to build carer-friendly workplaces, a free online course called Creating Caregiver-Friendly Workplaces is available through McMaster University. Here you can learn how to structure and offer supports within your workplace, while also gaining a professional development microcredential.

Without unpaid carers, society as we know it would not be able to function. The Canadian employers has an ethical and moral responsibility to support carer-employees. More resources are available to both employers and employees at ghw.mcmaster.ca.

Dr. Allison Williams is a professor in the school of geography and earth sciences at McMaster University. A health geographer by training, Williams currently leads a multi-year Canadian Institute for Health Research/ Social Science Humanities Health Research Healthy Productive Work Partnership Grant.

The Hill Times

The Hill Times Policy Briefing | February 14, 2024

HEALTH

And much more...

Fixing health system flaws requires better data sharing and workforce strategies, say health-care experts

Improving data accessibility and ways to facilitate co-ordinated care, and reducing the administrative labour for health practitioners are among the recommendations in a new C.D. Howe Institute and HealthCareCAN report.

BY JESSE CNOCKAERT

Health Minister Mark Holland says 'without a sustained and efficient workforce, Canadians cannot access the care they need, when they need it.' *The Hill Times photograph by Andrew Meade*

Canada's health-care system is in "crisis," with reforms needed that go beyond additional funding, such as addressing human resource difficulties and improving data accessibility, according to health-care experts.

"One of the big pieces that's missing is both quality metrics about the health-care system that are comparable and meaningful to patients, as well as health-outcomes information that can really empower policymakers and researchers to see what the effects of a policy change are," said Rosalie Wyonch, a senior policy analyst who leads the C.D. Howe Institute's Health Policy Council and Research Initiative. "If we don't know what the results of a change are with certainty, then you're kind of trying to innovate in the dark. You have to be able to see the results of your experiment to know if it was a success … or whether you need to adjust."

Challenges facing the health-care system include a lack of access to primary care for many Canadians, strained resources, and health-care professionals experiencing burnout following the COVID-19 pandemic, according to a report released on Feb.7 by the C.D. Howe Institute and HealthCareCAN. The report details the input provided by health-care experts from the private and public sectors during a conference to discuss the factors holding back health outcomes in Canada, held on Nov. 2, 2023, in Toronto.

"Leftover from the pandemic, we are still in the process of addressing the shortcomings in seniors care, and the population does continue to age. It's difficult to find an area that you would call not a priority for health care," said Wyonch in an interview with *The Hill Times*. "I'll say that there was broad consensus among the attendees and presenters that simple infusions of funding is not likely to solve … many of our problems, and much more fundamental reform of the health-care system is going to be needed."

Finding ways to improve data accessibility and facilitate more co-ordinated care and reduce the administrative labour for health practitioners were among the recommendations put forward during the event.

Health data sharing was also identified as a challenge in Canada in a report sponsored by the Public Health Agency of Canada and released by the Council of Canadian Academies (CCA) on Oct. 19, 2023. Health data sharing in Canada is less about overcoming technical hurdles, and more of a cultural challenge, according to the CCA report. It said that concerns about potential breaches of privacy and cybersecurity, as well as stigmatization of data-sharing technologies, are holding back its implementation.

"Depending on the province, [a health-care provider] may have no information about different specialists' waitlists, for example. There might be someone with a two-month wait or a 12-month wait, but your primary care physician doesn't have that information when referring you. Similarly, if your primary care physician ordered tests, those results won't necessarily be available to the specialists," said Wyonch. "All of this wastes time and resources where they need to communicate this information or reorder the tests."

Health-care professionals predominantly rely on resources such as Canada Health Infoway or the Canadian Institute for Health Information (CIHI) to collect statistical information, according to Wyonch.

"We don't have abundant sources of information regarding patient outcomes, quality metrics, even population health data can be difficult to get," she said. "The federal government can potentially, through the bilateral agreements, get more data inflows from the provinces. I think these agencies have a role to play in standardizing certain data across the country so that we can actually do meaningful comparisons and understand the impacts of policy."

During the December conference, speakers also discussed staffing shortage issues, and offered recommendations such as implementing pan-Canadian medical licensure to allow health-care professionals to practice across provincial and territorial borders, and finding ways to reduce administrative burdens.

To help address these problems, Health Minister Mark Holland (Ajax, Ont.) announced the launch of Health Workforce Canada on Dec. 6. The organization's mandate includes working with CIHI and other health-care system stakeholders to improve the collection and sharing of health workforce data.

"Without a sustained and efficient workforce, Canadians cannot access the care they need, when they need it. Health Workforce Canada will help us better understand the root causes of health workforce issues by understanding data gaps and supporting planning efforts for the future. A pan-Canadian approach to these challenges will support all levels of government, partners and stakeholders, which will improve health outcomes for Canadians," said Holland in a Health Canada press release.

Michael Gardam, board chair of HealthCareCAN and CEO at Health PEI, told *The Hill Times* that Canadians' pride in the health-care system has been shattered over the last 20 years.

"I think Canadians feel they can't have access to health care anymore, and the data bears that out. It's very hard for people to access primary care. The emergency departments are overwhelmed partially because of not being able to access primary care. Our hospitals are overwhelmed," he said. "We're in this perfect storm of health human resource shortages. The ones that are left are burned out, the population is aging, [and] our infrastructure hasn't kept up."

Gardam said that improving Canada's health sector is a challenge in part because of how health-care responsibilities are divided across different regions. Instead of having a national plan, Canada has 13 provincial and territorial health-care insurance plans.

"It's one of the great handicaps that the Canadian health-care system has. Because it's a provincial responsibility, provinces want to do their own thing, [and] the territories do their own thing," he said.

In regard to Holland, Gardam said he's been impressed with how the health minister acknowledged that reforms to health care will be about more than money.

"What it's going to require is somebody who can pull different opinions together, and be a leader

Continued on page 17

Rosalie Wyonch, a senior policy analyst at the C.D. Howe Institute, says 'it's difficult to find an area that you would call not a priority for health care.' *Photograph courtesy of Rosalie Wyonch*

HealthCareCAN board chair Michael Gardam says 'we're in this perfect storm of health human resource shortages.' *Photograph courtesy of Michael Gardam*

Prof. Samira Abbasgholizadeh-Rahimi says AI tools can be useful in health-care systems. *Photograph courtesy of Samira Abbasgholizadeh-Rahimi*

UofT professor Rahul Krishnan says one of the key challenges to overcome is how to create incentives for hospitals to bring health-care data back into 'a unified view.' *Photograph courtesy of Rahul Krishnan*

Continued from page 16

to lead them through what needs to be a serious health transformation. I don't know [Holland] well enough to know if he's able or willing to do that. I also think there's a huge political risk in doing that," said Gardam. "Ministers aren't always free to do what they think is necessarily the best thing to do, because in the end, in Canada, it comes down to politics when we talk about health care."

Gardam said it's time to get serious about health-care reform, and Canada has fallen behind in terms of health research.

"If you go wander the street and you ask your average Canadian, 'is health research the most important thing in your life?' The answer is going to be 'no,' right? Yet, that's our investment in the future," said Gardam. "The Canada of yesteryear, where we discovered insulin, and we discovered stem cells … all those things are at risk now because the funding has not kept up to any other developed country, and so we're starting to lose people to the United States."

Samira Abbasgholizadeh-Rahimi, an assistant professor in the department of family medicine and Canada Research Chair in Advanced Digital Primary Health Care at McGill University, told *The Hill Times* the federal government could play a role in implementing regulations aimed at ensuring artificial intelligence (AI) systems are properly developed and integrated into the health-care system.

"I can say we are in the area that our health-care system is still using fax machines. In order to shift into a smartphone area, and in order to shift to an AI area, we have to think about modernizing this health-care system," she said. "Its uses could be very impactful if we can properly integrate AI in our health-care systems for data management, for diagnosis and prediction of different disease, for personalizing medicine, [and] for personalizing treatment plans."

Rahimi said there are a lot of regulatory barriers from governments and ministries in terms of data collection or algorithm development.

"The first step [towards] the implementation of these AI systems, or even advanced digital health technologies in real practice, is to conduct research on that, pilot test it, and then conduct research on the implementation side of it, and then implement it," she said. "There needs to be investment … from the government side for AI health research, and regulations with regard to responsible use of AI for sure."

Rahul Krishnan, an assistant professor in the department of computer science and medicine at the University of Toronto, told *The Hill Times* that one of the big challenges facing researchers is that health data is "siloed," in part because of how medicine has bifurcated into specialized disciplines, such as radiology, oncology, and pathology.

"The department of pathology is where the pathology data is, [and] the department of laboratory medicine is where the clinical values and the lab measurements are housed, and so this bifurcation was useful up until we decided that we could actually make use of the clinical data to start making predictions about a patient," he said. "I think one of the key challenges that we have to overcome is: how do we create incentives for hospitals to really bring back this data into a unified view?"

Krishnan said that all parties involved in health care—including the federal government, the provincial and territorial governments, and the hospital system—need to create "a unified system of data where we now have a patient-centric view." The federal government could partly facilitate that through investment in research and development, he said.

"Continuing to push for investment in that space so that we can better support grad students and postdocs—who are pretty much the lifeblood of research and innovation here—is, in my opinion, one of the key ways to support it," he said. "There's this question of how we make sure that data is being used to drive better outcomes, and I think … to start with a provincial strategy, and perhaps in the future move towards a national health-care data strategy will be a really critical way by which, I think, the federal government could improve the ability for researchers such as myself to think about building and deploying models, as well as testing the utility out for all Canadians."

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The Hill Times

Health-care provider access statistics

- While 85.5 per cent of Canadians living in the provinces had a regular health-care provider in 2021, a total of 14.4 per cent of Canadians (4.7 million people) did not.
- Lower proportions of bisexual or pansexual Canadians (77.4 per cent) reported having a regular health-care provider, compared with heterosexual Canadians (85.6 per cent).
- Lower proportions of First Nations people living off reserve (81.2 per cent) reported having a regular health-care provider, compared with non-Indigenous Canadians (85.7 per cent).
- Having a regular provider also varied across racialized groups, from 71.7 per cent among Latin American people, to 89.8 per cent among Filipino people.
- In 2021, almost 2.5 million Canadians had unmet health-care needs, meaning they felt that they needed health care in the past 12 months, but did not receive it. Unmet health-care needs were more prevalent in the Atlantic provinces (10.7 per cent), compared with the rest of Canada. More females (8.9 per cent) than males (6.9 per cent) reported unmet health-care needs.
- Population aging and the increasing prevalence of some chronic conditions mean that the need for home-care services is growing. In 2021, a total of 3.2 per cent of Canadians used home-care services, and 1.6 per cent had unmet home-care needs. Canadians with the lowest household incomes used home-care services more (6.2 per cent), and had more unmet home-care needs (3.3 per cent), compared with Canadians with the highest household incomes (2.2 per cent used home care services; 0.5 per cent had unmet home-care needs).

—Source: Health of Canadians report, released on Sept. 13, 2023, by Statistics Canada

Federal budget health measures (2023)

- In the 2023 federal budget, the Liberal government announced an additional $195.8-billion in health transfers over the next 10 years, including $46.2-billion through new Canada Health Transfer (CHT) measures.
- The funding envelope included an immediate and unconditional $2-billion top-up to the CHT to all provinces and territories to address immediate pressures on the health-care system.
- The federal government promised $25-billion over 10 years through a new set of bilateral agreements to address individual provincial and territorial health system needs, such as expanding access to family health services, supporting health workers and reducing backlogs, increasing mental health and substance use support, and modernizing health systems.
- The federal government also promised $505-million over five years, starting in 2023-24, to the Canadian Institute for Health Information, Canada Health Infoway, and other federal data partners, so they may work with provinces and territories to develop new health data indicators, support the creation of a Centre of Excellence on health worker data, advance digital health tools and an interoperability roadmap, and support provincial and territorial efforts to use data to improve the safety and quality of health care.

—Source: A Made-in-Canada Plan, released on March 8, 2023

Solutions exist, but only if leaders are willing to listen to health-care professionals

Experts have offered a range of explanations for the current crises with actionable solutions, and if we listened to them, we could have been on our front foot, proactively planning and properly resourcing.

Liberal MP
Jenica Atwin

Opinion

Health care is the dominant issue constituents raise in every conversation with me, and it is referenced in some form or another in nearly every meeting I take.

When the problems with our system are so pervasive, where do I even begin to address them? Do I start with a jurisdictional discussion? With funding models? Do I highlight the glaring gaps in Indigenous health? Or the crisis in mental health and addictions? Do I focus on the long-fought battle for reproductive rights in my home community? Or how about lack of access and expertise in trans and gender-affirming health, especially considering recent attacks on these elements of care?

How about the serious shortage of family doctors, bottlenecks, wait lists, and hallway medicine, with ERs—like the one in my city—at 360 per cent capacity? The issues with foreign credential accreditation, staff burnout, recruitment, and retention? Thinking about the compounding crises in our current system of health care has become overwhelming and, frankly, distressing. Canada is a nation that prides itself on our universal public health-care system, and its distinct advantages over the system of our neighbours to the south, so how did we find ourselves in such a time of crisis?

In my many conversations with health-care providers, unions, and medical societies with administrators, physicians, nurses, pharmacists, and beyond, the experts offer a range of explanations with actionable solutions. The vast majority have pointed to a serious lack of data collection, and an unwillingness to listen to the people on the front lines. Perhaps we could have seen this cliff approaching if we were properly tracking services, if we were mapping policy impacts, population growth, distinctions-based information, and other trends. Even with the vast differences across provinces and territories, we could have been better prepared for the tsunami that characterizes our current reality. We could have been on our front foot, proactively planning and properly resourcing. We may have also been able to protect our health-care workers who have been left to float adrift.

The solutions exist, but only if leaders are willing to listen to our health-care professionals. They are urging us to reduce barriers to accreditation and transferring foreign credentials, modernize record-keeping, improve our data collection and analysis, invest in more infrastructure and expand models of group practices and telehealth. Indigenous health-care professionals and patients alike are calling for mandatory cultural competency training and the inclusion of traditional healing and Indigenous knowledge. Those who deliver care in smaller cities and in rural areas are asking governments to invest in the services and amenities needed for them to build their lives and raise their families. Investments in rural communities for education, infrastructure, housing, and recreation will not only attract more health-care providers, but will also encourage them to remain and serve those communities throughout their careers.

I think we have lost sight of the most basic elements of health, as well as the individual agency we each possess, and it's no wonder that we have as we stare down the hopelessness caused by the current experience. To find solace, I continue to turn to the experts, such as the Canadian Medical Association, who have called for practical solutions and initiatives such as a national school food program as one of the most effective tools in preventative care available to us. There is light at the end of this tunnel with the recent historic investments, buy-in from provinces and territories, and a national dialogue around standards and expectations of care.

One thing is for sure, we can no longer take health care in Canada for granted. The time for action was long before the COVID-19 pandemic, but sadly it took a national trauma to expose our vulnerabilities, and those most at risk among us are paying the highest price. There have been a multitude of proposals put on the table, it's time to implement them. Let's be creative, let's be bold and forward thinking, let's roll up our sleeves and plug the holes in the sieve. All of our lives depend on it.

Jenica Atwin was first elected as the Member of Parliament for Fredericton, N.B., in 2019, and became the first woman to hold this title. Atwin is passionate about addressing the climate and affordability crisis, improving the quality of our health system and fighting for social justice.

The Hill Times

Why are the Liberals abandoning hungry children across Canada?

The feds have failed to create or allocate funding to a national school food program in recent budgets, despite the urgent and growing need across Canada.

NDP MP
Don Davies

Opinion

Childhood hunger in Canada has become dramatically worse in recent years, with skyrocketing food prices and record food bank use across the country.

Every day, millions of Canadian children struggle through the school day without the benefit of a healthy breakfast or lunch. Deprived of access to nutritious food, their health, learning, and future are jeopardized.

This is a preventable problem with a well-established solution: a national school food program. Yet Canada remains the only G7 country without one in place. As a result, we rank 37th out of 41 wealthy countries in child food security, according to UNICEF.

The adage, "you are what you eat," holds true. If we aspire for our children to be healthy, happy, and successful, we must ensure they are well-nourished. Implementing a national school food program is not just a moral imperative, it is also a prudent investment in our country's future.

Such a program would guarantee that every Canadian child has access to healthy, affordable, and culturally appropriate food at school. It would also serve as a platform for children to learn about nutrition and food preparation, support local farmers and producers, and reduce food waste.

Indeed, the benefits of a national school food program are well documented and widely acknowledged.

School food programs play a pivotal role in enhancing student health. They encourage the intake of nutritious whole foods, while curbing the consumption of items high in fat, sugar, and sodium. This balanced dietary approach helps mitigate the risk of obesity, heart disease, diabetes, and other chronic conditions.

Moreover, the availability of healthy food at school has proven to bolster academic performance, graduation rates, and regularity in attendance. School food programs can also help alleviate anxiety and depression, and reduce bullying and aggressive behaviour, thereby fostering a more conducive learning environment.

In addition to their health benefits, school food programs provide a significant long-term boost to the economy. A recent Canadian study found that a national school food program would save families up to $2,268 per child every year on grocery bills, contribute $4.8-billion to local economies through domestic food purchases over a decade, increase students' lifetime earnings by up to 5.8 per cent, and boost mothers' labour-market participation by five per cent.

In 2019, both the NDP and the Liberal Party committed to invest $1-billion to create a national school food program, in partnership with provinces, territories, Indigenous communities, and civil society. This historic commitment marked a rare moment of cross-party consensus.

However, the Liberal government has since quietly abandoned its 2024 deadline to implement this program without any explanation or consultation. It has also failed to allocate any funding for this program in its recent budgets, despite the urgent and growing need across Canada.

This is a betrayal of the millions of Canadian children who face hunger daily. It also shows a stunning disregard for the evidence and the experts who have advocated for a national school food program for decades.

The Liberal government professes to care about the health and well-being of Canadians, and to champion human rights globally. Yet, it is neglecting one of the most effective ways to improve the health and well-being of Canadian children and to respect their rights to equality and development.

With food prices soaring and food insecurity worsening across the country, this is an ideal time to act. We can make an immediate difference in many families' lives, and plant the seeds for a much healthier future for our children.

The NDP will continue to hold the Liberal government to account for its broken promise, and to advocate for a national school food program that meets the needs and aspirations of Canadian children and families.

We believe that no child in Canada should go to school hungry, and that every child deserves a healthy start in life.

It's rare to find a policy that makes economic, health, and social sense. Establishing a national school nutrition program is such a policy, and should be started at once.

Don Davies is the NDP MP for Vancouver Kingsway, B.C., and is his party's health critic and deputy critic for foreign affairs. He previously served as official opposition critic for international trade, citizenship and immigration and multiculturalism, and as public safety and national security.

The Hill Times

Stop patching holes in our health-care system and rebuild the ship

We continue to work within and build upon a framework that does not serve Canadians, and the costs of this on both individual and societal levels are immense.

Shauna Cronin

Opinion

According to Statistics Canada, more than five million Canadians met the diagnostic criteria for a mental health disorder in 2022, and only half spoke to a health professional about it, highlighting at a high-level that something beneath the surface of our mental health system is not working.

The problem we're facing is a deep systemic inertia: an entrenchment in existing systems driven by the status quo and the cost or risk associated with change. We continue to work within and build upon a framework that does not serve Canadians, and the costs of this on both individual and societal levels are immense. Our health sector is oversaturated with short-term models and projects that continue to take priority over improving current services to match need, or even de-implementing projects to create space for ideas that work.

If we're going to fix this problem, we're going to need to think outside this existing framework.

Consider the very real impact that outdated evidence paired with systemic inertia has on people across the country. We can see this most evidently in health disparities affecting Indigenous communities. Our health-care system is built upon evidence rooted in colonialist ideals that are often at odds with Indigenous beliefs. Not to mention that accessing these resources from remote communities—many without reliable internet access—presents its own challenges. Then reports state that suicide rates for Indigenous Peoples are three times the national, and we ask why?

The lack of evidence-based care for Indigenous populations drives individuals to crisis before they seek support, if they do at all. Upon reaching crisis, they face long wait times in the ER, staff who lack training in cultural sensitivity and colonial trauma, among other barriers. Long-term, sustainable funding for research opens opportunities to explore and implement services that decolonize traditional beliefs, are built upon Indigenous knowledge, and are further shaped to meet the needs of different communities. In other words, we can implement services based on the right evidence to find solutions that work.

Crisis response and care is another area where this impact rises to the surface. Today, a Canadian experiencing or nearing a mental health crisis is told to call 911 or visit their nearest emergency department. While emergency departments are vital resources, they are not the right place for someone at that time. A visit can be a traumatizing experience, with bright lights, security guards, and claustrophobic spaces. However, it's important to note that the ER is often the only option when we consider that some young people wait 67 days on average for access to counselling, and 92 days for intensive treatment. If we could reimagine an approach to crisis support, what would it look like?

Fortunately, our partners in the United Kingdom are doing just that. They've developed a model called the Recovery Café, an inviting space where people in crisis can go to access support, decompress, and connect with peers. They are open when other supports are closed, and require no referral. Many Cafés see 20-25 people per evening, and up to 9,100 annually. In just the first six months these Cafés were operating, there was a reported 33 per cent reduction in psychiatric admissions, showing great potential for reducing systemic burden on hospitals.

The Recovery Café is a powerful example of what mental health interventions can look like—and the profoundly positive impacts they can have—when we consider and respond to the expressed needs of those relying on these services.

We have an opportunity to reflect on the past and use what we've learned to change the future. Our sector is not short on solutions, but those solutions are met with barriers that inhibit innovation. As we work together towards system reform, we must recognize the harm that's been done by patching holes in a broken system, rather than creating space for new, more holistic approaches to care. The evidence is clear, we just need to use it.

Shauna Cronin is the executive director of Frayme, a national youth mental health and substance use intermediary working to create a more equitable and accessible health-care system.

The Hill Times

Health Minister Mark Holland speaks to reporters in Ottawa on Jan 30. The growth in demand for health care is expected to outpace taxation's ability to finance the labour-driven supply of services, writes Zayna Khayat. *The Hill Times photograph by Andrew Meade*

Harness the current momentum to shift the health workforce from a position of crisis to one of strength

The government can reframe the issue by focusing on the demand side of work instead of on the domestic supply of labour.

Zayna Khayat

Opinion

The Canadian government has little authority over levers that affect the health workforce: education, recruiting, training, deployment, compensation, retention. Despite this, it has rightly prioritized this matter, enacting federal policies to increase supply of health workers, such as by expediting the licensing of foreign-trained health professionals and the cross-province mobility of workers, as well as by creating an agency to obtain data that can make planning and decision-making processes more transparent.

The federal government is also helping to address worker attrition with a pan-Canadian challenge under way to support retention and engagement, as well as with plans to release a tool kit to improve the nursing work environment.

However, simply adding more people is not likely to solve access challenges. Despite this, the present supply-strategy projections are assumed to be sufficient, both in terms of services that will be required and how health care is designed, paid for, and delivered by the current mix of professionals. That is, the projections speculate that more workers doing the same work, having an easier path to obtaining the necessary credentials, being more easily transferred to areas that require their services, and being incentivized to remain in their roles are sufficient conditions to tackle this important challenge.

Yet, the growth in demand for health care is expected to outpace taxation's ability to finance the labour-driven supply of services. As such, we are overdue for a reframing of the health-care challenge.

Some considerations: does spending more than 60 per cent of our health investments for staff match the labour intensity needed? Is the anticipated workforce growth expected to come from training and recruiting health professionals using long-standing means, methods, and talent pools? Is our current mix of licensed health professionals fit for purpose? Have we augmented our talent with the necessary technologies to allow them to focus on what humans can do best?

Our suggestion: Canada is in a strong position to bring needed policy and investment to a new stage, beginning with rethinking the demand side of the work of health care.

To clarify, "demand side" does not presume a focus on reducing the demand for health services alone (i.e., via prevention strategies). Rather, it is meant to highlight the untapped opportunity that exists to reimagine the way our health system currently deploys workers. We see three levers currently at the federal government's disposal that could make use of existing infrastructure:

1. Removing lesser-value work: According to sources including the national Choosing Wisely campaign, roughly 30 to 40 per cent of health workers' tasks are unnecessary, duplicative, and even unsafe. Could the federal government inject new life into Choosing Wisely, and set expectations for engaging in higher-value work to care organizations funded through the Canada Health Transfer program?

2. Deploying technology to improve health work: To help the health-care system and restore joy and humanity in the work of caring, it's essential to accept that many tasks undertaken by health workers can be done equally well or better by partnering humans with simple technology such as automation, analytics, logistics, and AI cognition. Similar to England's review of their national health service, could the Government of Canada conduct an analysis of the opportunity afforded by technology to free up our healthforce capacity? A national plan that lays out concrete strategies and a role for federal agencies such as the Canadian Institute for Health Information, Canada Health Infoway, and the Canadian Institutes of Health Research might help jurisdictions realize the promise of—and the means to invest in—a digitally enabled health workforce.

3. Redesigning and redefining work itself: The global workforce is emerging from an industrial-era construct wherein "work" was defined as a fixed, static job tied to a specific professional and strict credentials, to one in which it's a dynamic landscape of skills that can be accessed and utilized as the nature of work evolves. This evolution requires separating jobs into their component skills, and then accessing a wider complement of talent that have or can readily acquire the needed expertise. We estimate that up to 60 per cent of work currently tied to a given credentialed professional could be performed by an alternate, such as a civilian who can be easily upskilled/reskilled (e.g., a retiree, student, volunteer), an extender (e.g., someone getting directive from and/or teaming with higher-licensed clinicians), or a second professional (e.g., a nurse practitioner, pharmacist, or nurse prescribing for routine ailments). What if the federal government provided the working capital for provinces to fundamentally redesign care models and to redefine work, from jobs to skills? This would mean changing the current work paradigm: assessing how we can educate, develop, upskill, and reskill a much wider and more varied mix of talent.

Zayna Khayat, PhD, is a health futurist with Deloitte Canada, and co-chair of the firm's Future of the Health Workforce signature issue.

The Hill Times

Working together for a healthy workforce

While the federal government can provide leadership and support, collaboration with provincial and territorial governments is crucial.

Liberal MP
Sean Casey

Opinion

Canada's health-care system is in crisis. An elevated demand for care and numerous vacancies have dramatically increased the workload of health professionals. They are working longer hours, burning out, and many are leaving these jobs, with effects that we are feeling across the country.

My home province of Prince Edward Island is no exception. One of the island's two main hospitals, Prince County Hospital, does not currently have an intensive care unit due to staffing shortages. Residents have vociferously expressed their dissatisfaction with the provincial government on this urgent issue, including at the ballot box where a Green Party candidate won a byelection recently in a long-held Progressive Conservative riding.

A pan-Canadian problem demands a pan-Canadian solution. This is why, in 2022, the federal government established the Coalition for Action for Health Workers with key stakeholders in health workforce management. This coalition's first priority is addressing staffing challenges across the country.

Federal action is, however, only one piece of the puzzle. As chair of the House of Commons Standing Committee on Health, I oversaw the group's study of this crisis. After hearing from expert witnesses, we submitted a report to the House in March 2023 underlining the federal government's role in addressing the health workforce shortage.

In Canada, provinces and territories manage health-care service delivery and workforce within their jurisdiction. It is then no surprise that the key takeaway from the study was this: while the federal government can provide leadership and support, collaboration with these governments is crucial.

Our government led this necessary collaborative approach by rolling out a 10-year $200-billion "Working Together to Improve Health Care for Canadians" plan in 2023, signing bilateral agreements with provinces and territories.

This plan centres four priority areas essential to a healthy care workforce: recruiting and training more workers, retaining professionals, planning for long-term sustainability, and modernizing the system.

First, let's talk recruitment.

Through programs like the Sectoral Workforce Solutions Program and Future Skills Initiative, the federal government can continue to support training and innovation. These directly build capacity by training new workers and supporting them as they enter the field.

Another important pool of workers is international-educated health-care professionals (IEHP). In 2021, only 58 per cent of these 259,695 qualified individuals aged 18 to 64 in Canada worked in this field. This is a huge amount of talent that remains available to bolster health-care capacity. The federal government must make it easier for IEHPs to practice in Canada, via programs such as the Foreign Credential Recognition Program, which reduces barriers to recognize their credentials and supports them as they enter their field of work.

This leads me to retention. To retain health workers, we must understand why they leave.

Our government is developing a Pan-Canadian Health Data Strategy as informed by an expert advisory group. The data collected in this plan will not only address the health needs of Canadians, but also that of the workforce. This is a unique opportunity to understand the major stressors contributing to burnout for the sector while sharing best practices to mitigate them.

Meanwhile, we must work with provincial and territorial governments to optimize the scope of practice of professionals such as nurses and pharmacists. By doing so, not only would we make it easier for Canadians to find the care they need, but also alleviate the burden on pressure points of the health-care system. The federal government can also provide a platform to share best practices and tools in managing administrative duties, which can take up to 30 per cent of a physician's time.

The actions above also address the last two priorities: planning and modernizing.

The federal government is perfectly situated to oversee the long-term sustainability of the health-care system by anticipating future health needs. Good planning, including investments in long-term and palliative care as well as preventative health strategies, would decrease the demand on acute care and avoid overwhelming the system.

Innovation is essential to keep up with a rapidly changing digital and social landscape. The federal government can explore alternate forms of care delivery, such as virtual and team-based care, which would provide a holistic approach to health-care delivery, helping those who need it most.

Health care is a complex issue that cannot be resolved by something as simplistic as a "blue seal standard." Canadians deserve better. A comprehensive, collaborative, thoughtful approach is the right one. And that's what we will deliver.

Sean Casey is the Liberal Member of Parliament representing the riding of Charlottetown, P.E.I. He currently sits on the Standing Committee on Veterans Affairs and is the chair of the Standing Committee on Health.

The Hill Times

How to achieve accountability in long-term care

It is impossible for provincial/territorial residents to hold their governments accountable for their responsibilities in LTC if the data available are biased, and the most important kinds of data are completely absent.

Michael Wolfson

Opinion

Canadian Armed Forces members help with meals and provide care to residents at the Grace Dart Extended Care Centre in Montreal, as part of Operation Laser on May 8, 2020. *DND photograph by Cpl. Genevieve Beaulieu*

Memories of the tragedy in Canada's long-term care (LTC) homes from the pandemic are fading all too fast. However, this tragedy was not an accident; it was the result of a series of deeper problems with the ways LTC is funded, managed, and understood. Without concerted action, these problems will continue to fester, and indeed grow with Canada's aging population.

Addressing these problems requires actions on a number of fronts, from operating standards to staffing, to assuring the human rights of LTC home residents. The most important actions form the core recommendations of a just-released report from the Royal Society of Canada (RSC).

One reason for the failures in Canada's LTC homes is their general invisibility. It has only been the unnecessary spike in residents' deaths from the pandemic that brought these to light. With this tragic visibility, there has been a flurry of government actions. But as myriad experiences have taught us, as soon as the light fades, actions weaken.

One of the core recommendations of the recent RSC report is the creation of a robust "accountability framework" based on strong data reporting. This is not a new idea; the 2003 First Ministers Health Accord also spoke repeatedly about accountability. However, governments' support for the underlying data waned over only two or three years, as did support for the short-lived Health Council of Canada a few years later.

In order to avoid yet another failure, we must understand what an accountability framework involves, and why it has failed in the past.

One fundamental reason for failures is the constitutional division of powers. The provinces and territories, with primary jurisdiction for health care, do not want to be "accountable" to the federal government, even though the federal government channels billions of Canadian taxpayer dollars to them. However, they should be accountable to their own populations.

The only way Canadians can learn what works and what doesn't from each region, no matter their differences, is if the data are comparable—this is a legitimate role for the federal government.

Here we come to the reason for past failures: no provincial/territorial government wants to be shown to have poor performance in any area of its jurisdiction, certainly including health care. In a phrase, "why shoot the messenger if instead you can prevent there ever being a messenger?"

In the face of such self-interested resistance, an obvious response is for the federal government to incent the needed standardized data generation across jurisdictions, and then assure these data flow in ways that can populate a well-designed accountability framework.

Such a framework should include key indicators, such as the levels of direct care staffing per resident on LTC homes, and the frequencies of falls leading to fractures and hospitalizations. But the data flows must be much more than a handful of indicators. Analysts need to be able to drill down in the data to see, for example, what kinds of staffing levels and mixes are associated with the lowest rates of hospitalizations for falls, and other factors, including language and broader social determinants of health.

The federal government has ample constitutional powers to give effect to the needed data, not least from its spending powers and its power for "peace, order, and good government."

The federal government does appear to be going through the right motions here. The major cash transfers announced in 2023 to the provinces and territories include $500-million for data, and assign the Canadian Institute for Health Information (CIHI) a central role.

Yet, in the 2017 First Ministers Health Accord, through which billions of dollars were transferred from the federal government focusing on LTC and mental health and addiction, all governments agreed that CIHI should be given the mandate to develop relevant indicators. Three years after the Accord, CIHI had published only one indicator relating to LTC, and it was based on hospital rather than LTC data.

CIHI does the best it can, but it is seriously limited by the data provided to it by the provinces and territories. For example, data about LTC residents are not connected to staffing levels, hospitalizations, and other kinds of health-care utilization, nor to surveys of all those waiting to access homecare or LTC homes.

It is impossible for provincial/territorial residents to hold their governments accountable for their responsibilities in LTC if the data available are biased, and the most important kinds of data are completely absent.

We take for granted in other areas—such as GDP, unemployment, and inflation—that there are ample underlying data enabling a dissection of the observed trends. We deserve the same for LTC.

It's long past time the federal government used all its constitutional powers.

Michael Wolfson, PhD, is a former assistant chief statistician at Statistics Canada and co-author of the Royal Society of Canada report, Repair and Recovery in Long-term Care.

The Hill Times

The federal government is failing Canadian health research

Canada risks losing out by inadequately investing in health researchers working to unlock new discoveries.

Paul-Émile Cloutier

Opinion

As the world embraces and pursues a far-reaching revolution in the life sciences, will Canada be there as a serious player?

With artificial intelligence and other new tools, Canada has the potential to cure long-standing diseases, address future pandemics, improve medical diagnostics, and develop innovations to ease pressure on the health system. The contributions of our health researchers in the global fight against COVID-19 showed we could make important science breakthroughs and achieve commercial success from these discoveries.

Yet by failing to invest in health researchers working to unlock new discoveries, Canada risks losing out. Rather than supporting and encouraging talent, governments are squeezing researchers financially, implicitly telling them there may be no careers in science in Canada, and that they are better off leaving for other countries where their talent is treated far better. Researchers who have often looked to Canada as a great place to pursue their careers may decide they can no longer afford to come here. Canada will be the loser.

Most graduate and postdoctoral researchers are funded through the federal grants received by their supervisors from the three federal research agencies: the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research Council of Canada, and the Social Sciences and Humanities Research Council of Canada. This funding has also stagnated and been hit hard by inflation. That is why, along with strengthening graduate scholarship and post-doctoral fellowship programs, it is imperative that the federal government also increase investments in the federal granting agencies. Both the Advisory Panel on the Federal Research Support System convened by the government and the House of Commons Standing Committee on Science and Research recommended last year that the federal government do so by at least 10 per cent a year for the next five years.

Ensuring Canada has the talent pipeline needed for a thriving, globally competitive knowledge-based economy goes beyond investing in researchers when they are training. Governments must ensure people see a future for themselves in Canada if they want to keep the talent we have invested in and supported, so they go on to work in hospitals, health authorities, health research institutes, government, and the private sector for the benefit of Canadians. This is another reason why the federal government must urgently increase investments in research through the three federal agencies.

In addition to the danger of losing our best and brightest research minds, the failure of the federal government to adequately invest in health research also undermines our ability as a nation to efficiently and effectively apply new research findings to improve access to care and outcomes. Building a better health system requires applying best practices.

It would be a tragedy if Canada opted out of the life sciences revolution and the opportunities it brings to improve human health, and enhance Canada's success as an innovation nation.

There is investor interest in the life sciences. Some $10-billion has been invested by venture capital groups in Canadian life science startups over the past decade. Investors in recent years have been putting more than $1-billion annually into initial public offerings by life science companies on the Toronto Stock Exchange.

That is why HealthCareCAN recommends the federal government immediately invest $3.8-billion to double current funding to the three federal granting agencies and commit to an annual increase that keeps pace with inflation and global benchmarks to ensure competitive and sustainable research funding.

HealthCareCAN also calls on the government to increase federal funding available through the three agencies for graduate scholarships and postdoctoral fellowships to a minimum of $25,000 and $35,000, respectively, tying funding levels to increases in inflation, and increase the overall number of scholarships and fellowships available by 50 per cent, adjusting annually to reflect the level of enrolment in graduate and postdoctoral programs.

Budget 2024 is a critical test of the federal government's commitment to the future and whether it wants to build on past success in life sciences, or let the global life sciences revolution pass Canada by.

Paul-Émile Cloutier is the president and CEO of HealthCareCAN, the national voice of hospitals, health authorities, health research, and health-care organizations.

The Hill Times

Iiyika'kimaat in Indigenous health: a call for change and empowerment

A physician who witnesses the realities of an often-inadequate health system for Indigenous communities urges the federal government to implement Truth and Reconciliation Calls to Action 18–24.

Lana Potts

Opinion

Indigenous Services Minister Patty Hajdu speaks with reporters in the House of Commons foyer on Dec. 13, 2023. Indigenous communities should have the power and resources to design and implement their health-care strategies and control their health systems in alignment with their cultural values, writes Lana Potts. *The Hill Times photograph by Andrew Meade*

The Truth and Reconciliation Commission (TRC) of Canada launched 94 Calls to Action in 2015, emphasizing the urgent need for systemic changes to recognize historical trauma and help establish a more fair and just society for all. To date, fewer than half of these 94 calls have been fulfilled, and none of the TRC's seven recommended health-care actions (Nos. 18-24) have been enacted.

The state of health care in many Indigenous communities is deeply troubling, as exemplified by the tragic circumstances seen in my First Nation community in Alberta. Over the past 10 months, we have had more than 50 funerals—primarily deaths from addiction, and mostly involving people aged 35-46. This devastating loss has yielded a large number of orphaned children who are now relying on child-welfare services.

Current health-funding models are focused on "sick care," and do not effectively allocate resources to address health inequities. Many First Nations lack access to primary health care, leaving them without essential preventative health services. The situation is exacerbated by high levels of poverty, geographical challenges, prevalence of chronic disease, and overcrowded living conditions. Compounded, this has resulted in a significantly reduced life expectancy: many of us don't reach the age of 50.

According to the Canadian Medical Association report, *Indigenous Health*, Indigenous Peoples in Canada can face racism in health systems. The general lack of acceptance of Indigenous healing models further deepens these disparities, as traditional and holistic approaches to wellness are for the most part not embraced by western medicine. Despite Indigenous Peoples making up more than 4.5 per cent of Canada's population, fewer than one per cent of the country's physicians identify as Indigenous. This under-representation further serves to hamper the development of culturally attuned health-care services.

A way forward: *Iiyika'kimaat*

In my Blackfoot language, we say *Iiyika'kimaat*—leading with purpose and determination. There is a crucial need for the Canadian government to adopt an *Iiyika'kimaat* approach to realizing a more equitable health-care system that will serve the needs of Indigenous populations.

A good starting point is to adopt funding models focused on upstream health and primary care, while elevating the importance of self-determination, resilience, and community support. These models can help break the cycle of disparity between Indigenous and non-Indigenous health outcomes. In parallel, Indigenous communities should have the power and resources to design and implement their health-care strategies, and control their health systems in alignment with their cultural values. Recognizing the rights of Indigenous Peoples in such a way also acknowledges that they possess valuable learnings and insights about their health and are best suited to act on behalf of their communities. This approach is in line with TRC Call to Action 21: prioritizing the creation of Indigenous healing centres that address the mental, emotional, physical, and spiritual needs of Indigenous people.

A precedent for the power and value of preserving Indigenous ways of knowing and healing is in the repatriation of a Thunder medicine bundle in my Blackfoot community. Prior to contact, our community enjoyed traditional ceremonies and bundles, benefiting from long, healthy lives free from chronic disease, poverty, and addiction. The leadership, dedication, and efforts of people including Jerry Potts Jr. and the late Allan Pard to bring our bundles home help ensure the preservation of our long-standing health-care systems.

One repatriation principle in action was the 2022 opening of Aisokinaki, a Blackfoot-led health-care clinic. The centre embodies the values of evidence-based practices seamlessly intermingled with *Iiyika'kimaat*. Aisokinaki offers a range of services, including land-based healing, connections with ceremony, and elder involvement to support each person in achieving health. This unique clinic takes a holistic approach by incorporating tools such as traditional medicine, rattles, and drums to aid in addiction recovery. Aisokinaki is the successful result of more than 20 years of convincing decision-makers that Indigenous communities are well-equipped to care for and heal themselves.

Transformative change in Indigenous health begins with a profound sense of enlightenment, as expressed in Blackfoot teachings. It emphasizes the importance of being aware of our surroundings, actively listening to the voices of and within Indigenous communities, and observing the interconnectedness of humans and the land. True enlightenment prompts us to recognize the injustices and disparities faced by Indigenous Peoples and compels us to act.

By working with the Canadian government to lead with purpose and determination—that is, to embrace *Iiyika'kimaat*—Indigenous communities and Canada at large may one day finally, fully help ensure our health-care systems benefit each of us equally.

Dr. Lana Potts is the national Indigenous health lead for Deloitte Canada.

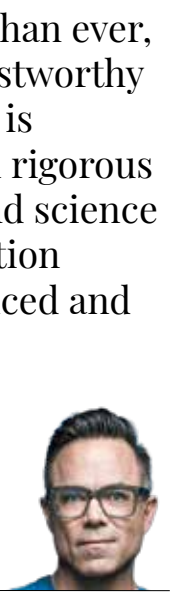
The Hill Times

Needed: less science hype!

Now, more than ever, we need trustworthy science that is grounded in rigorous methods, and science communication that is balanced and accurate.

Timothy Caulfield

Opinion



Yes, science is exciting, but how we talk about science matters, especially in this era of health misinformation, writes Timothy Caulfield. *Unsplash photograph by Ambreen Hasan*

Science hype has become a serious problem. There is more and more hype in the peer-reviewed scientific literature. There is hype in the institutional press releases about that literature. There is hype in the news reports about the research—especially in those hype-y headlines. There is hype on social media. And, perhaps most worrisome, the hype exists in the marketing of the health products associated with the science.

Throughout the knowledge-production process, exaggeration and overly optimistic language is injected into the public representations of research. It has become a hype pipeline, one that starts when researchers search for research funds.

In a study involving anonymous interviews with senior academics from the United Kingdom, the participants admitted that the hyper-competitive funding environment led them to routinely lie and exaggerate in research grants about the potential impact of their work. As one of the researchers was quoted as saying, "If you can find me a single academic who hasn't had to bullshit or bluff or lie or embellish in order to get grants, then I will find you an academic who is in trouble with [their] head of department."

This kind of data is depressing, but it shouldn't be surprising. The pressure to hype, hype, and hype is baked into the current pub-

Continued on page 26

It's time health-care workers learned how to work in teams

We need to reorganize the work of health-care workers to better use their expertise, reduce duplication, and enhance the co-ordination of care experienced outside of hospitals.

Ivy Oandasan &
Ivy Bourgeault

Opinion

Canada is in the midst of a primary care crisis. Primary care is the first point of contact Canadians have with the health-care system outside of hospitals, often via a family physician or nurse practitioner. Unfortunately, an estimated 6.5 million Canadians do not have a family physician or a nurse practitioner.

Provincial government plans to address the crisis have largely focused on increasing the number of health workers. But increasing numbers alone—by making more spots available in medical and nursing schools, and recruiting health workers from out of country—will not be enough to solve the crisis.

We need to reorganize the work of health-care workers to better use their expertise, reduce duplication, and enhance the co-ordination of care experienced outside of hospitals to improve health-care access.

No one practitioner can do it all because this no longer fits the reality of the kind of health issues people face today. Patients—especially those with chronic or complex health needs—are better served by a team of health-care workers whose skills complement each other.

A team-based approach can better balance the workload among team members, and enable each to better use their skills and training. Not only can this help to reduce burnout, it can also improve job satisfaction.

Some provincial governments have been creating more practice opportunities for primary care teams working collaboratively. Many provinces are implementing new practice approaches like the Patient's Medical Home, with family physicians working in teams with other health-care professionals providing accessible, high-quality care for their patients.

But effective teamwork doesn't just happen magically without dedicated training and support.

Training health-care workers to practice in primary care teams is a necessary part of any strategy to address the crisis. Teamwork among health-care workers must be fostered through knowledge about what each other can do and opportunities to practice working together.

It may come as a surprise to many Canadians that few health-care workers learn explicitly about the roles each plays, or could play, in the care of patients. For example, various health professionals, including physicians, may not be aware that registered nurses can conduct annual wellness exams, including pap smears; that midwives have the authority to prescribe drugs; of the role that occupational therapists have in providing mental health services; that audiologists can help older adults with hearing problems develop new listening and communication skills; and that pharmacists have prescribing authority to collaboratively manage chronic diseases and minor ailments.

Team-based care operates on the premise that enabling these primary care providers to complement rather than substitute each other in co-ordinated ways offers better access to care.

Without this critical knowledge, health workers don't know how to work together most effectively. Lack of knowledge can lead to a lack of trust and duplications of services without co-ordination that can be costly and time consuming to both patients and the health system.

Like any team, successful primary care teams require training and practice together to learn how to leverage their strengths.

This idea is not new. More than 20 years ago, the Commission on the Future of Health Care in Canada argued that: "If health-care providers are expected to work together and share expertise in a team environment, it makes sense that their education and training should prepare them for this type of working arrangement."

A unique federally funded pilot project called Team Primary Care: Training for Transformation is working to address this foundational and outstanding gap. It brings together more than 20 practitioner groups representing all aspects of primary care to create training content, tools, and approaches that enable each team member to learn about, from, and with each other, and enhance their ability to work better together delivering more and better primary care.

The project focuses on enhancing the training of specific primary care practitioner groups as well as practice-based training of existing primary care teams, bringing on new providers to accomplish transformational change at many levels. Spreading and scaling the tools and approaches of this project is paramount and will begin with the support of more than 100 health professional and educational organizational partners across the country.

It's time health-care workers learned how to work in teams.

Now, all governments need to work with health provider educators to support necessary education reform as part of the transformation to primary care teams. Patients, health providers, and the health system alike will benefit.

Dr. Ivy Bourgeault is a professor in the school of sociological and anthropological studies at the University of Ottawa, and leads the Canadian Health Workforce Network. Dr. Ivy Oandasan, a professor with the department of family and community medicine at the University of Toronto, is director of education at the College of Family Physicians of Canada. They are co-leads of Team Primary Care.

The Hill Times

No one practitioner can do it all because this no longer fits the reality of the kind of health issues people face today, write Ivy Bourgeault and Ivy Oandasan. *Unsplash photograph by Luis Melendez*

The partnership approach works because the provinces, territories, and people from across Canada jointly contribute to our national cancer strategy, write Jeff Zweig and Craig Earle. *Unsplash photograph by the National Cancer Institute*

Cancer will strike almost half of all Canadians in their lifetime

A challenge of this magnitude requires a national response, and the Canadian Partnership Against Cancer is a unique model of collaboration that is working to make a meaningful difference in cancer outcomes across the country.

Jeff Zweig & Craig Earle

Opinion

The reality is that we will all likely be affected by cancer in our lifetime, either directly or through someone we love. More than 200 Canadians die from cancer every single day. It is the leading cause of death in the country.

In the positive column, cancer survival rates are improving, and Canada ranks highly compared to other countries in cancer outcomes. But, with a growing and aging population, more Canadians are getting diagnosed with cancer than ever before.

A challenge of this magnitude requires a national response. In 2006, Canada was one of the first countries in the world to create a national cancer strategy. There are 14 different health-care systems across Canada between federal, provincial, and territorial governments. Who you are and where you live determines which system provides your care. Less-resourced jurisdictions and communities often do not have access to the same quality of health care. Remote and Indigenous communities are often seriously disadvantaged, and cancer outcomes are worse as a result.

It was against this context that the Canadian Partnership Against Cancer was created in 2007 as the steward of the Canadian Strategy for Cancer Control. An arm's-length agency funded by the federal government, the Partnership's model is based on identifying shared cancer priorities across those 14 health systems, identifying leading practices, and accelerating their implementation to improve cancer outcomes. It has enabled unprecedented collaboration, knowledge sharing, and co-ordination across the country. The Partnership's board of directors is composed of representatives from federal, provincial, and territorial governments, cancer organizations, Indigenous communities, and other people affected by cancer from across the country.

The Partnership is a pan-Canadian approach to addressing one of the biggest challenges of our time.

With federal support over the last 15 years, the Partnership has collaborated with more than 700 partners in cancer care-related initiatives. We track cancer outcomes across the country and benchmarks around the world to help inform opportunities and promising approaches. We convene a diverse range of cancer leaders on specific topics to exchange information, prioritize actions and develop plans to improve outcomes.

For example, last November, the Partnership organized a national summit in Halifax bringing together 150 decision-makers from across the country to drive action on the elimination of cervical cancer. Representatives from every province and territory, including First Nations, Inuit, and Métis leaders, health-care professionals, patients, community and equity partners attended this event. They left with actionable next steps to advance the elimination of cervical cancer in their communities and support Canada's commitment to eliminating cervical cancer by 2040. Every year, 1,300 people in Canada are diagnosed with cervical cancer and more than 400 die. Through the human papillomavirus (HPV) vaccine and HPV test, we now have the means to prevent cervical cancer and eliminate this disease altogether.

Another example relates to screening for lung cancer, which often goes undetected until it reaches an advanced stage. At current rates, one in 14 Canadians will be diagnosed with lung cancer. Unfortunately, the mortality rate is high because it is not caught early enough. Five years ago, working with partners across the country, we identified lung cancer screening as a priority. Today, planning and implementation of lung cancer screening programs is underway in all 10 provinces.

This partnership approach works because the provinces, territories, and people from across Canada jointly contribute to our national cancer strategy, setting the common priorities, and committing to work together to improve. There are four clear goals in the Strategy:

- People in Canada have equitable access to quality cancer care;
- Fewer people develop cancer;
- More people survive cancer; and
- People in Canada affected by cancer have a better quality of life.

These are supported by eight agreed-upon priorities with clear actions, which are measured quantitatively and reported on the Partnership's website.

Cancer care is complex, compounded by the nature of Canada's health-care landscape. The Canadian Partnership Against Cancer is a unique model of collaboration that is working to make a meaningful difference in cancer outcomes across provinces, territories, and Indigenous communities, and helping to close the gap for disadvantaged regions and groups. It is a successful pan-Canadian response to a national priority.

Jeff Zweig is the board chair of the Canadian Partnership Against Cancer, and partner, vice-chair, and head of Natural Capital (Agriculture & Timberland). Dr. Craig Earle is the CEO of the Canadian Partnership Against Cancer.

The Hill Times

Needed: less science hype!

Continued from page 24

lish-or-perish research ecosystem. For example, to attract the needed investment to an area—especially for large, expensive, and time-consuming interdisciplinary projects—the research needs to be framed as revolutionary, cutting-edge, and paradigm shifting, even though science is very rarely any of those things. Doing science is hard, messy, and slow. It rarely unfolds exactly as promised. And the results are almost always more modest than initially promised. No revolutions, but lots of iterative—but, it should be emphasized, *still* important—advances.

I've seen this cycle unfold again and again. Over the past three decades I've been fortunate to work closely with the biomedical research community on many of the hottest "Big Science" topics, including stem cells, genomics, nanotechnology, neuroscience, and the microbiome. There has been lots of very interesting science and exciting niche (and tremendously expensive) applications, such as gene therapies for sickle cell disease and a few (a *very* few) new stem cell treatments for diseases like multiple sclerosis. But despite decades of research and the global investment of billions of dollars, I have yet to see a single "revolutionary" advance—that is, a broadly relevant technology that altered our health-care system or that had a drastic impact on population health—play out in the manner originally promised.

Not only is this kind of hype disingenuous, but it can also do significant harm. It can, for example, misinform and skew research priorities and resources away from less exciting but more impactful population health strategies (exercise, diet, smoking cessation, etc.). It can create false expectations, and misinform the public and desperate patients about the actual state of the science. And the hype can be leveraged to market unproven and potentially harmful therapies and products, a process I've called scienceploitation.

Perhaps the biggest concern, however, it that science hype has the potential to further erode how the public views biomedical research. Trust in science and scientific institutions is declining. A recent Pew Research Center survey, for example, found that only 57 per cent of Americans think science has had a "mostly positive effect on society," down from 73 per cent in 2019.

Now, more than ever, we need trustworthy science that is grounded in rigorous methods, and science communication that is balanced and accurate. Yes, science *is* exciting. New discoveries *are* often worthy of enthusiastic declarations. And all of us in the research community *must* do more to engage with the public to help foster critical thinking and heighten science literacy. But how we talk about science matters, especially in this era of health misinformation.

So, to be clear, I'm *not* arguing against the funding of big and well-justified science projects. Indeed, funding rigorous biomedical research is more important now than ever. And advances like the mRNA vaccines—which saved millions of lives—and the rise of artificial intelligence demonstrate that world changing science does happen.

We need more good science. But we also need good science communication.

Timothy Caulfield is an author and professor at the University of Alberta's faculty of law and school of public health.

The Hill Times

Health

Canada is on track to cure Type 1 diabetes, and we can get there with the right support

Research innovation is becoming increasingly competitive in the post-pandemic world, and Canada is at risk of losing its foothold.

Sarah Linklater

Opinion

An estimated 300,000 Canadians (growing at a rate of 4.4 per cent a year) live with Type 1 diabetes (T1D), an autoimmune disease resulting in the pancreas not producing enough insulin for the body, causing blood sugars to rise. Until cures are found, people with T1D must monitor their blood glucose throughout the day and take multiple daily insulin injections to survive. But insulin is only a treatment, and Canadians with T1D have a high risk of life-threatening complications, lower quality of life, and life expectancy that is 10 years less than that of the general population.

When it comes to diabetes research, Canada has historically punched well above its weight on the world stage. Since the discovery of insulin in Toronto in 1921, Canada has continued to make significant breakthroughs towards curing T1D: from the discovery of stem cells in 1961, to the development of the Edmonton Protocol—a method of transplanting pancreatic cells—in 1999.

In 2022, the federal government published the Framework for Diabetes in Canada, highlighting a need to better recognize, collaborate with, and support those affected by diabetes. The framework provides a common policy direction to help align national efforts to address diabetes. Like previous reports, however, it recognizes that Canada continues to lack the necessary funding for diabetes research and for translating discoveries into practice. The federal government has an opportunity to make meaningful investments into research, and demonstrate its leadership and commitment for better treatment and support for people living with diabetes.

Canada has the talent and capacity to continue its legacy of success, and can be the place where the next major breakthroughs in T1D cures are discovered, driven to commercialization, and delivered to improve lives. But to maintain our leading research position and to reduce the immense pressure on our health-care system caused by T1D and its complications, there needs to be sustained investment in research and innovation throughout the entire pipeline. That is why the Juvenile Diabetes Research Foundation (JDRF) is recommending the federal government invest $50-million over five years in the JDRF-CIHR Partnership to Defeat Diabetes to support new and ongoing translational T1D research—from discovery to clinical trials—to improve health outcomes, drive commercialization, create good jobs, and bolster Canada's life sciences sector.

Investments in this space not only create jobs for highly qualified personnel and research trainees, but also allow for the potential of discoveries to spin-off into businesses. Without the right incentives, Canadian projects—and the research talent behind them—may choose to relocate to other countries with better opportunities. This leaves Canada in a position of starting research projects with heavy initial investment, but then losing out on the economic benefits that would flow from its discoveries, as well as the benefits of early access to new treatments that Canadians need. By effectively moving research projects through the full pipeline into commercialization, Canada can demonstrate that it values innovation and that we can be a destination for new talent and investments.

Funding translational research is essential for bringing innovations to market. Along with improving the lives of Canadians with T1D, bringing innovative solutions to market will also realize long-term benefits for governments looking to reduce health-care costs (which in Canada are $30-billion annually due to all diabetes). Innovations in T1D research will reduce hospitalizations caused by diabetes complications (including diabetic ketoacidosis, hypoglycemia, kidney and cardiovascular disease, and mental health disorders), as well as improve quality of life and health outcomes, thereby reducing absenteeism and presenteeism related to T1D in working-age Canadians.

As research around the world brings us closer to cures for T1D, we cannot afford to abandon the progress we have made in Canada. It is crucial for our government to provide consistent and stable funding for Canadian researchers to launch the next moonshots that will transform T1D therapy, and lead to cures. Canada discovered insulin. Canada discovered stem cells and pioneered the Edmonton Protocol. Canada can lead the world in the discovery of a cure.

Sarah Linklater is chief scientific officer of JDRF Canada, a non-profit organization focused on Type 1 diabetes research funding and advocacy. Linklater holds a PhD in experimental medicine from the University of British Columbia.

The Hill Times

MENTAL HEALTH

New federal Minister of Mental Health and Addictions and Associate Health Minister Ya’ara Saks, pictured July 26, 2023, shortly before she was sworn in to cabinet at Rideau Hall. *The Hill Times photograph by Andrew Meade*

'Woefully inadequate' funding spurs association's calls for fulfilled mental health transfer

About 10-15 per cent of people who call a distress line require additional community-based supports, according to the Canadian Mental Health Association's national director of public policy.

BY JESSE CNOCKAERT

A nationwide suicide crisis hotline launching in November could save lives, but will also create greater demand for community-based mental health supports that are already under strain, according to mental health advocates.

"We know this service is life-saving. It's going to have a huge positive impact, but at the same time drive up demand for service where there are already long waitlists," said Sarah Kennell, national director of public policy at the Canadian Mental Health Association (CMHA). "Having federal funds that would really focus on the mental health crisis and alleviating the pressures on our acute health-care system would go a long way to, I think, reduce some of the strain that this system is under and that Canadians are facing."

In July, then-mental health minister Carolyn Bennett (Toronto-St. Paul's, Ont.) announced an investment of $156-million over three years to the Centre for Addiction and Mental Health (CAMH) for the implementation of a national three-digit phone number for suicide prevention and emotional distress. Bennett also announced an additional investment of $21.4-million towards CAMH intended to help the organization bolster the capacity of distress centres that are part of the existing Talk Suicide Canada network in order to better meet increased demand. The 988 Suicide Crisis Helpline will be available in English and French, 24 hours a day, seven days a week, starting on Nov. 30.

Kennell said that it remains a question of what other supports will be available for people whose needs are not met during a call to the helpline. According to Kennell, about 10 to 15 per cent of people who call a distress line require additional community-based supports, which could include crisis counselling, a safe bed to sleep in, or a mobile crisis response team that can go to the caller's location.

"All of these services are provided by community-based mental health organizations, and as of yet, there's been no funding to support that," she said.

Kennell argued that the need for greater community-based mental health supports could be addressed by the Liberal government following-through on a promised mental health transfer. The Liberals' 2021 election campaign included a promise to launch a Canada Mental Health Transfer that would send $4.5-billion to provinces and territories over five years. Kennell said the transfer would be a game-changer, but "we have yet to see any kind of commitment to create that dedicated transfer," which she called a failed promise.

The launch of the crisis helpline in November could be a chance for the Liberal government to address the mental health transfer, according to Kennell. Canada currently spends between three to five per cent of its health care budget on mental health, which is "woefully inadequate," she said.

"As we look ahead to the launch of 988 … there's an opportunity for the feds to say, 'In addition to this line, we'll also be allocating resources to not only address crisis when they happen by providing wrap-around follow-up supports to ease pressure on police departments and hospitals, but we also need to be investing in prevention,'" she said. "A dedicated mental health transfer would help fill the gap by resourcing all of those services that provide wraparound support to people in crisis. But not only that, [it would] invest in the crisis prevention work that needs to be done, so that we can actually prevent people from getting into a mental health crisis in the first place."

Sarah Kennell, national director of public policy at the Canadian Mental Health Association, says that, as of yet, there has been no funding to support community-based mental health organizations.' *Photograph courtesy of Sarah Kennell*

Minister of Mental Health Ya'ara Saks said that "[Crisis centres] provide that urgent support to people who need it most, no matter their race, religion, culture or socio-economic background,' in a Public Health Agency of Canada press release on Sept. 8. *The Hill Times photograph by Andrew Meade*

The Hill Times reached out to Minister of Mental Health Ya'ara Saks (York Centre, Ont.) to ask about the promised funding for the mental health transfer. Press secretary Alex Fernandes responded on Sept. 27 with an emailed statement, attributable to Saks' office, stating that the Liberal government is committed to supporting the mental health of Canadians, which includes supporting the expansion and delivery of quality and accessible mental health and substance use services across Canada.

The 2023 federal budget outlined a plan by the Liberal government to invest close to $200-billion over 10 years to improve health care for Canadians, including $25-billion through tailored bilateral agreements to support individual provincial and territorial needs, according to the emailed statement.

The $25-billion through bilateral agreements is intended to be split between "four areas of shared priority," one of which is mental health and substance use, according to a press release from the Prime Minister's Office on Feb. 7. The other three areas are family health services, health workers and backlogs, and the development of a modernized health system.

"This investment builds on work initiated with the 2017 bilateral agreements, which distributes targeted funding for provinces and territories over 10 years to improve access to mental health and substance use services," said the emailed statement. "This includes efforts in priority areas such as expanding access to community-based mental health services for youth, integrating evidence-based models of care and culturally appropriate interventions with family health services, and expanding availability of mental health and substance use services for people with complex needs."

Kennell argued this funding isn't likely to help with the needed community-based mental health services, because it is being provided through the health care system's existing funding mechanisms under the Canada Health Act.

"We're looking at services delivered in hospitals and by doctors," said Kennell. "Unfortunately, that means that the community-based mental health services that are delivered outside of that context won't see the funding in all likelihood, unless provinces, by their own political will or [because of] pressure from their constituents, demand that they see those services funded."

Kennell said it's been known that the bilateral deals had been signed since February, but no action plans have yet been made public.

NDP MP Gord Johns says 'when someone calls and they need help, we need to make sure that there's community-based care … to help people in their time of need.' *The Hill Times photograph by Andrew Meade*

"We don't actually know the state of the negotiation between the feds and the provinces and territories, which is really concerning," she said. "At the end of the day, we need to understand, as stakeholders and recipients of mental health care, that dollars are going to flow equitably to mental health. And we just don't know yet what that's going to look like."

Under the Canada Health Act, most mental health services are publicly covered only if they are deemed "medically necessary" and provided by doctors or in hospitals, and millions of Canadians do not have a family doctor, according to a CMHA press release on Aug. 30. About one-third of Canadians—or about 9.1 million people—will experience a mental illness or substance use disorder during their lifetime, according to data from Health Canada.

To improve the service provided by the 988 helpline, Saks announced on Sept. 8 a call for proposals to access $8-million in federal funding to address gaps in equity, diversity and inclusion within Canada's distress line sector. The purpose of the grant funding is to help existing and eligible distress centres build their capacity, as well as their ability to meet the diverse needs and experiences of those who call and text for help, in order to ensure equitable service, according to a Public Health Agency of Canada press release.

"[Crisis centres] provide that urgent support to people who need it most, no matter their race, religion, culture or socio-economic background. With access to this funding, these important service organizations will be able to increase their ability to support and respond to the diverse needs and experiences of every person who reaches out to them," said Saks in the press release.

NDP MP Gord Johns (Courtenay—Alberni, B.C.), his party's critic for mental health and addictions, told *The Hill Times* that the 988 suicide crisis helpline is important and will save lives, but agreed it may create more need in terms of community-based services.

"Hopefully, more people are going to use it and we're going to be able to save lives, but of course, when someone calls and they need help, we need to make sure that there's community-based care … to help people in their time of need," he said.

Rolling out investments promised for the mental health transfer could help "absorb some of the new demands that are going to be on the system," according to Johns.

"The government needs to get [the transfer] out the door to support community-based, mental health," said Johns. "The urgency is so real … because the bilateral agreements on their own, first, are going to take a long time before they're finally rolling out. Secondly, in our discussions with Health Canada, there is still no assurances of how much money is going to go to mental health. It is going go to the provinces, and the provinces are going to determine where that money goes."

Sen. Stan Kutcher (Nova Scotia) of the Independent Senators Group told *The Hill Times* that the 988 suicide crisis helpline will be potentially a key tool for reducing suicide rates, but argued phasing in the helpline across different regions of Canada might be useful for better gauging its effectiveness. Kutcher, a psychiatrist with a medical degree from McMaster University, said that, when it comes to helplines as a tool to reduce suicide rates, the data is mixed.

"The question that we have to answer is, how effective is this tool at reducing suicide rates? And the only way we can answer that in Canada is to bring it in in a stepped approach, where we can look at interventions in one part of the country compared to other parts of the country," he said. "If you bring it in in a step-wise manner—ensuring that you have control sections of the country, which are similar in geography, population density, etcetera—then you have a much better idea of how much of an impact this intervention is actually having on decreasing suicide rates in the country."

Kutcher argued that the foundation for mental health care begins with mental health literacy, which is also in need of greater funding support from the federal government.

The four components of mental health literacy are understanding how to obtain and maintain good mental health; knowing about mental disorders and their treatments; eradicating stigma against mental illness; and "providing competencies" so that people will know when they need to access care, and when they don't, according to Kutcher.

As an example, federal money could be set aside to support school boards or youth organizations such as 4-H Clubs that would like to provide mental health literacy intervention, according to Kutcher.

"They have to utilize existing organizations and institutions to help in their delivery," said Kutcher. "If the federal government just did that, in the whole field of mental health, that would make such a difference, because we know from the research on health literacy that the more health literate a population is, the better the health of the population is."

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The Hill Times

Independent Senator Stan Kutcher (Nova Scotia) says the only way Canada could answer the question of how effective a crisis helpline is in reducing suicide rates would be a stepped approach. *Photograph courtesy of Facebook*

Canada mental health statistics

- One in three Canadians—about 9.1 million people—will be affected by a mental illness during their lifetime.
- Examples of mental illness include: major depressive disorder, bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, schizophrenia, eating disorders and substance-related disorders.
- Every year, about 15 per cent of Canadians use health services for a mental illness.
- Close to 5.5 million Canadians received health services for a mental illness in 2016-2017, which is more than the population of British Columbia.
- Canadian females are 30 per cent more likely than males to use health services for mental illness.
- In 2016-2017, Canadians aged 19 and under had the lowest proportion of health services use for a mental illness (10.7 per cent).
- However, there is an increasing trend in the use of health services for mental illness among young Canadians. From 2000-2001 to 2016-2017, the proportion of Canadians aged 19 and under using these services rose an average of 2.6 per cent per year.

Source: Mental illness in Canada (2020-10-08), Health Canada

Mental health and addiction facts and statistics

- Young people aged 15 to 24 are more likely to experience mental illness and/or substance use disorders than any other age group.
- Thirty-nine per cent of Ontario high-school students indicate a moderate-to-serious level of psychological distress (symptoms of anxiety and depression). A further 17 per cent indicate a serious level of psychological distress.
- Men have higher rates of substance use disorders than women, while women have higher rates of mood and anxiety disorders.
- Mental and physical health are linked. People with a long-term physical health condition such as chronic pain are much more likely to also experience mood disorders. Conversely, people with a mood disorder are at much higher risk of developing a long-term medical condition.
- People with a mental illness are twice as likely to have a substance use disorder compared to the general population. At least 20 per cent of people with a mental illness have a co-occurring substance use disorder. For people with schizophrenia, the number may be as high as 50 per cent.
- Canadians in the lowest income group are three to four times more likely than those in the highest income group to report poor to fair mental health.

Source: Mental Illness and addiction: Facts and Statistics, Centre for Addiction and Mental Health

Mental Health Policy Briefing

Launch of 988 suicide prevention hotline is important step, but there's more to do on mental health file

One-third of Canadians will experience a mental illness or substance use disorder in their lifetime, and more than 200 Canadians attempt suicide every day.

Conservative MP Todd Doherty

Opinion

We are two months away from Canada launching our first 24-7 suicide prevention hot line. On Dec. 11, 2020, the House of Commons unanimously passed my motion to bring 988 to Canada.

It's taken the Liberals three years to get here, but Canadians will finally have access to help when and where they need it. Starting on Nov. 30, people in crisis will be able to dial 988 anywhere in Canada and be connected with trained responders 24 hours a day by phone or text message.

All Canadians, regardless of their geographic location, or economic status, deserve access to critical mental health and prevention services, writes Conservative MP Todd Doherty. *Photograph by Nick Youngson, distributed under a CC BY-SA 3.0 license*

While this is positive step in the right direction, there is still much to be done on the mental health file.

Budget 2023 proposed to provide $158.4-million over three years, starting in 2023-24, to the Public Health Agency of Canada to support the implementation and operation of 988; however it does not provide any community mental health funding.

One-third of Canadians will experience a mental illness or substance use disorder in their lifetime. More than 200 Canadians attempt suicide every day. Twelve Canadians will die by suicide every day. One in four Canadians are experiencing high levels of anxiety, and 56 per cent of those who are struggling in Canada are not getting the help they need.

As the Liberal government flounders on issues that matter to Canadians, housing costs—excessive taxation, ballooning interest rates—approximately, 8.2 million Canadians, or 20 per cent of Canada's population, are forced to use food banks each month.

Over half a million Canadians are unable to work each week due to poor mental health.

The mental health crisis costs Canada at least $50-billion per year in direct health-care costs, lost productivity, and decreased quality of life. Substance abuse costs the Canadian economy an additional $46-billion a year in direct healthcare costs, lost productivity, and criminal justice costs.

All Canadians, regardless of their geographic location or economic status, deserve access to critical mental health and prevention services.

Community organizations—typically charities and non-profits—offer many mental health services at no cost, or help individuals navigate the system. However, the demand for mental health services is already high, and existing community-based services are overstretched. These include mobile crisis response services, safe beds, peer support, and social support like emergency housing and food.

Until we as a country realize the cost/benefit of sound mental health policy, we will not move forward. We need to recognize that programs like 988 should not be the end of the service, but the beginning. When I envisioned this program, I thought back to my 15-year-old friend who died by suicide; the countless other friends that I've lost; families that I've sat with who are struggling to pick up the pieces.

Would 988 have helped? Would my friends, their families or loved ones have taken that first step and dialed the number? Would they have received the reassurance they needed? Would help have been offered? What about follow-up care?

I truly believe the additional of 988 will help. But its just one tool in the toolbox. If we want to make a lasting difference, we need to look at where mental health services are offered. We need to support community-based mental health organizations. Investments in all aspects of care—from crisis prevention to crisis response to recovery support—will divert unnecessary use of hospital, paramedic, and police services in the short term, and lead to long-term savings and reduced pressures on health, court, and correctional systems.

These investments will save lives.

Canadians are facing an unprecedented mental health crisis. The Liberal government is failing to deliver basic mental health services.

It's time for real leadership. Let's bring it home.

Conservative MP Todd Doherty, who represents Cariboo-Prince George, B.C., is his party's critic for mental health and suicide prevention.

The Hill Times

A perfect storm for mental health needs and care in the economic downturn

Rising costs of living are having a major impact on the mental health of millions of Canadians.

NDP MP Gord Johns

Opinion

The mental health of Canadians continues to worsen with alarming numbers of the population experiencing higher levels of anxiety, depression, mood disorders, and suicidal ideation in this economic downturn.

We know this from recent research by the independent Mental Health Research Canada (MHRC), and from warnings from the Canadian Mental Health Association (CHMA).

We also know this from our own families, friends, and co-workers. Members of Parliament know this from constituents, including heartbreaking stories from parents faced with mortgaging the family home to finance substance use disorder treatment for a child, or from a low-income worker unable to afford a private practitioner and stuck on a months-long wait list to see a hospital psychologist.

And we all know, both from recent research and from family and friends, that rising costs of living are having a major impact on the mental health of millions of Canadians.

Inflation is forcing people to cut back on health-related expenses. A recent MHRC survey found that 40 per cent of respondents say the economic downturn is having a negative impact on their mental health, while those with lower incomes or who are in financial trouble are at even greater risk of anxiety, depression, or substance use disorder. The CMHA tells us that Canadians affected by inflation are experiencing higher self-rated anxiety (33 per cent) and depression (32 per cent), higher rates of recent diagnosis of a mood disorder since the pandemic (14 per cent), and higher suicidal ideation (31 per cent).

Most Canadians in need of mental health care look for help from mental health professionals operating within hospitals or community-based settings, funded through our public health-care system. Others turn to the private sector for services covered by employer insurance plans, or paid for directly by patients at their own expense.

The private sector is growing, and at the expense of our public system. Graduates in mental health disciplines are drawn to higher-paying private practice—only 25 per cent of new psychologists choose to work in the public sector, including hospitals and community mental health service organizations. Of those graduates who choose the public sector, 40.5 per cent leave within their first five years for higher-paying jobs and better working conditions in the private sector.

This exodus from the public system, combined with chronic underfunding by successive Conservative and Liberal governments, is contributing to a crisis in accessing mental health services, particularly for Canadians dealing with financial stress.

Almost one-third of the MHRC survey participants cite an inability to pay as the reason for not accessing mental health care, even though they need it. They can't afford the private system, and publicly funded community-based services are unavailable to them in a timely manner, or not at all for those who live in many rural areas.

During the 2021 federal election campaign, the Liberals promised a dedicated Canada Mental Health Transfer to provinces and territories, with permanent funding and an initial investment of $4.5-billion over five years. Budget 2023 failed to delineate funding for mental health care. Instead, it buried it along with other healthcare spending priorities within a $2.5-billion annual budget over 10 years.

There is a massive disparity between mental health and physical health-care services in our universal health care system. Canadians do not receive the same ongoing care from a mental health professional for anxiety, depression or mood disorders as they have come to rely on for a broken ankle, heart disease, or diabetes.

Without the government's promised investment or follow-through on its mandates to ministers, the CMHA tells us that a possible increase in mental health care provided by doctors and hospitals will not address the rising demand for community-based mental health and substance use health care.

Canada faces a perfect storm of worsening mental health for millions of Canadians coping with the rising costs of living and a public mental health care system out of reach as service providers can't afford to provide care due to chronic underfunding.

The NDP is fighting to weather this storm calling for dedicated funding through a Canada Mental Health Transfer and parity of mental health with physical health services for all Canadians through our universal health-care system.

NDP MP Gord Johns represents the riding of Courtenay-Alberni in British Columbia. He is the party's critic for Mental Health and Harm Reduction.

The Hill Times

Moving beyond the crisis helpline requires care after the call

Crisis support like the 988 crisis line is only part of an effective action plan to prevent suicide. People will need urgent care after the call, and the federal government is on the hook.

Margaret Eaton

Opinion

It's a common refrain from our politicians: "there is no health without mental health." But for the many Canadians who are grappling with lengthy wait times, limited local services, or the burden of unaffordable care, that mantra may feel hollow.

The toll on mental health is startling: every day in Canada, an average of 12 people die by suicide, and about 60 people are hospitalized for self-harm. The suicide rate has not changed since the government established a Federal Framework for Suicide Prevention seven years ago. The emotional costs of suicide are incalculable. Economically, suicide and self-harm account for $2.9-billion in direct expenses to the healthcare system and indirect costs to society. These numbers are unsettling, but not surprising, considering that health policymakers continually fail to address the chronic underfunding of mental health care in this country.

Parliamentarians worked across party lines to make the national 988 suicide prevention and emotional distress helpline possible, which launches on Nov. 30. The crisis line is intended to de-escalate emergencies and provide callers with immediate crisis counselling. It will undoubtedly save lives. It is also part of the federal government's commitment to replacing the outdated Framework for Suicide Prevention with a comprehensive, action-oriented plan.

The helpline can only be one part of an effective action plan to prevent suicide. Having created 988, the federal government—guided by Mental Health and Addictions Minister Ya'ara Saks as the lead on mental health and addictions—now has the responsibility to ensure that people receive the care they urgently need *after* they call.

By its very nature as a crisis line, 988 will only offer short-term support. Callers will frequently need follow-up care and community mental health resources like mobile crisis response, crisis beds, referrals to housing, income or food supports, counselling and other programs and services. Often these services do not exist, and when they do, there are intolerable wait times. Establishing a "care after the call" fund to create and expand after care would signal the government's genuine commitment to addressing and preventing crises.

Based on government projections of 988 call volume, community providers are anticipating significantly increased demand for services. While the Public Health Agency of Canada received funding for the implementation and operation of 988, the last federal budget ignored frontline providers of crisis response and suicide prevention. Likewise, the recently negotiated health accords fund hospitals and physicians, but overlook the other community-based supports that 988 callers will need.

We should be deeply concerned that people's symptoms will become increasingly urgent if they have to wait for services. With nowhere else to go, people who need help will turn to emergency departments, placing even greater strain on our hospital resources. Others will encounter law enforcement because we criminalize people with mental health issues rather than giving them the care they need. And yes, others will die.

The federal government has a role in resolving the pressures and challenges in the mental healthcare system that are within its jurisdiction, such as mental illness prevention and mental health promotion. We need to get at root causes. To do that, policy-makers must prioritize services that prevent crises in the first place.

The urgency of suicide and mental health crises in Canada demands a suicide prevention action plan in more than name only. We see people in our communities struggling every single day. People need support before, during, and after a crisis. Minister Saks must make federal health-care commitments to prevention and allocate funding for care after the call. Because while the government is diligently preparing for the launch of 988, a significant question mark is looming: to what services will callers in crisis be connected?

Margaret Eaton is the national CEO of the Canadian Mental Health Association (CMHA), the most established and extensive community mental health organization in Canada. Through a presence in more than 330 communities across every province and the Yukon, CMHAs provide advocacy, programs and resources that support recovery and resilience and help to prevent mental health problems and illnesses.

The Hill Times

Bridging the gap between public safety and mental health

With the new federal ministers for Justice, Public Safety, Housing, Health, and Mental Health and Addictions comes an opportunity for change.

Michel Rodrigue

Opinion

Ya'ara Saks, left, is sworn in as addictions and mental health minister in the July 26, 2023, cabinet shuffle. *The Hill Times photograph by Andrew Meade*

You've seen the articles, you've heard the soundbites, the ones that group everyone with a mental illness into one category: dangerous. But what's dangerous is when we dehumanize people who live with a mental health or substance use concern. Public safety is a concern to everyone—but casting people living with a mental illness as the villains is a weak narrative that's harmful to us all.

The lack of access to mental health and substance use services in Canada remains significant. People seeking help often face long wait times, limited availability of specialized care, and in their vulnerability, having to navigate a patchwork system that often fails to provide wraparound supports. But to bridge this gap, we need increased investment in mental health services, including the expansion of community-based programs, early intervention initiatives, and services that reach underserved populations.

Right now, it is disheartening to witness how public safety concerns have overshadowed the urgent call for comprehensive mental health and substance use health services and supports. While maintaining public safety is undoubtedly important, it should not be achieved at the expense of people who need help. We must recognize that mental illness and substance use concerns are complex and multifaceted, requiring a nuanced and compassionate approach.

The rhetoric surrounding public safety and its intersection with mental health and substance use is cause for alarm. In recent years, public policy, debates in the House, and political rhetoric have shaped the narrative in ways that often perpetuate stigma, hinder access to essential resources, and can exacerbate self-stigma among individuals living with mental health or substance use concern.

Self-stigma surrounding mental illness and substance use concerns is a reality. Earlier this year, the Mental Health Commission of Canada released a survey where 72 per cent of people living with a mental health or substance use concern also reported feelings of serious self-stigma. Adding the burden of stigma to someone already facing challenges only compounds the issue. As a society we need to work on lifting our most vulnerable up—not perpetuating harmful stereotypes.

Many people internalize the negative stereotypes and misconceptions associated with mental illness and substance use disorders, leading to shame, isolation, and avoidance of necessary support. Telling people who are struggling that they are a danger to society is not the solution.

To combat the harmful rhetoric and foster a more inclusive and supportive society, we must encourage open and honest conversations about mental illness and substance use. Political leaders of all stripes, policymakers, and the media have a responsibility to use their platforms to disseminate accurate information, challenge stereotypes, and advocate for evidence-based approaches. It is crucial to move away from stigmatizing language and instead promote empathy, understanding, and compassion in public discourse.

It is time to reshape the narrative and build a healthier, safer, and more equitable Canada.

Michel Rodrigue is the president and CEO at the Mental Health Commission of Canada.

The Hill Times

Mental Health Policy Briefing

We'll bring the fiddle

Life promotion, which can be as simple as bringing people together around a fiddle, addresses mental wellbeing by strengthening our connections to life and to each other.

Métis fiddler Olivier Boulet holds a fiddle in August 2017. *The Hill Times photograph by Jake Wright*

Reagan Bartel

Opinion

The fiddle sings tunes of wellness. Métis youth laugh as they dance the Red River Jig's changes. The tunes speak our connections to our ancestors and to our present-day kin. They speak of hope and continuity. The laughter spreads to aunties, to uncles and to Elders. Life is present in these moments, and we are well.

The music ends. In such moments of silence, rare at a Métis gathering, I am reminded that despite advances, we continue to struggle to meet the same benchmarks for mental wellness that our non-Indigenous neighbours take for granted. Métis men die, on average, five years younger than their non-Indigenous counterparts (health status of Canadians; projections of the aboriginal population in Canada; aboriginal statistics at a glance). In my own community, Métis Albertans are twice as likely as non-Métis people to engage in self-harm.

The current system, with its continued paternalism and prioritization of narrow biomedical approaches to mental wellbeing, is failing Indigenous Peoples in Canada. It has failed us from the beginning, and it is failing us now. We need a reset—one marked by truly equitable investments in self-determined, strength-based life promotion strategies.

Life promotion, which can be as simple as bringing people together around a fiddle, addresses mental wellbeing by strengthening our connections to life and to each other. Rather than focusing on individual problems, life promotion brings the strengths of the community to the fore, often in the face of oppressive policies and conditions (Wise Practices). It fosters connections to community, culture, and identity by developing experiences, relational resources, and social conditions that re-engage people with the joy of life, offering a powerful sense of vibrant belonging, meaning, and hope (Of the Heart).

A key principle of life promotion is that programming is driven by the community. I am reminded of my community's wisdom. For decades, Métis people have said that fostering a sense of pride in Métis identity, leveraging our culture as a source of strength, celebrating our diversity, and connecting people to community are sources of healing for us. These things will save more Métis lives than any hotline that the federal government is willing to provide.

Canadian governments and society have been slow to recognize the healing power of an intergenerational community gathering, of cultural teachings, or of a dedicated beading circle. Although recognition of life promotion has increased over the past five years, funding remains unpredictable and deeply inequitable. Indigenous communities are relegated to petitioning racist systems for short-sighted grants to fund one-off life promotion activities with no hope for stable investment or the tracking of long-term outcomes. Yet our people know that these gatherings and cultural activities have kept self-harm from our communities since time immemorial.

As we reflect on Sept. 30, a National Day of Reconciliation, I offer these thoughts: until Canada is willing to match existing investments in the current and Indigenous health systems with equitable investments in community-based life promotion, the gap in life expectancy for Métis and other Indigenous people will continue to widen. Come to the table and sit with us, Canada. We'll bring the fiddle.

Reagan Bartel (MPH, BScN, RN) (she/her) is a proud Métis-settler woman with more than 16 years of critical care nursing experience delivering front line care in amiskwacîwâskahikan (ᐊᒥᐢᑲᐧᒋᐧᐋᔅᑲᐦᑭᐣ), commonly known as Edmonton, before moving into population health as the director of health for the Métis Nation of Alberta (MNA). In her role, Bartel focuses on ensuring that Métis stories, experiences, and perceptions gifted to the MNA are incorporated into health advocacy, policy, programs, and services. She values leadership, culture, community, growth and transparency in her life and work.

The Hill Times

Access to mental health care must remain a priority for all governments

When it comes to supporting the mental and substance use health of Canadians, failure is not an option.

Ellen Cohen, Florence Budden & Glenn Brimacombe

Opinion

With the crescendo of the 2023 10-year health agreement coming and going, the heavy lifting still remains for all governments to improve and expand timely access to accessible and inclusive mental health care and substance use health-care services in Canada.

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) found that 47 per cent of those accessing care over the past 12 months gave their provincial government a rating of "F" in this year's Mental Health Report Card. When it comes to supporting the mental and substance use health of Canadians, failure is not an option.

Notwithstanding the Trudeau government's failure to deliver a Canada Mental Health Transfer valued at $4.5-billion over the next five years, there is plenty of work for both levels of government to pick up their game when it comes to ensuring the people of Canada have access to mental health and substance use health care when in need.

The federal government can do more in three areas. First, it can pass a Mental Health and Substance Use Health Care For All Parity Act that enshrines in legislation timely access to mental health and substance use health programs, services and supports that are equally valued to those for physical health. The act would include a clear set of objectives and accountabilities (e.g., guiding principles, performance indicators, national standards) that need to be adhered to by the provinces and territories in order to receive ongoing federal funding.

Second, meeting the act's objectives will require sustained investment from the federal government, along with additional financial support from the provinces and territories to ensure the people of Canada have timely access to the mental health and substance use health care they need, when they need it. Recent publicly available data suggests that Canada's public mental health investments account for five per cent of its health budgets, which falls significantly below the recommendation of 12 per cent by the Royal Society of Canada. There is plenty of room to do more.

Third, all governments need to work towards developing a clear set of pan-Canadian mental health and substance use health system metrics. As it stands, the work undertaken by the Canadian Institute for Health Information is not adequate, nor does it provide the people of Canada with a clear sense of how their provincial or territorial health system is performing in this sector. Much more needs to be done to develop: a national, community-based, and private health expenditure data series; comprehensive health system performance indicators; and a comprehensive and ongoing mental health and substance use health workforce sector analyses to identify gaps and project future needs.

As stewards of their own health systems, the provinces and territories must do more to improve and expand timely access to accessible and inclusive mental health and substance use health-care programs, services, and supports. While some important and innovative steps are being taken in a number of jurisdictions, CAMIMH strongly encourages all jurisdictions to expand access to publicly-funded integrated and coordinated team-based delivery models of care.

As part of the federal government's 10-year funding agreement with the provinces and territories, CAMIMH was pleased to see $25-billion earmarked to four priorities, of which one is mental health and substance use health. However, it remains unclear how the provinces and territories will invest these funds given that the bi-lateral agreements have not yet been made public. We look forward to reviewing each agreement.

If the past is a predictor of future performance, previous federal funding agreements have come and gone without significant transformation of our health care system. Now is not a time for governments to pat themselves on the back and move on to other priorities. Rather, it is a time for us all to roll up our sleeves and commit to working together to give the people of Canada what they need when it comes to timely access to care to mental health and substance use health care services. They deserve no less.

Given the composition of CAMIMH—which includes organizations representing people with lived and living experience, their families and caregivers, and health care providers—we stand ready to work with all levels of governments, employers, and others to make this a reality.

Our entire health matters...and health includes mental health and substance use health.

Ellen Cohen is co-chair of CAMIMH and CEO of the National Network for Mental Health, which advocates, educates and offers expertise and resources to increase the health and well-being of Canadians with lived and living experience. Florence Budden is co-chair of CAMIMH and represents the Canadian Federation of Mental Health Nurses. Glenn Brimacombe is CAMIMH chair, Public Affairs Committee, and director of policy and public affairs at the Canadian Psychological Association.

The Hill Times

Canadians struggling with higher costs for mental health services

Canada's mental health system is fragmented, with the burden of responsibility falling on the individual to find appropriate care.

Lindsey Thomson

Opinion

Inflation is not just about the economy—it is a driver of Canada's mental health crisis. The root of this issue is the long-standing unaffordability of mental health care in Canada.

The unaffordability issue stems from the lack of true inclusion of mental health as a part of our health system. While 'universal' is a term often used to describe our health-care system, this is not the case. If it were universal, the federal government would allocate funds for mental health through the promised mental health transfer to provinces and territories. This would mean fewer Canadians needing to choose between groceries or mental health treatment.

Our mental health system is fragmented, with the burden of responsibility falling on the individual to find appropriate care. While programs like Ontario's structured psychotherapy program offer free mental health services, these services are rare due to budget ceilings and competing government funding priorities. Programs that do exist are limited due to program exclusion criteria, therapist shortages, scarce program locations, and insufficient funding.

Other mental health services, such as community centres, employee assistance programs, and private practices, also have limitations.

The need for mental-health treatment for everyone in Canada outpaces the service that can be offered through community-based services, leading to extensive wait times of upwards of months, depending on the location. Employee assistance programs are time-limited and often don't offer enough treatment sessions to see lasting positive outcomes in those who use the service. Private practices may have shorter wait times depending on location, but this can lead to Canadians making difficult decisions on their financial priorities and what they can afford to pay. Demand for community services outpaces supply, which causes long wait times, employee programs are often too brief, and private practice costs strain individual's finances.

September 2023 polling results from Mental Health Research Canada show that inflation and increasing living costs significantly and negatively impact Canadians' mental health. It revealed that those with lower incomes or who experience financial stress are more likely to have high anxiety and depression. Thirty-nine per cent of respondents feel the economic downturn is impacting their mental health, 24 per cent have gone into debt because of inflation.

Disturbingly, 29 per cent of Canadians now cite affordability as a reason not to access mental health services, up from 18 per cent in previous polls from MHRC. Thirty per cent of Canadians now pay out of pocket for mental health services due to insufficient benefits coverage, up from 23 per cent. The data is clear: as Canadians increasingly struggle with higher costs for their essentials, mental health services become more unaffordable.

So, what can be done to address the issue? Long-term strategies are, of course, vital to addressing this issue. But we need immediate solutions. One simple and cost-effective solution for the federal government to do this is by implementing tax-free therapy for counselling therapists and psychotherapists.

Based on my clinical experience using manualized treatment protocols for cognitive behaviour therapy, an adult seeking treatment for depression will require a minimum of 16 treatment sessions. Most individuals will need multiple rounds of treatment throughout their lives to integrate the knowledge and skills taught in therapy. Individuals could access additional treatment sessions by removing the requirement to pay tax on therapy. Being able to afford extra sessions can be life-changing and lifesaving.

The Canadian Counselling and Psychotherapy Association has been championing tax-free therapy for counselling and psychotherapy services since 2015. In January 2023, over 14,000 Canadians signed a petition for tax-free therapy. Bill C-323, a House of Commons bill initiated to remove tax from counselling and psychotherapy services, had its second reading in the House of Commons on Sept. 25, 2023. The bill received multi-party support for it to be sent to the House Standing Committee on Finance.

Now, more than ever, Canadians need quick and innovative solutions to reduce the financial burden felt by inflation, ensuring accessible and affordable mental health services. Removing GST/HST from counselling and psychotherapy services is a solution. To learn more, visit taxfreetherapy.ca.

Lindsey Thomson is the director of public affairs for the Canadian Counselling and Psychotherapy Association (CCPA). She has been a member of the CCPA for the past decade and is also a registered psychotherapist.

The Hill Times

Investing in student mental health: a critical imperative for Canada's future

The pandemic put new and unprecedented pressures on Canada's health systems, including mental health care. In response, universities have been rethinking how to provide adequate mental health support for an entire generation of students.

Benoit-Antoine Bacon

Opinion

The COVID-19 pandemic has revealed a second pandemic: the wide-spread mental health and substance use issues that so many people are facing around the world. Among those most profoundly affected are post-secondary students who not only have to navigate a challenging transition into adulthood, but also the emotional toll of doing so through socially and economically challenging times. Now more than ever before, it is imperative that we prioritize mental health and wellness, especially among the younger population.

In 2021, the Canadian government made the visionary commitment of introducing a $500-million fund for student mental health services at post-secondary institutions. The goal at the time was clear: to improve wait times and increase access to mental health care on campuses nationwide. Two years later, it is high time for the government to fulfill that promise and to provide this critical investment in the future of our country. It is truly regrettable that many students who were directly impacted by the pandemic have now graduated without the benefit of this much needed additional support. The generation of students that follows them, now starting their university journey or preparing their applications for next fall, is showing even higher rates of anxiety, depression and other serious concerns.

The need for this long-awaited $500-million investment is pressing, as evidenced by alarming statistics. A recent report by the Canadian Alliance of Students Associations in partnership with the Mental Health Commission of Canada show that more than one in four students report their mental health as poor. Factors such as poor sleep habits, the cost of living, academic workload, financial responsibilities, and job/career pressures weigh heavily on students' minds. A staggering 74 per cent of students say the pandemic worsened their pre-existing mental health challenges, and 61 per cent claim it created new struggles. Behind those numbers are thousands of young adults who are struggling with their mental health on a daily basis.

The pandemic has put new and unprecedented pressures on our health systems including mental health care. In response, universities have been rethinking how to provide adequate mental health support for an entire generation of students affected by these extraordinary circumstances. Faced with a rising crisis, universities have invested significantly and have been at the forefront of providing innovative mental health services to students. However, with demand for these services growing every year, they need help, and they need it urgently.

Investing in the mental health of young people is not just a matter of moral responsibility; it's also a sound social and economic policy for Canada. Mental health challenges in young adulthood can have long-lasting consequences, as it affects academic performance, employability, relationships and overall well-being. It can lead to damaging substance use and also is known to have adverse effects of physical health. As the government collaborates with provinces to enhance health outcomes through renewed long-term funding, it is paramount to acknowledge that student mental health and wellness are integral and vital components of the overall health of Canadians.

The economic burden of mental illness in Canada is staggering, estimated at $51-billion per year. This cost includes health-care expenses, lost productivity, and reductions in health-related quality of life. By investing in student mental health today, we can pre-emptively alleviate some of this burden in the future. In the same vein, healthy students are also more likely to be successful and to contribute to our society in positive, meaningful, creative and productive ways. Proactively investing in student mental health both reduces long-term societal costs and increases long-term productivity.

It is absolutely imperative that the federal government upholds its commitment of $500-million from 2021 for student mental health services. This is a sound investment in both the mental well-being of an entire generation and the future prosperity of our country. In other words, by prioritizing student mental health now, we are both alleviating the suffering of individuals and fostering a healthier, more resilient, and economically vibrant Canada. The time to invest is now.

Benoit-Antoine Bacon, PhD, is the incoming president and vice-chancellor of the University of British Columbia.

The Hill Times

BIOTECH

Can biotechnology put patients' NEEDS ahead of PROFITS?

p. 21

Biotech sector is having a GENERATIONAL *moment in Canada*

p. 18

TALENT *a priority for* BIOTECH *sector emerging from pandemic*

p. 16

New SAFETY GUIDANCE *sets up corporate self-regulation of GMOs*

p. 18

Seizing the moment: building Canada's ACADEMIC LEADERSHIP *into a commercial powerhouse*

p. 19

CANADA'S PLACE *in the world of biotechnology research and application is in* JEOPARDY

p. 20

Talent shortage a priority for biotech sector emerging from pandemic

Canada is likely to face a shortfall of about 65,000 workers in the bio-economy by 2029, according to BioTalent Canada.

BY JESSE CNOCKAERT

Federal investments are allowing infrastructure to roll out in the biotechnology and life sciences sector, but a shortage of talent remains a critical concern to its long-term success, according to the president and CEO of BioTalent Canada.

"There seems to be a great deal of capital investment going along, and a lot of buzz around the industry, but it still faces a lot of challenges, and probably the one that is the most daunting is the talent," said Rob Henderson. "The fact that we've avoided recession probably makes it even worse, which means that companies are going to be hiring again assuming that the toxic recession has abated."

Canada is likely to face a shortfall of about 65,000 workers in the bio-economy by 2029, according to a report released on Oct. 13, 2021, by BioTalent Canada.

To help build Canada's domestic capabilities in biomanufacturing and life sciences, the Liberal government launched a biomanufacturing and life sciences strategy on July 28, 2021. Recent investments as part of the strategy include $10-million announced on March 14, 2023, in support of the creation of five research hubs across Canada, including the Canadian Biomedical Research Fund (CBRF) PRAIRIE Hub, led by the University of Alberta, and the Canadian Pandemic Preparedness Hub, led by the University of Ottawa and McMaster University. The investment, made through Stage 1 of the integrated CBRF and Biosciences Research Infrastructure Fund competition, is intended to bolster research and talent development efforts led by the institutions, working in collaboration with their partners.

"To continue to protect Canadians and to build a resilient biomanufacturing ecosystem, our government is taking every action possible to be equipped with the best tools. We're proud to foster the research needed to produce cutting-edge discoveries and products in our very own labs that will help us build a stronger, more robust life sciences sector that responds to the needs of Canadians for decades to come," said Innovation Minister François-Philippe Champagne (Saint-Maurice-Champlain, Que.) in a press release by the Tri-agency Institutional Programs Secretariat.

Henderson said the overall state of Canada's bio-economy is vibrant and growing, but federal investments announced since the launch of the biomanufacturing and life sciences strategy so far haven't gone far enough to address the talent shortage.

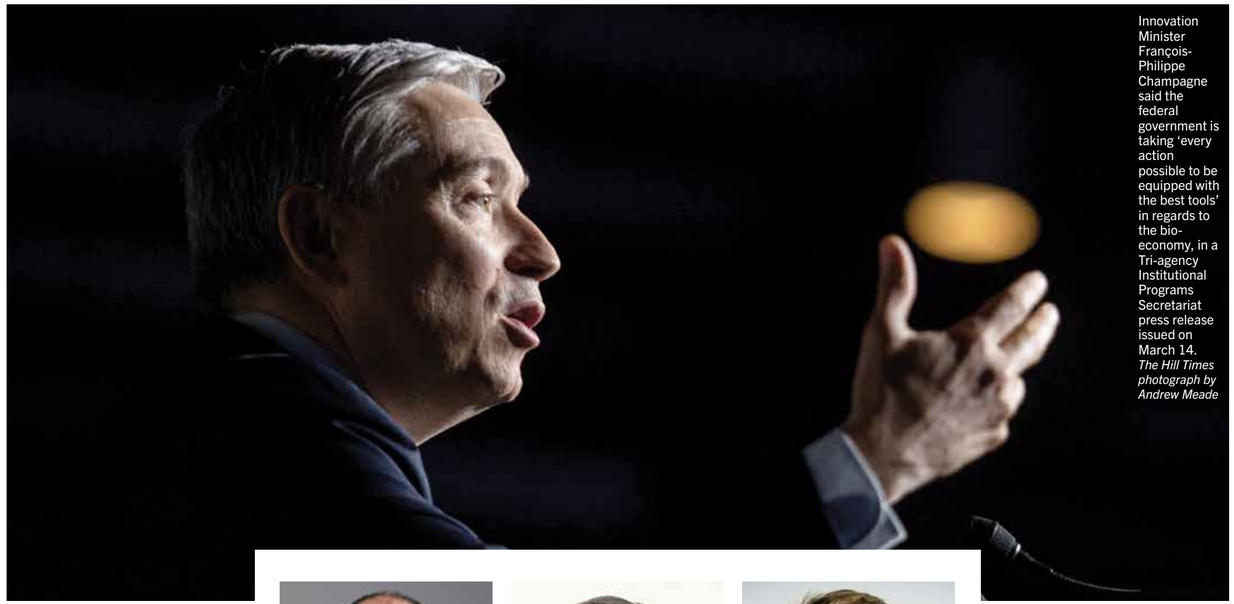
About 16,000 of the workers in BioTalent Canada's estimated talent shortage before the end of the decade will be in the biomanufacturing sector, which is an issue because "vaccines don't manufacture themselves," according to Henderson.

"The federal government, in bringing vaccine biomanufacturing back to Canada, has simply exacerbated that problem," said Henderson. "It's a great announcement, and it's a great initiative, but the problem is we're already starting in a deficit situation."

One important hurdle to company development in the bio-economy is a lack of human resources (HR) capacity to attract and retain candidates, according to Henderson. Small- and medium-sized companies dominate in the bio-economy, and few of them have their own formal HR departments, according to the BioTalent Canada report.

Henderson told *The Hill Times* that, as a result of missing HR personnel, many of these companies have scientists handling HR responsibilities.

"Seventy per cent of the companies don't have any HR resources. It's an area of expertise that they lack, and as a result, it's like getting a plumber to do your taxes. It's just not a good fit," said Henderson. "These people were not trained, nor did they ever want to pursue a career in human resource management, but that's what they have to do as a small business."



Innovation Minister François-Philippe Champagne said the federal government is taking 'every action possible to be equipped with the best tools' in regards to the bio-economy, in a Tri-agency Institutional Programs Secretariat press release issued on March 14. *The Hill Times photograph by Andrew Meade*

Rob Henderson, president and CEO of BioTalent Canada, says bringing vaccine biomanufacturing back to Canada has exacerbated an existing talent shortfall problem. *Photograph courtesy of Rob Henderson*

Declan Hamill, vice-president of policy, regulatory and legal affairs for Innovative Medicines Canada, says the two-year average for an approved new pharmaceutical treatment to be listed on Canada's public drug plans is 'almost twice the amount of time that this process takes in peer [nation] jurisdictions.' *Photograph courtesy of Declan Hamill*

Jordan Thomson, the vice-president of strategic partnerships and programs for Ontario Genomics, says there should be synergy between the federal government's biomanufacturing and life sciences strategy, and the Pan-Canadian Genomics Strategy. *Photograph courtesy of LinkedIn*

To help access more talented workers, one of the most important programs for the federal government to continue is the Innovative Work Integrated Learning initiatives (I-WIL), said Henderson. The I-WIL are intended to help post-secondary students find opportunities, such as short-term work placements, related to their studies.

Canada also needs to encourage more immigration of skilled workers, according to Henderson. The BioTalent Canada report argues that wage subsidies could be effective in drawing skilled immigrants to Canada.

"As much as we have a great deal of an influx of new immigrants, we have to get some skilled immigrants, specifically in the areas of life sciences and bio manufacturing, and fast-track their entry into Canada. That's for sure," said Henderson. "It's very difficult to drive a car 300 miles without gas. The unfortunate thing there is the gas in the car is the talent."

Declan Hamill, vice-president of policy, regulatory and legal affairs for Innovative Medicines Canada, told *The Hill Times* that Canada's bio manufacturing and life sciences strategy is a step in the right direction, but more work needs to be done because a healthy life sciences sector is a marathon and not a sprint.

A challenge for Canada's life sciences sector is a prolonged drug access pathway, according to Hamill. He described the approval process of new medicines in Canada as "highly fragmented," with involvement from Health Canada, the Patented Medicine Prices Review Board, the Canadian Agency for Drugs And Technologies In Health, the pan-Canadian Pharmaceutical Alliance, as well as provincial public drug plan components.

"It takes, on average, two years for an approved new pharmaceutical treatment to be listed on Canada's public drug plans. That's almost twice the amount of time that this process takes in peer [nation] jurisdictions. That's something that is noted internationally," said Hamill. "We think that a reasonable, predictable, stable system whereby treatments can get to patients faster and in greater numbers would help from a life sciences ecosystem perspective."

A successful bio manufacturing and life sciences strategy requires an attractive market for life science investments and innovation, and that requires innovations to become available to Canadians more quickly, according to Hamill.

"This really needs to be pan-Canadian approach," said Hamill. "There needs to be greater coordination …with those other provincial life sciences strategies. It doesn't have to be one strategy, but we need to understand that the world perceives us as an entity, and therefore we need to act accordingly when we're making improvements to our domestic drug access environment."

Health Canada is currently updating its drug regulations through a proposed "Agile Licensing" framework, which could expedite pre-market regulation of pharmaceuticals.

Then-health minister Jean-Yves Duclos (Québec, Que.) said "a more agile regulatory world" is an example of how the federal government is supporting pharmaceutical innovation, when addressing the House Health Committee on April 27.

"During COVID-19, we were able to streamline the regulations for drug approvals and clinical trials. We've been able to work with companies that are now investing strongly in Canada to invest even more in research and development. That is absolutely essential to reduce the cost and increase the availability of drugs," Duclos told the committee. "We need the two. We need drugs to be affordable, but we also need drugs to be developed and accessible to those who need them."

Consultation for the Agile Licensing framework were held from Dec. 17, 2022, to April 26, 2023.

Hamill said that the finalization of the agile licensing framework will probably be a positive development, but "we'll have to wait and see what happens."

In terms of addressing talent in the biomanufacturing and life sciences sectors, Hamill said significant efforts have been undertaken, but more can be done.

"It's both important to attract talent from other jurisdictions, but also to cultivate talent here through our colleges, through our universities," he said. "Attracting and retaining talent, both in terms of research, but also managerial talent, is very important, and it's something that Canada has had great success in many other areas — of attracting talent from other jurisdictions."

Murray McCutcheon, the senior vice-president of partnering for biotechnology firm AbCellera, told *The Hill Times* Canada has a gap between research and clinical testing.

"[Canada is] recognized as being innovative and productive from a research standpoint," said McCutcheon. "Where we have recognized gaps is our ability to advance the products of that research and bring them through preclinical development and into a clinical setting where they can be tested in patients."

On May 24, Champagne and David Eby, Premier of British Columbia, jointly announced funding of $300-million to AbCellera. The federal and provincial funding contributes to a $701-million project by AbCellera to create a new biotech campus equipped with a preclinical antibody development facility, as well as to make upgrades to the company's existing facilities in Vancouver, B.C.

McCutcheon said that Canadians should understand that the life sciences is a high growth sector, but requires continuous investment because of the length of time involved in building infrastructure and developing medicines.

"It takes typically more than 10 years to move from an idea to a medicine that has been shown to be safe and effective, and authorized for treating patients," he said. "These are decades-long problems that we're working on. They're complex, and they require a long view to building the base of the foundation to be successful at that."

AbCellera has grown from a company of about 200 employees to more than 600 in the last two years, according to McCutcheon.

"We're building a major tech campus and manufacturing facility in Vancouver, which collectively is about 600,000 square feet of space, [which are] really sorely needed facilities," he said. "This is I think, exemplary of the kind of investments that the we need to be doing as a nation, and I think it's proof-point of the bio manufacturing strategy of the federal government."

Another federal government approach intended to support the bio-economy is the Pan-Canadian Genomics Strategy (PCGS). The 2021 federal budget announced an investment of $400-million for the design and implementation of the PCGS, which is intended to advance the translation and commercialization of genomics and related technologies, and strengthen Canada's position in the global bio-economy.

Jordan Thomson, the vice-president of strategic partnerships and programs for Ontario Genomics, told *The Hill Times* that success in the bio-economy will require synergy between the PCGS and the biomanufacturing and life sciences strategy.

"In the Canadian genomics strategy, they talked about bio manufacturing [and] synthetic biology, which is really core technology that allows these vaccines and other products to be made," he said. "Trying to ensure that there's connectivity between those and a recognition of how the two can feed into each other, I think that's going to be a trickier thing for our government to do — and just make sure that these kinds of synergistic investments do actually yield the most synergy possible."

Thomson argued that the federal government shouldn't forget about supporting the smaller biotechnology and life sciences companies in Canada while showing support for the larger firms.

"Making sure that we support those homegrown small firms and not just … attracting these international companies, which seems to be a really big focus for [the federal government], I think that's important. I think we can't forget about nurturing those smaller Canadian companies to grow into larger players. We need them in the next pandemic, or whatever challenge we face," said Thomson.

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The Hill Times

Image courtesy of Pixabay

Image courtesy of Pixabay

Canada Pharmaceutical Research and Development Statistics:

- In 2020, the research and development (R&D) pharmaceutical sector contributed $15.9-billion to the Canadian economy in gross value added (GVA), an increase of 5.8 per cent from the $15-billion generated in 2019. Just under half of this ($7.9-billion) was attributable to the direct impacts of the sector, which rose 4.5 per cent from the $7.6-billion generated in 2019. Indirect impacts accounted for 28.3 per cent of the total GVA in 2020 and increased 6.1 per cent to $4.5-billion, while induced impacts advanced 8.7 per cent to $3.5-billion.
- Nearly $13.9-billion (87.4 per cent) of the total GVA that the sector contributed to the Canadian economy was generated in Ontario ($8.7-billion) and Quebec ($5.2-billion). Likewise, 88 per cent of all labour income was related to these provinces, with close to $5-billion coming from Ontario and $3.1-billion from Quebec.
- R&D pharmaceutical businesses in Canada generated $31.3-billion in operating revenues in 2020, up 3.9 per cent ($1.2-billion) from the year before. Operating expenses also rose, increasing by three per cent to $30.6-billion with the sector paying $190-million (4.1 per cent) more in wages, salaries and benefits, and $953-million (four per cent) more in raw materials and services.
- An additional 5,378 jobs were created by the Canadian R&D pharmaceutical sector in 2020, increasing overall employment to 107,973 full-time equivalent jobs, up 5.2 per cent from the previous year.
- The R&D pharmaceutical sector is comprised largely of three core industries: pharmaceutical and medicine manufacturers; pharmaceuticals and pharmacy supplies merchant wholesalers; and R&D performers in the physical, engineering and life sciences.

Source: The Canadian Research and Development Pharmaceutical Sector, 2020, Released on Jan. 30, 2023, by Statistics Canada

Canada Biomanufacturing and Life Sciences Strategy:

- The 2021 federal budget included $2.2-billion toward implementing a comprehensive strategy to build a strong domestic biomanufacturing and life sciences sector in Canada. The strategy consists of five pillars: Strong and coordinated governance; Laying a solid foundation by strengthening research systems and the talent pipeline; Growing businesses by doubling down on existing and emerging areas of strength; Building public capacity; and Enabling innovation by ensuring world-class regulation.
- To advance the Strategy, the 2021 federal budget announced investments in bio-innovation research, including $500-million over four years for the Canada Foundation for Innovation for a new Bio-Science Research Infrastructure Fund to support the bio-science infrastructure needs of post-secondary institutions and research hospitals; and $250 million over four years for the federal research granting councils to create a Tri-Agency Biomedical Research Fund.
- The 2021 budget also included $1-billion on a cash basis over seven years of support through the Strategic Innovation Fund, which will be targeted toward promising domestic life sciences and biomanufacturing firms.
- On March 2, 2023, the Liberal government announced an investment of $10-million in support of the creation of five research hubs: CBRF PRAIRIE Hub, led by the University of Alberta; Canada's Immuno-Engineering and Biomanufacturing Hub, led by the University of British Columbia; Eastern Canada Pandemic Preparedness Hub, led by the Université de Montréal; Canadian Pandemic Preparedness Hub, led by the University of Ottawa and McMaster University; and Canadian Hub for Health Intelligence & Innovation in Infectious Diseases, led by the University of Toronto.
- The investment in the five research hubs, made through Stage 1 of the integrated Canada Biomedical Research Fund and Biosciences Research Infrastructure Fund competition, is intended bolster research and talent development efforts led by the institutions, working in collaboration with their partners.

Source: Canada's Biomanufacturing and Life Sciences Strategy, released on June 28, 2021, and a March 2 press release from Tri-agency Institutional Programs Secretariat

Biotech sector is having a generational moment in Canada

It is not possible to predict what or when the next global health challenge will be, or what solutions will be needed.

Andrew Casey

Opinion

Finance Minister Chrystia Freeland, left, and Innovation Minister François-Philippe Champagne, pictured July 26, 2023, at Rideau Hall. Canada has the foundational elements for the next phase of a competitive biotechnology economy, writes Andrew Casey. *The Hill Times photograph by Andrew Meade*

The pandemic's economic, social, and health impact has effectively focused the attention of policy-makers and the public on the strategic importance of building a competitive domestic life-sciences industry and biomanufacturing capacity. Nearly four years after the onset of the pandemic, all governments, including those in Canada, are prudently preparing for another pandemic or some other global health emergency.

It is not possible to predict what or when the next global health challenge will be. Correspondingly, it is impossible to know what solutions will be needed. In this context, when considering how to prepare for the next inevitable health crisis, the more strategic approach for Canada is to build its life sciences and biomanufacturing sector broadly so it can offer many potential solutions while also acting as an innovator and economic driver during non-crisis periods. Both objectives can be met by focusing on creating a competitive environment which generates ideas and attracts the investors, partners, and talent required to turn ideas into businesses, and scale them to become Canadian anchor companies.

With the 2021 federal budget, the government began investing significantly to grow Canada's life-sciences sector and biomanufacturing capacity. The commitments and corresponding life sciences and biomanufacturing strategies have accelerated the growth of our biotech sector beyond just a crisis response. Accordingly, now is the time for the federal government to capitalize on the sector's momentum. In so doing, they will deliver on the preparedness objective and, if done strategically, will drive the sector's growth.

Importantly, Canada is building its capacity from a position of strength. Our country has a vibrant ecosystem founded on a global reputation for excellent scientific research. As a result, Canada is home to an ecosystem which includes hundreds of early-stage biotech companies, and a strong global pharma presence. The sector's strategic competencies include regenerative medicine, artificial intelligence in the field of drug discovery and development, vaccines, clinical trial expertise, and genomics. The more than $4-billion in investments and partnerships Canadian biotech firms have signed with global pharma companies and other investors over the past few months alone demonstrate the sector's value as a generator of scientific discovery and business creation.

Looking ahead, Canada must acknowledge it is not alone in recognizing the value of a domestic life sciences sector. Indeed, other nations are equally aware of the sector's strategic value, making the global competition for biotech ideas, companies, talent, and investment more intense than ever before. In this context, it is imperative for us to act urgently, aggressively, and ambitiously to enhance our competitive position by establishing: a globally competitive tax and policy environment that drives the creation and scaling up of biotech companies; a modern and agile regulatory system for domestic innovation and the attraction of global biotech and pharma partnership and investment; and a dedicated life sciences investment fund to grow our domestic life sciences investment pool.

Canada has the foundational elements for the next phase of a competitive biotechnology economy. The generational moment before us presents a significant opportunity for us. Creating an enabling policy environment and setting the stage for anchor company growth will position our biotech ecosystem as a global leader in generating the solutions for the challenges already before us, and the ones which lie ahead.

Andrew Casey is president and CEO of BIOTECanada, the national industry association representing biotechnology companies in Canada. For more than 25 years, Casey has provided government relations and communications advice to various trade associations.

The Hill Times

New safety guidance sets up corporate self-regulation of GMOs

Health Canada and the Canadian Food Inspection Agency both recently updated their guidance on regulating genetically engineered foods and seeds.

Lucy Sharratt

Opinion

The emergence of new genetic engineering techniques for food and farming renewed the deregulation ambitions of the biotechnology industry. The federal government has responded quickly with a hands-off approach. However, the use of new genomic technologies in our food system, such as gene editing, demands strong regulatory oversight.

Health Canada and the Canadian Food Inspection Agency both recently updated their guidance on regulating genetically engineered foods and seeds. These updates are significant policy decisions about the future of genetic engineering and consumer choice that will change how many Canadians view the food system and federal regulation, and may impact food and environmental safety.

The regulatory guidance results in corporate self-regulation of most future genetically engineered foods and seeds (genetically modified organisms or GMOs). Health Canada has described this conclusion as mistaken, but this is precisely the outcome, and it is both dangerous and anti-democratic. More than 100 environmental, farmer, and social justice organizations jointly wrote to the ministers of health and agriculture to demand that all genetically engineered foods and seeds be subject to government safety assessments and mandatory reporting to government.

Rather than strengthen oversight and ensure transparency, the government is deferring to industry and unseen industry-generated science. Faced with the advent of the new genetic engineering techniques of gene editing, government departments have chosen to further narrow regulatory triggers in order to exempt many gene-edited products from pre-market regulation. The sound option is to expand the triggers to capture all new products of genetic engineering.

The updated regulatory guidance could have ensured that all GMOs, including those produced with gene editing, are assessed for safety. At the very least, "novelty" could have been defined such that departments secured the option to review them. Establishing this regulatory authority would have allowed the government flexibility into the future, to regulate as the technology changes and the science evolves. Instead, the guidance confirms the ability of many (or most) new GMOs to make it to market without any government oversight or public knowledge. This includes products of future—as yet undeveloped—genomic technologies. There is no government tracking of "non-novel" GMOs, and no ability to reliably track them.

Until now, all of the GMOs we eat have been reviewed for safety by government regulators, but this is about to change. Now, how should we refer to "non-novel" GMOs that do not trigger the pre-market regulations? Is it accurate to refer to these GMOs as "unapproved" or "unregulated" GMOs?

Like all foods that we eat, there are regulations that will still govern GMOs generally. For example, companies are required to report any food safety issues that may arise. However, unless a non-novel GMO is linked to an observable or reported problem once on the market, it may never be seen by any department or made known to the public.

Health Canada has disputed our description of its approach as corporate self-regulation because the guidance defines five categories of product characteristics that would trigger regulation. Critically, however, Health Canada will not be assessing whether products meet any of these categories. That determination is left to product developers, and Health Canada will be dependent on them to adequately investigate these questions and to truthfully report any negative results.

Pre-market government assessments of gene edited products will be rare. Most safety assessments will be conducted by product developers without independent government review. There will be no government access to these private safety assessments and there may be no relevant published science. How is this not corporate self-regulation?

There is no mandatory labelling of GM foods in Canada, and the updated guidance does not establish mandatory reporting of non-novel "unregulated" GMOs. Canadians may soon be eating some unknown GMOs that regulators have not assessed for safety. The federal government has concluded that this does not matter. We think it does. A majority of Canadians, according to public opinion polling, agree with us.

Creating a supportive environment for innovation does not require the surrender of government authority. This approach shows either a lack of imagination and foresight, or a lack of commitment to safety and transparency.

Lucy Sharratt is co-ordinator of the Canadian Biotechnology Action Network (CBAN), a network of 15 organizations including farmer associations, environmental and social justice organizations, and regional coalitions of grassroots groups. CBAN is a project of the MakeWay Charitable Society. www.cban.ca

The Hill Times

Canada is ranked ninth by the World Intellectual Property Organization, however this success has not translated into growth in domestic commercialization, writes Gordon McCauley, president and CEO of adMare BioInnovations. *Image courtesy of Pixabay*

Seizing the moment: building Canada's academic leadership into a commercial powerhouse

Too much high-quality research is failing to make it out of laboratories to the benefit of patients and the Canadian economy.

Gordon McCauley

Opinion

For years, Canada's life sciences research community has punched above its weight on a global scale. Over the last few years, tremendous progress has been made to convert that research into innovative companies serving Canadians and the world. We cannot stop now. We are living in a generational moment where the opportunity exists, if we act swiftly, to finally build a sustainable industry commensurate with our research leadership.

Life science companies not only generate innovative treatments to improve the health of the population and resolve major public health challenges, but they are also key contributors to the economy, generating high-quality jobs and attracting worldwide investments and talent.

Our country is ranked ninth by the World Intellectual Property Organization, which grades nations based on markers such as research and development, venture capital, and high-tech production. Unfortunately, this success has not translated into growth in the domestic commercialization. On other indicators, such as infrastructure and business sophistication, Canada falls behind, leaving us 17th overall in the global innovation index rankings.

Canada's knowledge infrastructure is strong. Within the ecosystem of our universities, teaching hospitals, research institutes, and private sector life sciences industry, our researchers are producing original research at a high rate. We are ranked in the top 10 countries for overall research output worldwide, we produce 3.8 per cent of global research publications, and we are over-represented in the top one per cent of publications across all specialties.

To reach patients, however, that research needs to move from bench through clinical trials to commercialization. And that is not happening with nearly enough frequency as it should.

To create a new biotech company, the first step is to identify the research with the highest potential of commercialization, and then support and nurture the research journey to venture creation. While researchers are experts in the science, they need to be supported with drug development expertise, business strategies, capital, and infrastructure. An extensive ecosystem and network are needed to develop a scientific discovery into a successful company.

Unfortunately, the success rate in drug development—the so-called "valley of death" from research to commercialization—is extremely low: among the 9,700 development programs active from 2011-2020, the overall likelihood of approval for a drug candidate entering Phase I clinical trials was only 7.9 per cent.

It's common knowledge that numerous companies must be launched before one drug can successfully treat patients. Encouraging a more active entrepreneurial spirit in Canadian universities is key to improving our performance—we must inspire the researchers to embark on the entrepreneurial journey and facilitate their onboarding.

The pandemic demonstrated the urgent need for a strong and well-aligned domestic life sciences industry—especially for the security of domestic medication supply, and for continued innovation to drive economic recovery.

Governments have taken decisive actions in response to the pandemic. For example, the 2021 Biomanufacturing and Life Sciences Strategy allocated $2.2-billion over seven years for life sciences. This is a significant step for the industry, but we can't stop there; we must continue to ramp up our collective efforts and investments.

As it stands today, too much high-quality research is failing to make it out of laboratories to the benefit of patients, the Canadian economy, and our leadership role. It doesn't need to be that way.

Instead, by leveraging the good work and investments made, and working together to build a national ecosystem of ideas, talent, and companies, we will increase the opportunity and the outcomes from this important industry and its contribution to the Canadian biotech economy.

Gordon McCauley is president and chief executive office of adMare BioInnovations, a position he assumed in 2016 after serving on adMare's Board for four years. McCauley earned a BA in political science from McMaster University, an MBA (with honours) from IMD in Lausanne, Switzerland, and holds the ICD.D certification from the Institute of Corporate Directors and the Rotman School of Business at the University of Toronto.

The Hill Times

The values of Canada graduate scholarship masters and postgraduate scholarship doctoral have not changed since 2003, and Canada's postdoctoral fellowships stipend has not changed since 2015, writes NDP MP Richard Cannings. *Photograph courtesy of Pixabay*

Canada's place in the world of biotechnology research and application is in jeopardy

Government of Canada-funded scholarships and fellowships are the primary sources of income for many biotechnology researchers. To stem the brain-drain, Canada must significantly increase the value and number of graduate student scholarships and post-doctoral fellowships and to index them to the cost of living.

NDP MP Richard Cannings

Opinion

Humans have been using biotechnology for millennia—the making of cheese, wine, and beer are only a few examples—but recent developments point to a dramatic increase in its applications.

One indication of that change is in the speed and cost of DNA sequencing. The Human Genome Project was an endeavour by 20 research institutes in six countries that began in 1990 and reached its goal—to discover the chemical sequence of the entire human genome—after spending US$3-billion over 13 years. Less than 20 years later, the average cost to sequence a genome was US$525 with results in days if not hours, according to the U.S.-based National Human Genome Research Institute.

Worldwide, the pace of biotechnology research and application is expected to continue this acceleration over the next 20 years. The U.S. director of national intelligence in 2021 found "a more multidisciplinary and data-intensive approach to life sciences will shift our understanding of and ability to manipulate living matter. Scientists are increasingly treating genetic instructions as a form of computational code and incorporating insights and new tools from the rapidly advancing realm of computational science. These disciplines, combined with cognitive science, nanotechnology, physics, and others, are propelling new leaps in our understanding."

Canada has always played an outsized role in biotechnology. In addition to the well-known invention of insulin, Canadians developed the first Ebola vaccine, and discovered the genes that cause ALS and cystic fibrosis. We pioneered in the field of regenerative medicine through the discovery of stem cells, while work by UBC's Dr. Pieter Cullis developed the lipid nanoparticle technology that is a key component of the m-RNA Pfizer-BioNTech COVID-19 vaccine.

However, Canada's place in the world of biotechnology research and application is in jeopardy. The danger does not come from lack of support for research infrastructure such as the new Canada Immuno-Engineering and Biomanufacturing Hub announced for my home province of British Columbia. The danger comes from the fact we have forgotten to support the people who do the research.

The vast majority of actual work done in scientific research is carried out by students working on their master's or doctorate degrees, or is done by post-doctoral fellows. Government of Canada-funded scholarships and fellowships are primary sources of income for many of these researchers.

Shockingly, the values of Canada graduate scholarship masters (C$17,500) and post-graduate scholarship doctoral (C$21,000) have not changed since 2003. Canada's post-doctoral fellowships stipend (C$45,000) has not changed since 2015. As both the cost of living and tuition have steadily increased since then, these levels no longer provide adequate support for graduate students. These government-funded scholarships amount to less than minimum wage, forcing some of the brightest minds in Canada into poverty or to seek better funded positions abroad. The economic hardship is even greater than it might first appear since students must also pay for their university tuition fees with these awards, and those graduate program tuition fees average C$7,472 each year.

These low rates are especially problematic for scientists who have families, which may contribute to the fact that women make up only 37 per cent of post-doctoral fellowship applicants, but comprise 59 per cent of master's scholarship applicants. Moreover, these funds come with essentially no social benefits or unemployment insurance.

However, other nations are willing to provide much more financial assistance to their scientists. For example, the American National Science Foundation graduate scholarship is worth US$37,000, plus US$12,000 for research expenses. It's no wonder many students leave Canada to continue their studies.

University of Ottawa PhD student Sarah Laframboise put this clearly to the House Standing Committee on Science and Research: "This means that every day we are losing our highly trained scientists to the United States and Europe where they don't have to live in poverty and will make two to three times more money than they would here in Canada. This means that our businesses are losing highly skilled workers. This means that every day, we are failing Canadian innovation by defining who can take on the financial challenges of higher education and excluding those who can't. This is a lost potential on a personal level and a national level."

To stem this brain-drain, Canada must significantly increase the value and number of graduate student scholarships and post-doctoral fellowships and to index them to the cost of living. Unless we give young researchers reasonable funding so that they can live above the poverty line, we will lose them and their innovative ideas. Ideas that will be the basis of the Canadian economy for decades to come.

NDP MP Richard Cannings represents the riding of South Okanagan-West Kootenay, B.C. He is his party's deputy critic for innovation, science and industry.

The Hill Times

Can biotechnology put patients' needs ahead of profits?

Prime Minister Justin Trudeau, pictured outside Rideau Hall on July 26, 2023, after shuffling his cabinet. 'Let's hope the cabinet shuffle breathes ethical reflection into the government's pursuit of excellence in the biotechnology sphere,' writes Sharon Batt. *The Hill Times photograph by Andrew Meade*

These are challenging dilemmas for a government that gutted a suite of policies designed to cap excessive drug prices, and that 'waxed lyrical' about the importance of accelerating vaccine access worldwide, then failed to support an intellectual property waiver that would expand global production of COVID-19 vaccines.

Sharon Batt

Opinion

When Canada launched a biotechnology strategy in 1998, feminist scholar Nandita Sharma opposed it. The strategy was focused on economic benefits, she said. It didn't address the objections of women and scientists to biotech corporations profiting from the commons by patenting seeds and life forms like the human genome.

Sharma's arguments still resonate. The federal government's Biomanufacturing and Life Sciences Strategy, introduced in 2021, promises a future in which Canadian innovation "leads in preventing, treating and curing all kinds of illness and disease," while also touting the sector's creation of high-paying jobs and economic growth, as if equitable access to health products flow naturally within capitalist structures.

Consider insulin, which the 2021 strategy document cites as evidence of Canada's "long and impressive history of achievement in health and life sciences innovation." Health researcher Colleen Fuller has documented the history of insulin and the biotech industry, and considers the 1921 discovery at Toronto's Connaught Laboratories an argument *against* modern biotech. Co-discoverers Frederick Banting, Charles Best and James Collip wanted to ensure "the best insulin is supplied at the lowest possible cost" to countries around the world, and reluctantly patented their discovery to prevent others from doing so.

> "Economist Marian Mazzucato calls on governments to improve transparency about R&D costs, and to recognize the considerable investment in virtually all drugs brought to market today.

Fifty years later, three American research teams competed fiercely to clone the human insulin gene sequence. The California start-up Genentech won the race, filed a patent on the process the next day, and signed an exclusive licensing agreement with pharmaceutical giant Eli Lilly. A campaign followed to use patents, aggressive marketing, and misinformation to shift patients first from animal insulin to the genetic imitation then to long-acting insulin analogues. Today. three global corporations control the multi-billion-dollar market, and insulin is unaffordable to many.

As a professor at the University of Toronto, Geoffrey Hinton pioneered the mathematical technique behind AI innovations like chatbots. Known as "the Godfather" of artificial intelligence, he deflected questions about his discovery's potential for serious harm until Google and Microsoft began competing in a global race. Last April, he resigned from a job at Google and went public with regrets about his life's work—the knowledge basis for misinformation flooding the internet. Hinton foresees the technology replacing jobs and creating "killer robots."

Chinese scientist He Jiankui shocked the genetic research community in 2019 when he used the gene-editing technology *CRISPR* to create three "edited" babies from embryos. *CRISPR* can both snip out bits of genetic matter known to cause serious diseases and introduce mutations that harm the subject they are meant to benefit. If performed on embryos, these errors can be passed on to future generations. Jiankui, a self-described "research-type entrepreneur," protected his research team's commercial secrets, while exempting the researchers from responsibility for any unexpected mutations. The health status of the three edited girls is shrouded in secrecy.

Editing heritable genes is currently a criminal offence in Canada, and scientists working through the Stem Cell Network argue this blocks the public's right to benefit from scientific discoveries. The federal biotech strategy aims to build strength in both artificial intelligence and gene therapies, citing their "high potential to solve current and future health challenges." The potential of these therapies to create problems goes unmentioned in the strategy, as do their potential price tags.

Canadian bioethicist Françoise Baylis argues for an approach to heritable genome editing she calls "slow science": taking the time to reflect on the big questions; and not just an inner circle, because the human genome belongs to all of us. She discusses *CRISPR*'s hazards, including its unique potential harms to women research participants. She recognizes that slow science is in tension with the political drive to commercialize knowledge, but asks, "at what cost do we keep racing about without knowing or understanding where we are racing to?"

Commerce also drives the patent games that increase profits without improving patient outcomes, a congressional investigation of drug pricing in the United States concluded. Governments "must create the conditions to ensure new drugs remain affordable and easily accessible" says economist Mariana Mazzucato. She calls on governments to improve transparency about R&D costs, and to recognize the considerable public investment in virtually all drugs brought to market today.

These are challenging dilemmas for a government that gutted a suite of policies designed to cap excessive drug prices, and that "waxed lyrical" about the importance of accelerating vaccine access worldwide, then failed to support an intellectual property waiver that would expand global production of COVID-19 vaccines. Let's hope the cabinet shuffle breathes ethical reflection into the government's pursuit of excellence in the biotechnology sphere.

Sharon Batt is an adjunct professor in Dalhousie University's Departments of Bioethics and Political Science, and has an adjunct appointment at Georgetown University in D.C. She is a member of Independent Voices for Safe and Effective Drugs.

The Hill Times

The Hill Times Policy Briefing | April 24, 2023

HEALTH

Health Minister JEAN-YVES DUCLOS *keeps a low profile*

Canada's PHYSICIAN SHORTAGE

Importance of LABELLING ALCOHOL

New HEALTH DEAL *needs transparency*

BURNOUT *among* HEALTH-CARE WORKERS

HEALTH BENEFITS *of community hubs*

NATUROPATHIC *medicine emerging answer to* HEALTH-CARE CONCERNS

Foundation of GENDER EQUALITY

COMPASSION, FATIGUE, *and health-care* PROVIDERS

Accelerating INTEROPERABILITY

Canada DISABILITY BENEFIT *needs to be hefty*

Experts call on Health Minister Duclos to rise to challenge of health-care system transformation

The federal health minister's job has likely never been more complex, given the global pandemic and human resources challenges, but funding alone cannot rebuild Canada's strained health systems and the biggest hurdle is 'breaking down the silos' between different jurisdictions across Canada.

BY JESSE CNOCKAERT

A transformation is needed to fix Canada's health-care system, with a recent multi-billion dollar funding deal struck between Ottawa and the provinces representing only the beginning, according to health-care sector experts.

To help improve the health-care system, the federal government pledged to increase health funding to provinces and territories by $196.1-billion over 10 years, including $46.2-billion in new funding, during a meeting of first ministers in Ottawa on Feb. 7.

Paul-Émile Cloutier, president and CEO of HealthCareCAN, says a transformation of Canada's health care system is a long-term issue, 'but if we don't start talking about it today, we'll be in the same position 10 years from now.' *Photograph courtesy of LinkedIn*

Health Minister Jean-Yves Duclos said 'Canadians deserve better health care and we need immediate actions to address current and future challenges,' in a press release from the Prime Minister's Office on Feb. 7. *The Hill Times photograph by Andrew Meade*

Paul-Émile Cloutier, president and CEO of HealthCareCAN, told *The Hill Times* that the funding deal is a good start for addressing the short- and medium-term challenges facing health care in Canada, but said long-term solutions are still needed.

"We need to look at the system as a whole and bring together key players across the health system … to discuss how to transform the way health care is delivered, so that it better meets the needs of the people across the country for now, as well as for the future," said Cloutier. "I feel that the timing is right for having that discussion … because all of the health-care providers, [and] the stakeholder groups are very much aligned that there's a need for transformation."

The funding deal included a $2-billion Canada Health Transfer top-up to address immediate pressures on the health-care system.

"Canadians deserve better health care and we need immediate actions to address current and future challenges. These investments will support those actions so that people have timely access to family health services and that we have less people waiting for treatments, diagnosis, and surgeries, and more mental health and substance use services across the country," said Health Minister Jean-Yves Duclos (Quebec, Que.) in a press release from the Prime Minister's Office on Feb. 7.

Provincial premiers initially expressed disappointment in the health funding proposal as it fell short of their ask of about $300-billion in new spending over 10 years. However, the premiers decided to accept the funding deal following a meeting of the Council of the Federation on Feb. 13.

An analysis by the Canadian Medical Association (CMA) released on April 20 concluded that the health funding deal between the provinces and the federal government represents the most significant investment into health care in more than two decades, with an average of $16-billion in increases per year over 10 years. Coming in second in terms of total money spent on health care was the deal struck by former Liberal prime minister Paul Martin in 2004, which amounted to an average increase of $12.3-billion per year, according to the analysis.

However, the CMA argues that funding alone cannot rebuild Canada's strained health systems, and said in the analysis that the 2023 health funding agreement "is an opportunity for governments to demonstrate to Canadians that they can work together to make meaningful and transformative changes to the way health care is delivered across the country."

"A significant increase in federal funding, the introduction of new accountability measures, and recently announced provincial and territorial plans to improve their respective health systems should give patients and providers hope that change is not only possible, but it's happening," said Dr. Alika Lafontaine, president of the CMA, in a press release. "What we now need is ongoing political will to make brave decisions to reform how we deliver care, improve access for patients and create better working conditions for providers. We owe it to the patients and health professionals to leverage this moment in time to expand access, support our workforce and drive lasting improvements."

Cloutier said that he thinks Duclos is up to the challenge of addressing the changes needed in health care over the long term. He described Duclos as an "outcome-orient individual" who wants to engage with people. As an example, Cloutier cited the Coalition for Action for Health Workers that was formed on Nov. 1, 2022, to address the challenges of health-care workers.

"This is not the conversation that you do over a weekend and you solve the problem. This is a long-term issue, but if we don't start talking about it today, we'll be in the same position 10 years from now," said Cloutier. "I don't think [Duclos] has got time for discussion just for the sake of discussion. He wants to engage people, but I think he likes to see results."

The biggest hurdle to transforming the health-care system is "breaking down the silos" between different jurisdictions across Canada, which has been a long-standing challenge from even prior to the COVID-19 pandemic, according to Cloutier. Every province and territory has its own public health act.

"This discussion has to be done in a very diplomatic way. It's got to be done in a very tactful way. But it has to be done. Someone has to start that conversation," said Cloutier. "[Duclos is] the right kind of person, because I think he understands the political environment. He understands Quebec. He understands the provinces very much. And I think that for him to start that conversation under his leadership … would be an excellent start."

The funding deal between Ottawa and the provinces also included an announcement of $505-million over five years towards the Canadian Institute for Health Information (CIHI), the Canada Health Infoway, and federal data partners to work with provinces and territories on developing new health data indicators, and to support the creation of a Centre of Excellence on health workforce data.

"We also need to … implement a pan-Canadian health workforce strategy that gather workforce data and develop solutions to tackle the health workforce shortage," said Cloutier. "I know that they put $500-million both to CIHI and also Infoway, but that needs to be implemented, and I think it needs to be implemented in consulting with the stakeholder groups. They just can't do that on their own."

The Canadian Public Health Association (CPHA) released a policy brief on Dec. 13, 2022, containing recommendations for how to strengthen public health systems in Canada. The association argued in the brief that the federal government should establish a cross-jurisdictional Public Health Systems Working Group, which would begin by defining a common set of core public health functions, along with a common framework of high-level goals for the provision of public health services. The federal government should also establish a new Canada Public Health Act that would detail the federal mandate for supporting public health services, according to the brief.

"What it means is establishing a pan-Canadian understanding of what public health services should be doing in our country, [and] ideally, setting standards to which they should be performing … and clearly laying out the role of the federal government in this area," said Ian Culbert, executive director of the CPHA. "Every province and territory has their own public health act. Some of them are very out of date, and they don't all address the different core functions of public health in the same fashion. They're not described equally. There's a great inconsistency. There's this binding force that federal legislation could have if it was developed collaboratively with provinces and territories."

The CPHA policy brief explains that "public health" is often misunderstood to mean the

Continued on page 26

HEAL

Organizations for Health Action

Health and Human Resources Survey

HEAL launched a Health and Human Resources Survey for our members. We received 5,000 responses across all provinces and territories, from large urban centers to remote communities. Collectively, HEAL represents over 650,000 health professionals across Canada.

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We need to overcome the barriers to address Canada's physician shortage

There are actions that can be taken now to help ameliorate the health human resource crisis.

ISG Senators Stan Kutcher & Mohamed Ravalia

Opinion

Concern remains about the many jurisdictional challenges that bedevil attempts to address the issue of quick, equitable and efficient access to licensure for international medical graduates, write ISG senators Stan Kutcher and Mohamed Ravalia. *Photograph courtesy of Pixabay*

More quick, equitable, and efficient access to licensure for international medical graduates (IMGs) who are Canadian citizens or permanent residents has been a longstanding issue which has finally piqued the interest of both federal and provincial/territorial governments alike.

While we applaud recent interest in addressing this complex issue, concern remains about the many jurisdictional challenges that bedevil attempts to achieve success. We are hopeful that some specific federally-led initiatives can overcome long-standing barriers, and thus rapidly help address our ongoing physician shortage while ensuring that Canadian standards of medical practice are met.

We have identified three considerations for immediate action.

Firstly, we support the two-stage examination format of the National Assessment Collaboration (NAC), but are concerned that many IMGs may not have had previous experience with objective structured clinical examination (OSCE) formats, and that this may be a significant barrier to exam success.

The federal government can assist in mitigating this barrier by directly funding OSCE preparation courses through medical schools or settlement agencies.

Secondly, upon successful completion of the NAC-mandated exams, IMGs are required to complete a time-defined clinical practice assessment. This is called the practice ready assessment (PRA) and can be conducted in both academic and community settings under the supervision of qualified physician evaluators. Successful PRA completion allows the IMG to challenge one of the two certification examinations (College of Family Physicians of Canada, or the Royal College of Physicians and Surgeons of Canada). A small pan-Canadian PRA network to evaluate IMGs clinical competencies exists, which allows for comparable, standardized and transparent assessment for all candidates, regardless of where the PRA is conducted. The provinces and territories are responsible for oversight of these programs.

However, the number of PRA slots available is very limited and demand far outweighs supply. This imbalance creates a bottleneck that limits the number of IMGs that can proceed on the pathway to licensure.

The federal government can provide limited and targeted funding to enhance the capacity of exiting PRA programs, and to create new PRA programs where needed.

Thirdly, for IMGs with insufficient residency training or for those who are identified through the NAC-mandated assessment process as requiring upgrading, access to residency training programs is necessary. This route does not require the creation of new medical schools with their attendant substantive costs and delays before coming online. This can be achieved by funding of residency training slots which can be located in rural and remote areas as well as in urban settings under existing programs.

The federal government could provide funding for increases in the number of residency spots in areas where patient need is greatest, for example: family practice; child and adolescent psychiatry; and geriatric medicine. While some additions to current numbers of residency training spots may be needed, many such spots already exist. These spots are filled by visa training programs that train IMG physicians who are not Canadian citizens or permanent residents, and who then return to their country of origin. Because of this visa cohort, these slots are not available to train IMGs who are Canadian citizens or permanent residents for practice in Canada. A reallocation of some of these would have almost immediate impact on addressing physician shortages in Canada.

Changing this allocation is a low-hanging fruit opportunity. Currently, about 50 per cent of all IMGs in residency training are not Canadian citizens or permanent residents, but are visa trainees. According to the National IMG Database report, the number of IMGs in residency training between 2011-2021 increased from 4,167 to 4,690, but this number was entirely made up of visa trainees, not by IMGs who were Canadian citizens or permanent residents.

The federal government can help address this issue either through its visa entry requirements, or by targeted funding that would increase access to residency training positions that are currently not available for IMGs who are Canadian citizens or permanent residents.

In short, while the House Health Committee's recent repot (*Addressing Canada's Health Workforce Crisis*) appropriately noted the importance of focused long-term collaboration between the federal government and provinces and territories, there are actions that can be taken now to help ameliorate this health human resource crisis.

The immediate question is: if it is clear that some interventions are possible now, who will act, and when?

Nova Scotia Senator Stan Kutcher is a psychiatrist and member of the Independent Senators Group. Newfoundland and Labrador Senator Mohamed Ravalia is a family physician and member of the Independent Senators Group.

The Hill Times

Health risks and the importance of labelling

Bill S-254 would amend the Food and Drugs Act to require a warning label on alcoholic beverages.

Senator Patrick Brazeau

Opinion

Only one in four Canadians is aware that alcohol is indisputably linked to at least seven fatal cancers, writes non-affiliated Senator Patrick Brazeau. *Photograph courtesy of Pexels*

My bill, S-254, An Act to Amend the Food and Drugs Act (warning label on alcoholic beverages), is making its way through the legislative process. The bill would make it mandatory to include that alcohol is a class-one carcinogen. Given that only one in four Canadians is aware that alcohol is indisputably linked to at least seven fatal cancers, there is no time to waste in making labels honest regarding health risks.

Since introducing Bill S-254, I have received overwhelming support and encouragement from far and wide. I have received many personal letters urging me to continue this fight. As well, many health authorities are publicly supporting this bill. At press time, these supporters include: the Canadian Cancer Society, the Canadian Public Health Association, the Ontario Public Health Association, Toronto Public Health, Princeton Alcohol Use Disorder Society, Fraser Health, Queen's University Health Board, Nova Scotia Health, Durham Region Medical Officer of Health, Vancouver Coastal Health, and radiation oncologist Dr. Fawaad Iqbal.

Other key organizations that support health-risk warning labels include the Canadian Medical Association and the World Health Organization.

Several Senators have spoken to Bill S-254, emphasizing how critical it is that the bill makes it to the committee stage. Within a Senate committee, it can be analyzed word by word, expert witnesses can testify and be questioned, and everyone will be able to critique it from every conceivable angle on live television.

We have reached out to every Senate group and received approval of S-254 in principle along with agreement that it should go forward to committee.

We have yet to hear from the official opposition within the Senate regarding its desire that it go to committee. But given the general popular support for honest health labels—apart from the alcohol lobby—I am optimistic that the bill will get to committee soon.

I invite all my colleagues to give this idea due consideration and to do the rigorous legislative work necessary so that Canadians are given facts about their most precious resource: their health.

Born in Maniwaki, Que., non-affiliated Senator Patrick Brazeau is a member of the Algonquin community of Kitigan Zibi. He is a vigorous advocate for mental health and suicide prevention issues, and has recently introduced Bill S-254 in the Senate regarding labelling of alcoholic products.

The Hill Times

LET'S ACCELERATE THE DELIVERY OF NEW MEDICINES TO CANADIANS

As Canadians, we aspire to have a leading health care system that includes access to the best medicines, enhancing quality of life for everyone. But the wait time to access new innovative medicines to treat mental health, cancers, autoimmune diseases like arthritis, and other chronic conditions has become unacceptably long.

In my past experience as a front-line pharmacist, I have seen first-hand the impact that delays in medication access have on Canadians. I remember one woman asking how her husband could access a cancer therapy that had recently been approved for sale in Canada but was not yet accessible to people who relied on a public drug plan. This situation stayed with me; I felt powerless to help her. Unfortunately, I know this scenario continues to happen today in pharmacies across Canada. I empathize with the health care professionals who are facing these anguishing situations and discussions daily.

The unfortunate reality is people who rely on public drug plans wait, on average, almost two years longer for approved medicines to be covered than people with private drug coverage. These delays are concerning for patients and should be for governments because new medicines often can contribute to the sustainability of the healthcare system by allowing people to return to work sooner, and avoiding costly hospital stays, surgical procedures, and other treatments. This is particularly important in the current context of health care staffing shortages across the country.

In some cases, access to innovative therapies is a time-sensitive issue, particularly for cancers and progressive chronic diseases. By working together, government and industry can – and should – do better for Canadians.

In theory, the objective is simple: ensure that new medicines that Health Canada have approved for use become available and accessible to patients in a timely manner. So, why is timely access to medication an issue?

Drug funding assessment and negotiation processes lead to long wait times and unpredictability

On average, Canadians with public drug plan coverage **wait two years** to access approved, new medications.[1] That's nearly **two times longer** than in most other peer countries.

On average, Canadians with public drug plan coverage wait two years to access approved, new medications. That's nearly two times longer than in most other peer countries within the Organization for Economic Co-operation and Development (OECD). For context, Canada ranks 19th out of 20 OECD countries in the time it takes to secure public reimbursement for new medicines. Fewer than half of new medicines launched globally are launched in Canada.

Innovative Medicines Canada notes that we experience lengthy and unpredictable price negotiations with the pan-Canadian Pharmaceutical Alliance (pCPA), a coalition of provincial and territorial drug plans. The pCPA process accounts for almost half the time from marketing approval to patient access. And a significant portion of this time is largely administrative – such as picking up a file for negotiation and listing a drug on formulary after the negotiation is complete.

A great place to start is to address the long delays in public reimbursement of approved innovative medicines. Here are three specific examples of how patients and the health care system suffer the consequences of delay.

Mental illness

According to the Mental Health Commission of Canada, one in five Canadians experience a mental illness in their lifetime. Poor mental health is among the top contributing factors leading to in-patient care for people living with schizophrenia and mood disorders, and is the lead cause of emergency room and acute hospitalizations. Treating mental health disorders can effectively decrease the impact on healthcare resource utilization and lead to better patient outcomes.

Medications to treat mental illness have a **76% rejection rate** for initial and subsequent medication submissions,[2] and a **100% rejection rate** for anti-depressant therapies.[3]

And yet the Canadian Agency for Drugs and Technologies in Health (CADTH), one of Canada's health technology assessment agencies, has a 76 per cent rejection rate for initial and subsequent medication submissions, and a 100 per cent rejection rate for anti-depressant therapies. Compare this to a 48.5 per cent rejection rate for non-mental health treatments. Rejected medications and delayed coverage of new medicines restrict the range of treatment options for patients. We applaud the federal government's focus on improving mental health care by supporting evidence-based solutions. We would encourage the federal government to extend this approach to the assessment of new mental health medicines by federal drug plans, which cover Indigenous people, refugees, and other vulnerable populations.

Cancer

Canada is amongst the slowest of the developed countries to reimburse medicines through public coverage plans.[5] This leads to **delays for breakthrough therapies**, which at times, can be up to **three years**.[6,7]

Cancer is the leading cause of death in Canada; one in four Canadians will die from cancer. Yet, Canada is amongst the slowest of the developed countries to reimburse medicines through public coverage plans. This leads to delays for breakthrough therapies, which can be up to three years in some instances.

Access to cancer care varies dramatically depending on the province or territory in which Canadians live, and the pandemic has only accelerated cancer care challenges when it comes to screening delays, surgical backlogs, resource challenges and increased public demand for support.

Inflammatory arthritis

Up to **25%** of approved arthritis therapies are **not accessible** to Canadians on public plans.[8]

Inflammatory arthritis includes a group of chronic autoimmune conditions including rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis. These are progressive diseases that can cause irreversible damage, therefore early diagnosis and treatment is paramount to delay or stop the progression of the disease and prevent long-term disability.

In 2020, the average time to list new inflammatory arthritis medications on public formularies following Health Canada approval was 665 days. Furthermore, up to 25 per cent of approved arthritis therapies are not accessible to Canadians on public plans.

The way forward

Optimizing the pathway for Canadians to access innovative medicines in a timely way would be a step in the right direction.

At AbbVie, we believe the federal government can play an important role in advancing policies that will improve patient access to new medicines by directing federal funds to the provinces to help them improve their drug plans, and by partnering with the provinces and territories to modernize the Health Technology Assessment process. We applaud the recently announced Drugs for Rare Disease strategy, which will allocate funding to the provinces to enhance screening, diagnosis and treatment of patients with rare conditions.

In addition, the federal government and many provincial governments have taken a step in the right direction by re-committing to life sciences in Canada. The pandemic made clear the importance of the sector to health system resilience and health security.

We are ready and open to work with government on solutions.

Sustainable solutions require us all to get involved. There is an opportunity and an urgent need for government, assessment and negotiation bodies, and industry to collaborate to evolve and enhance our medication access systems. We have a collective duty to work together to elevate the current standards of care for Canadians and ensure people have more timely access to innovative medicines. This allows our front-line health care workers to do what they were trained to do: offer the best care and treatment for each individual patient.

So let's change the paradigm and ensure that each patient gets the right treatment when they need it most. We owe it to Canadians.

By: Arima Ventin, Executive Director,
Market Access and Government Affairs, AbbVie Canada

References available upon request

abbvie

Canada needs urgent solutions to address burnout among health-care workers

Canada's health workforce is being pushed to the breaking point under the accumulated weight of years of resource constraints.

NDP MP
Don Davies

Opinion

Canada's health workforce crisis has reached a breaking point. Across the country, staffing shortages are leading to emergency room closures, hospital overcrowding, delayed surgeries and diagnostics, family doctor shortages, and long wait lists for continuing care.

This places enormous strain on care existing providers. Unfortunately, this chaos has become a day-to-day reality for Canada's health-care workers.

Despite their sacrifices and best efforts to provide every patient with timely, high-quality care, they are being pushed to the breaking point under the accumulated weight of years of resource constraints.

And this is not new.

Prior to COVID-19, Canadian health-care workers were already experiencing burnout and job dissatisfaction at alarming rates. However, the pandemic made working conditions far worse. Consequently, health care workers are now leaving the profession in greater numbers than ever before. This, in turn, is creating a vicious cycle by adding additional pressure on remaining staff.

And the consequences are stark. According to the Mental Health Commission of Canada, 40 per cent of Canadian health care workers are burned out, 50 per cent intend to leave the profession, and only 60 per cent are satisfied with the quality of care they can provide.

Without adequate resources to keep up with patient needs, health care workers are facing what experts call 'moral distress.' Moral distress occurs when a person is unable to take what they believe to be the ethically appropriate course of action due to institutional or systemic barriers. For example, staff at the Alberta Children's Hospital recently reported experiencing moral distress when they were so overwhelmed with patients they worried a child could die in the waiting room.

This should not be happening in a country as wealthy as Canada. Parents should never have to fear that their child could die for want of care in a hospital, and health-care providers should never be abandoned without the necessary resources to take care of their patients.

Frontline health-care workers, experts, and professional bodies have put forward many practical solutions for revitalizing Canada's health workforce in both the short and long term. These include increasing training and residency opportunities for Canadian students, expanding pathways to licensure for internationally trained workers, implementing pan-Canadian licensure, improving data collection and sharing, investing in preventative health, implementing team-based care models, expanding public long-term care beds, restoring administrative capacity, and improving financial incentives for underserviced areas.

Health-care worker retention and return will require comprehensive action to address the root causes that are currently driving people from the sector. After all, any effort to add workers to Canada's health care sector will be futile if we are simultaneously losing experienced practitioners. All levels of government must, therefore, work together to ensure manageable workloads and safe workplaces, improve compensation and benefits, provide better support for mental health, and protect work-life balance for health-care workers.

My home province of British Columbia has recently shown important leadership on this front by becoming the first Canadian province to adopt mandatory nurse-to-patient ratios as part of its plan to improve workload standards. This policy is a key element of the province's new tentative agreement with British Columbia nurses, which also includes "record-setting compensation."

However, Canada's health workforce crisis is ultimately a national issue. It cannot be resolved by forcing jurisdictions to compete for a shrinking pool of staff. The federal government urgently needs to partner with the provinces and territories to scale up best practices for the retention, return, and recruitment of health-care workers.

After recently establishing bilateral health funding agreements in principle, the federal government is currently negotiating detailed targets, timelines, and common indicators with the provinces and territories. These discussions will provide a key opportunity to establish ongoing intergovernmental collaboration for resolving Canada's health workforce crisis.

Nevertheless, these bilateral agreements will be grossly insufficient in the absence of immediate action.

The federal government must not stand by in the face of this mounting crisis. Our country needs urgent solutions to address burnout and moral distress among health care workers. In their absence, both the well-being of frontline providers and the quality of patient care will continue to needlessly suffer.

NDP MP Don Davies, who represents Vancouver Kingsway, B.C., was first elected in 2008, and re-elected in 2011, 2015 and 2019. Davies serves as the NDP critic for health and deputy critic for public safety and emergency preparedness.

The Hill Times

Policies to protect kids' health good for future health spending, too

Banning e-cigarette flavours and restricting the marketing of unhealthy food and beverages to children are vital to making our kids healthier adults.

Andrew
Pipe

Opinion

The short- and long-term health consequences of what people consume are dramatically different.

In the short term, indulge in something a little too much and you are likely to suffer for a day or two. But you can fix it by giving your body a little TLC.

In the long term, unhealthy behaviours eventually catch up to you with big consequences, both for your personally and for our health system.

Federal government health policies also have two timelines: the short-term and the long-term. While short-term policies providing immediate results are popular, long-term policies are critical to ensure future generations grow up in an environment that protects their health to the greatest extent.

Successful long-term policies prevent the types of short-term challenges the government faces today, while ensuring a healthier population in the future. What better legacy could a government leave?

To their credit, the current federal government has recognized the need to make long-term policy decisions to improve the health of Canadians. Many of these initiatives have, laudably, received multi-party support, including enacting front-of-package nutrition labelling requirements which will make shopping for healthier food choices much easier.

But there is more the federal government can—and must—do to protect the health of Canada's youth. We suggest starting with two vital policies addressing youth vaping and nutrition.

The first is to expand the proposed ban on e-cigarette flavours to include mint/menthol—an initiative that would help limit the attractiveness of vaping to young Canadians. Nine out of 10 young people cite flavours as an important reason why they started vaping and why they continue to do so. The allure of vaping flavours, the popularity of vaping among youth, and the nicotine addiction which occurs so rapidly are concerning due to the adverse health impacts associated with e-cigarettes.

Five provincial and territorial government have adopted or implemented policies that include mint/menthol in the flavours they prohibit, allowing only tobacco flavours to be sold.

The federal government is in the process of banning certain fruit and candy flavours, but has not included mint/menthol, which it must do to be truly effective in preventing young Canadians from starting to vape and becoming addicted to nicotine.

The second is finally making good on a long-standing promise: introducing regulations to restrict the marketing of unhealthy food and beverages to protect the health of children in Canada. This crucial element of the government's long-held healthy eating strategy has had a tortuous legislative journey, having been supported in 2019 by the House, but never completing the process before that year's federal election.

We are in a long-term epidemic of poor dietary health for our kids, fuelled by ultra-processed foods and sugary drinks, and driven in large part by their daily, unrelenting exposure to marketing of unhealthy food and beverages across all media in many settings.

The marketing of unhealthy food and beverages, often using attractive and well-known cartoon characters or mascots, increases our children's vulnerability to desiring—even demanding—these products. It is an onslaught against which even the most determined parent can be found wanting.

It is time to speak up for our children and prevent them from being unfairly influenced by food marketers. We have a duty to protect them.

The government must introduce comprehensive regulations restricting the marketing of food and beverages high in sodium, sugars and saturated fat to children under 13 years by this fall, as committed to by Health Canada. Industry self-regulation simply is not sufficient to control this marketing onslaught.

Improving the health of Canadians is a big effort. It takes immediate short-term measures such as increasing health funding to meet urgent needs, but we also have to play the long game. We need to make policy decisions today, particularly those affecting the long-term health of our children, that will have a big positive impact on their health, and our health system, for years to come.

Andrew Pipe, MD, is a board member with Heart & Stroke and a clinical researcher at the University of Ottawa. He has been described as Canada's foremost expert on smoking cessation and the former chief of the division of Prevention and Rehabilitation at the University of Ottawa Heart Institute.

The Hill Times

The needle-free future of vaccines

McMaster's new inhaled vaccine provides more protection with none of the pain.

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Zhou Xing
Professor, Medicine

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Canada Disability Benefit needs to be hefty enough to lift Canadians with disabilities out of legislated poverty

The Canada Disability Benefit would provide regular income support to Canadians with disabilities aged 18-64 years, supplementing provincial or territorial disability assistance. The benefit could provide people with disabilities enough income to lift them out of poverty, but this can't happen until Parliament passes Bill C-22.

Rabia Khedr & Art Eggleton

Opinion

Imagine having to sell the wheelchair, walker, or cane that you rely on to get around just to pay your rent or buy groceries.

Imagine skipping meals because you cannot afford to buy enough food for yourself and your children. Imagine worrying each month that you could be evicted if you cannot scrape together enough money to pay your rent.

Low-income Canadians with disabilities do not have to imagine these hardships. The 1.4 million Canadians with disabilities who live in poverty face this reality every day, and inflation and the rising costs of food and housing are only making life more difficult for them. Many have disabilities that prevent them from working full-time—or at all—or that put them in low-paying jobs.

The meagre amounts that provincial and territorial disability support payments provide do not come close to covering the costs of groceries, rent, medication, specialized equipment and other expenses, keeping people in poverty and forcing many to work illegally or under the table or to live precariously just to make ends meet.

Many Canadians with disabilities feel abandoned and unvalued by society, and overwhelmed by the daily hardships they face. They need help, and they need it now.

One long-awaited solution is the federal government's proposed Canada Disability Benefit. It would provide regular income support payments to Canadians with disabilities between the ages of 18 and 64 years. The payments would not replace provincial or territorial disability assistance, but would supplement it.

The benefit could transform the lives of people with disabilities, providing them with enough income to lift them out of poverty.

However, they cannot receive the extra support until Parliament passes Bill C-22, which creates the framework for the benefit. The bill has been before Parliament since last June when it was first introduced by the government. It recently passed in the House of Commons and is now before the Senate.

While the bill must follow the usual course to become law, time is of the essence. Low-income Canadians with disabilities need the money in their pockets now.

The federal disability benefit would offer them a lifeline.

While many of the important details of the benefit—including the amount—are still to be determined by regulation, the draft legislation offers hopeful signs that the benefit will actually reduce poverty for Canadians with disabilities.

The draft legislation importantly requires the benefit to be indexed to inflation, meaning that the amount people receive would automatically increase each year to match the cost of living.

Bill C-22 also requires the federal government to take into consideration Statistics Canada's official poverty line when setting the benefit's amount.

These two considerations are critical. Without it, the amount of the benefit could be too low to make a significant difference.

The Canada Disability Benefit must not be a symbolic gesture, but needs to be of an adequate amount to make a difference to the many Canadians who are struggling every day.

Before the COVID-19 pandemic, the rate of poverty for working-age disabled Canadians was far higher than for those without disabilities, with 28.3 per cent of severely disabled people between the ages of 25 and 64 years living in poverty, compared to 10 per cent for those without disabilities.

During the pandemic, working-age people with disabilities were mostly excluded from federal pandemic-related financial supports, keeping them in a precarious situation. Since then, things have only gotten worse.

The housing crisis in Canada today acutely affects low-income people with disabilities. Affordable housing is simply not available. While some provinces do include a shelter allowance as part of their disability assistance, the amount provided is far below the average cost of rent in most locations.

Inflation has increased the costs for almost everything, yet most provincial and territorial disability benefits are not linked to the cost of living. With rising prices for food, shelter, and other goods and services, many people with disabilities are falling deeper into poverty.

Another important part of the bill is a requirement for the federal government to collaborate with Canada's disability community to design the benefit, including the application process, eligibility criteria, amount, and an appeal process. This brings Canadians with disabilities to the planning table, giving them a voice, and respecting the disability mantra of "nothing about us without us."

People with disabilities cannot afford to keep waiting. Parliament must pass Bill C-22 this spring.

Then, work must begin immediately to create the benefit, ensure that it is substantial enough to make a difference, and get it into people's hands as soon as possible.

Rabia Khedr is the national director of Disability Without Poverty and CEO of DEEN Support Services. Art Eggleton is a former Senator, MP, cabinet minister, and a former mayor of Toronto. He is a long-time advocate to alleviate poverty in Canada.

The Hill Times

Naturopathic medicine continues to be an emerging answer to Canada's health-care concerns

Shawn O'Reilly

Opinion

Today, more people than ever before are seeking and benefiting from naturopathic medical care and the number of naturopathic doctors (NDs) is growing at record rates to accommodate this increased demand. There are more than 3,000 NDs in Canada from coast to coast to coast who continue to be the answer to Canadians' growing health-care needs.

Naturopathic medicine is a distinct primary health-care system that blends modern scientific knowledge with traditional and natural forms of medicine. It has been practised in Canada since the end of the 19th century. The individualized approach which focuses on the overall health of a patient rather than solely focusing on addressing symptoms is a hallmark of the primary care provided by Canada's NDs.

Despite the longevity of and increased demand for naturopathic medical care, misconceptions exist that need to be addressed in order to have a complete understanding of the practice. One of the greatest misconceptions is that NDs lack formalized and regulated credentials. However, becoming an ND in Canada requires seven or more years of post-secondary education including four years of full-time study with clinical rotation in an accredited naturopathic medical program, and successful completion of standard entry to practice exams. NDs have a broad scope of practice (including prescribing and IV therapies where permitted) and oversight by a regulatory authority in six Canadian jurisdictions to date– requisites which no one can suggest are negligible.

NDs work collaboratively with other health-care professionals, including medical doctors, to promote a more holistic approach to care, integrating standard medical diagnostics such as blood work with a broad range of therapies including clinical nutrition, diet and lifestyle counselling, herbal medicine, physical medicine, homeopathy, traditional Chinese medicine/acupuncture and intravenous/injection therapies.

For a country that is constantly looking for innovative ways to address our growing health care challenges, naturopathic medicine has the potential to become a positive disruptor due to its ability to address primary health-care needs, particularly in the areas of chronic diseases such as diabetes, heart disease and depression along with lifestyle-associated challenges, while also providing highly qualified professionals to bolster the primary care workforce. For example, NDs are increasingly approached by veterans for mental and emotional care as well as pain management, knowing that NDs use a broad range of therapies to help veterans face health problems such as post-traumatic stress disorder, anxiety, sleep disturbances, opioid dependencies, and chronic pain.

Additionally, naturopathic medicine has a strong role to play in improving health-care access for Canada's Indigenous populations. Through NDs' evidence-informed use of plant medicine and therapies, as well as their focus on the body's natural abilities to heal itself and the connection between the physical, mental, and spiritual aspects of healing, NDs can provide culturally safe care for health-care systems and Indigenous Peoples respectively—aiding in the removal of systemic barriers that currently exist.

With the increased strain on our health-care systems, the inclusion of NDs in publicly funded multi-disciplinary primary health-care settings is proposed as an achievable strategy to fill gaps in health human resources and advance the movement toward individualized holistic care. But, to accomplish this, there must be continued collaboration with governments to improve access to and coverage of the services provided by naturopathic doctors.

To learn more about the important role NDs play in Canadian health care visit: cand.ca.

Shawn O'Reilly is the executive director and director of government relations of the Canadian Association of Naturopathic Doctors.

The Hill Times

Black communities miss out on public health benefits that community hubs offer

Community centres led by ethno-cultural communities provide a safe space to obtain culturally appropriate support services, contributing to the community's health and wellbeing.

Amina Mohamed

Opinion

Community and cultural centres play a critical role in public health.

The sports and recreation activities, and the leisure and education programs they offer, give people an opportunity to improve their fitness, live healthier lives and learn new skills. They also serve as a meeting place where individuals can connect with others in their community, reducing loneliness and isolation.

Community centres led by ethno-cultural communities not only offer these benefits, they also provide a safe space for community members to share and preserve their history and culture and obtain culturally appropriate support services, contributing to the community's health and well-being.

Yet not all groups have equal access to this type of social infrastructure.

A recent study on public investment in Black infrastructure by the Somali Centre for Culture and Recreation (SCCR) and the Infrastructure Institute at the University of Toronto found that neighbourhoods in Toronto with a high proportion of Black residents, particularly those of Somali origin, lack access to such facilities.

Of the 36 cultural centres the study examined, only five were Black-led and they focused on arts and activism rather than recreational and other programming.

The lack of community centres is made worse by the effects of quickly gentrifying cities that push many Black residents into poorly resourced and underfunded neighbourhoods.

The gap in social infrastructure can and has negatively affected the health and well-being of Black communities already burdened with years of systemic discrimination and anti-Black racism that have resulted in higher levels of poverty and poorer health outcomes for many Black Canadians.

While efforts are underway by the SCCR to build a Somali-led culture and recreation facility in Toronto, the centre, and others like it, need financial and policy support from all levels of government, including the federal government, if they are to succeed.

The biggest barrier to creating Black-led cultural and community centres is the cost. They are expensive to build, requiring large capital investments. While other ethno-cultural communities have previously funded their centres through donations from community members and by land sales, the legacy of anti-Black racism and discriminatory policies against Black communities mean that there are fewer opportunities for Black communities to raise all the needed funds themselves.

The federal government can help remove the cost barrier by making capital funding for Black-led community centre projects a priority in its infrastructure investments.

Besides capital funding, the federal government must prioritize investments in community-led projects that focus on building multi-purpose centres in neighbourhoods without other social infrastructure. Multi-use facilities in these neighbourhoods would provide a hub where community members and others could take part in recreational and cultural programs and access other social services.

The centres could be a resource for new parents. They could provide a safe space for young people in the neighbourhood to interact with each other and learn new skills. They could connect seniors and newcomers with support services. They present a meaningful opportunity to transform marginalized communities through direct investments in public health through mental health services, family-oriented programming and the promotion of healthy living.

Historically, marginalized groups have been left out of government decision-making processes, leading to outcomes that do not always meet the community's needs. This trend requires immediate disruption. It is essential that the federal government create a policy and funding structure that clearly identifies and addresses how investments will benefit the community.

Amina Mohamed is the head of strategic communications for the Somali Centre for Culture and Recreation.

The Hill Times

Compassion fatigue, moral distress and moral residue facing health-care providers

This is not a call for yet another report on how to fix a health-care system which appears to be collapsing under the weight of unrelenting demands at a time of decreasing personnel and financial resources. It's a call for a new kind of sustained commitment.

Françoise Baylis

Opinion

Health-care providers of all stripes, in all parts of the country, are burned out—they are physically and mentally exhausted and, in some cases, they suffer from compassion fatigue. Compassion fatigue is where the trauma of others is experienced by health-care providers as their own trauma which makes it difficult, if not impossible, for them to provide effective patient care. Imagine, for example, the trauma experienced and, in some cases, internalized by those who witnessed untold deaths as a direct result of the COVID-19 pandemic.

For some health-care providers, moral distress and moral residue are layered on top of this.

Moral distress arises when there is a disconnect between what a person sincerely believes should be done and what they actually do. This can be the result of institutional constraints, hierarchical structures, errors of judgment, personal failings, or other circumstances beyond a person's control. Consider, for example, the decision to discharge frail patients when they are not medically or functionally ready in an effort to free-up beds or to alleviate pressure in the emergency room. Perhaps the equipment required for safe discharge is not available. Perhaps community services and home care are unable to provide the necessary supports because they are already at full capacity.

Moral residue is the emotional remnant of moral distress. It is what a person carries with them from those times when they were unable do the right thing.

Taken together, compassion fatigue, moral distress and moral residue account for high levels of absenteeism. They also explain why some health care providers have chosen to work part-time or to retire early. The resulting staff shortages have increased the workload for others which, in turn, has increased stress in an already heavily burdened and fractured health-care system.

To date, responses to the labour shortages have been many and varied. Across the country there has been increased use of information technology and artificial intelligence in operational and administrative tasks, increased use of video communications, increased efforts at worker retention, compressed training programs for nurses, an expanded role for pharmacists, and increased use of nurse practitioners and certified physician assistants. Nurse practitioners are registered nurses with additional training and experience. Physician assistants are medical professionals with a two-year degree modeled on the training provided to physicians. These various responses have proven insufficient, however.

Against this backdrop, the question arises: can the federal government help the health-care system contend with inadequate staffing and worker retention?

As health is a shared responsibility, this is a complicated question. My best answer at this time is for the federal government to complement ongoing efforts by the provinces and territories to financially shore up the existing heath-care system while at the same time making targeted investments in creative design projects aimed at revamping the current system to better address the needs and challenges of the 21st century. To be clear, this is not a call for yet another report on how to fix a health-care system which appears to be collapsing under the weight of unrelenting demands at a time of decreasing personnel and financial resources. Rather, it is a call for a new kind of sustained commitment to co-operative federalism to achieve the goal of providing Canadian residents with high quality health care.

To this end. the federal government, in the role of convenor, could facilitate important grass-root conversations among care providers and residents about hopes and expectations for health and wellness. At this time, access to health care is a high priority for Canadians. This has translated into calls for more primary care physicians without much discussion about the current hub and spoke model where "information flows through and decisions are made by" the primary care physician (the hub). This is not the only way to provide care. Moreover, there are many good reasons to think that it may not be the best way to provide patient-centred care. Critical questions to consider are: do we need more primary care physicians or more primary care? And how might these be different?

Françoise Baylis, CM, ONS, PhD, FRSC, FCAHS, FISC, is a member of the Governing Board of the International Science Council, and a distinguished research professor emerita for Dalhousie University.

The Hill Times

New health deal needs transparent monitoring and evaluation process to make sure health-care outcomes improve

Gail Attara & Louise Binder

Opinion

The Canadian health-care system is letting us down. Cancer care is just one of the many disease areas harmed by the pandemic resulting in a lack of access to doctors, hospital beds and operating rooms. We need to do better.

Patients are waiting longer than ever to receive medically necessary treatments.

Specialist physicians surveyed report a median waiting time of 27.4 weeks between referral from a general practitioner and receipt of treatment. This is the longest wait time recorded in this survey's history—and it is a whopping 195 per cent longer than wait times reported in 1993, when it was just 9.3 weeks.

Lengthy wait-times result in more cancer patients dying. For all patients, wait times have serious consequences, such as increased pain, suffering and mental anguish. In many instances, wait times can result in poorer medical outcomes, transforming potentially reversible illnesses or injuries into chronic, irreversible conditions or even permanent disabilities.

Canada also has a doctor shortage. Many Canadian families might not even be able to access primary care. A recent *Canadian Medical Association Journal* survey found that more than one in five Canadians—an estimated 6.5 million people—do not have access to a family physician or nurse practitioner.

The devastating human costs behind the statistics should concern all of us.

Some organizations have put hard numbers around this. A report from All.Can Canada predicts that disruptions to cancer diagnosis and care alone could lead to 21,247 more cancer deaths in Canada over the next decade, representing 355,173 years of lost life.

For breast cancer screening, a six-month interruption could lead to about 670 additional advanced breast cancers and 250 more breast cancer deaths. For colorectal cancer, a six-month delay in screening could increase colorectal cancer cases by about 2,200 with 960 more colorectal cancer deaths.

The good news is that the federal government has taken steps to try to ameliorate the problem.

In February, the prime minister announced an investment of over $198-billion to help improve the health care system, noting that the public will judge whether this deal is a success. The four key areas of investment include family health services, health workers and reducing backlogs, mental health and substance use services, and modernizing the health care system.

As the leaders of a new grassroots collective of patients and patient group leaders, Patients for Accountable Healthcare, we will hold the federal, provincial and territorial First Ministers accountable for this deal.

Of concern, the agreements do not have a transparent monitoring and evaluation process built in, so the federal government should take immediate steps to track and determine the success of these investments. Eventually, the data plan that the Canadian Institute for Health Information is leading will provide some answers, but that is years away.

Canadians deserve accountability now. We need to know how this money is being spent and we need to see direct improvements in health care quality and access as a result.

Our health-care system must provide timely, equal, and equitable access to resilient, safe health care, respecting the Canada Health Act, while being accountable to the public.

If the government doesn't monitor progress of the new deal, you can be sure Canadians will.

At Patients for Accountable Healthcare, the underlying values guiding our work are respect, meaningful and ethical engagement, accountability, transparency, timely access, excellence, capacity building and mentorship, social justice and safety. We should expect no less from our health system.

We are enlisting the help of patients in urban and rural and remote parts of the country, and from all ethnicities and backgrounds, to join us in monitoring and sharing findings from each jurisdiction.

We will not shy away from undertaking relevant education to patients, caregivers, and the public. We will monitor and evaluate the progress of this new deal using measurable, transparent, patient-oriented outcomes, to assess changes that adapt to the needs of the individual.

It would be most effective if the government invited us to the table. After all, health care is for the people.

Gail Attara is the chief executive officer of the Gastrointestinal Society. Louise Binder is a health policy consultant with the Save Your Skin Foundation. Together they lead Patients for Accountable Healthcare.

The Hill Times

Without a foundation of gender equality, health infrastructure everywhere will continue to crumble

Health workers, especially women, reported high levels of burnout and moral distress during the COVID-19 pandemic, with many leaving the field all together.

Julia Anderson

Opinion

The COVID-19 pandemic taught most of us a lesson that health-care workers have long known: 'just' enough is not enough.

Having just enough staff, who make just enough money, working in clinics and hospitals with just enough resources doesn't produce stable health systems. It's the health-care equivalent of living paycheque to paycheque, crossing your fingers for no unforeseen expenses.

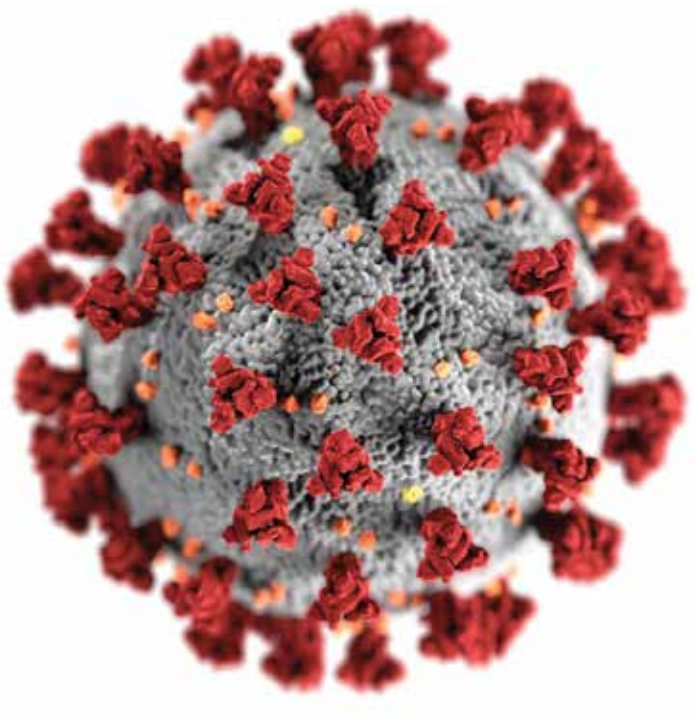
COVID-19 was the ultimate unforeseen expense, and health-care workers in Canada and abroad were left to pay the price. Health workers (especially women) reported high levels of burnout and moral distress, with many leaving the field altogether. Within a few short months, the same workers who had been pointing to cracks in the system before the pandemic were surrounded by evidence that they were right all along.

For women in health care, who occupy 90 per cent of frontline positions globally, this 'I told you so' moment is overdue.

Health workers around the world have been scraping by with a *just enough* approach for years. At work, they have carried the burden of inadequate resources, insufficient pay, and exclusionary systems. At home, they have borne the brunt of unpaid caregiving responsibilities, while contending with unequal access to their own health services.

Women in the health workforce contribute US $3-trillion annually to the global economy, but half of this is unpaid work. When women health workers are paid, they are making 24 per cent less than their male counterparts.

Now, as governments work to rebuild the health architecture that crumbled during the pandemic, they have an opportunity to draw a new blueprint—one that incorporates gender equality at every level. Canada's inclusion of expected gender impact of new measures in annual federal budgets is one example of what this type of consideration could look like.



As governments work to rebuild the health architecture that crumbled during the pandemic, they have an opportunity to draw a new blueprint that incorporates gender equality at every level, writes Julia Anderson, the CEO of the Canadian Partnership for Women and Children's Health. *Photograph courtesy of Pixabay*

The invaluable health workforce must also be properly recognized. This starts with paying all health workers a fair living wage, from those who keep our clinics and hospitals clean, to community healthcare workers and midwives—the backbone of care in many communities globally.

Currently, there is a shortage of 900,000 midwives worldwide, creating a dangerous lack of contraceptive care, maternal care, and sexual and reproductive health care, particularly in rural and remote areas.

These individuals are the first line of defence when we are faced with new and unprecedented threats to global health, as we are today.

Building strong, resilient health systems demands a more global outlook. COVID-19 erased any doubt that the health climate of one part of the world affects all others. Nearly overnight, the world watched as a cluster of dots on a map in China became a sea of red spanning the globe.

Polling conducted by the Canadian Partnership for Women and Children's Health highlights the growing understanding of the importance of global solutions. Nearly 80 per cent of Canadians agreed that unless COVID is controlled in all parts of the world, we can't return to normal life in Canada, while more than 70 per cent supported the government investing to help ensure healthcare workers everywhere in the world get access to a COVID-19 vaccine.

Over the past three years, we've seen firsthand that global health is Canadian health. When health systems in any part of the world are stretched thin, we all feel the tension. And when health workers anywhere are pushed to their limit, we all suffer the consequences.

The barrier to creating strong resilient health-care systems is not a lack of know-how. It's the political will to do things differently, to overhaul the systems that have failed to protect the women on the front-lines of healthcare, and the girls inspired to follow in their footsteps.

Calls to invest in a more gender responsive, integrated and equitable health-care system have been repeated many times before, but the stakes have never been higher. With years of progress on global health undone due to the pandemic and climate change and international conflict posing additional threats, we must put the right systems in place to reclaim lost gains.

It is time we work here at home and around the world to create stable, equitable, resilient health systems that are built to last. Anything less is simply not enough.

Julia Anderson is the CEO of the Canadian Partnership for Women and Children's Health (CanWaCH).

The Hill Times

Notable and noteworthy:

- Women in the health workforce contribute US$3-trillion annually to the global economy, but half of this is unpaid work. When women health workers are paid, they are making 24 per cent less than their male counterparts
- Currently, there is a shortage of 900,000 midwives worldwide, creating a dangerous lack of contraceptive care, maternal care, and sexual and reproductive health care, particularly in rural and remote areas.

Experts call on Health Minister Duclos to rise to challenge of health-care system transformation

Continued from page 16

publicly-funded medical care systems that help patients after they become sick or injured, but public health actually refers to the organized societal effort to keep people healthy, and to prevent injury, illness and premature death.

The brief cited data gathered by the Canadian Institute for Health Information, which found that spending on public health services in 2020 amounted to about six per cent of total health expenditures in Canada, compared to hospitals at 26 per cent and pharmaceuticals at 15 per cent.

Culbert told *The Hill Times* that addressing public health could be "a legacy initiative" for any government willing to undertake it.

"We're really hoping that the federal government can play a leadership role in the renewal of public health systems across the country," said Culbert. "In the current phase of the pandemic, we've seen the burden that has been put on public health systems. They've been stretched to the limit. We've seen where they have underperformed because of decades of underinvestment and the lack of consistency in public health systems across the country. That shouldn't be acceptable in 2023."

The CPHA argued in the brief that public health interventions can lead to economic benefits. For example, every dollar spent on immunizing children with the measles-mumps-rubella vaccine saves $16 in health care costs, and every dollar invested in fluoridated drinking water saves $26 on dental care, according to the brief.

"A great deal of attention has focused on the preventive role of public health systems in this country, [and] their ability to protect populations, and we want to capitalize on that to be able to get these conversations going, because what happens in public health is that we have these boom and bust cycles of funding and political attention," said Culbert. "We have to start somewhere. And I do believe that, based on Minister Duclos's training as an economist, he can see the merit of investing in prevention. Preventing disease is cheaper than curing illness."

Brett Skinner, founder and CEO of the Canadian Health Policy Institute, argued that reforms in the health-care system should involve decentralization, and greater involvement with the private sector as a partner.

"When talking about decentralization, we're really talking about respect for provincial jurisdictions. When we talk about private-sector involvement, we're talking about supplementary, complementary, involvement of the private sector, [and] not the application of public subsidization to ensure universality," he said. "That would allow for physician groups and clinical groups or hospitals to provide services for public payment and for private payment, without being penalized. And without being restricted to one or the other sectors."

Skinner said that provinces can serve as little laboratories, each experimenting with the best approaches and best practices for health care before they are adopted elsewhere in Canada.

"Populations differ by province, by age and other factors. And provinces have designed approaches within constraints of what the law allows … [and] they've designed programs that specialized in certain population needs. And they experiment in different ways," said Skinner. "We have a high degree of similarity between the provinces, but [also] just small differences that allow us to improve our system overall over time. It's a strength, and not a weakness, that we have these separate jurisdictions doing things in much the same way but with slight differences that allow us to make improvements over time."

Liberal MP Adam van Koeverden, (Milton, Ont.), who is also the parliamentary secretary to Duclos, told *The Hill Times* that he doesn't think the health minister's job has ever been more complex than it is now, given factors such as the global pandemic and the human resource challenges in the health-care system.

"There's just really nothing that has fallen off of [Duclos's] radar, which I think is quite remarkable," said van Koeverden. "We recognize that Canadians are proud of our health-care system, but that is not really meeting everybody's expectation. From a citizen perspective, we're really focused on making sure that those expectations are met, and that we reduce wait times and increase the number of doctors and nurses in the system. It's just about serving Canadians and making sure that we continue to have one of the healthiest countries in the world."

One recent focus for the health minister's office includes improving dental care, according to van Koeverden.

The Liberal government has plans to begin rolling out the Canadian Dental Care Plan by the end of this year, with expectations of full implementation by 2025, according to a PMO press release from March 31. The plan will be available in 2023 to uninsured Canadians under 18, persons with disabilities, and seniors who have an annual family income of less than $90,000. By 2025, the Canadian Dental Care Plan will be fully implemented to cover all uninsured Canadians with an annual family income under $90,000.

"When I was an athlete, I didn't have insurance for dental care, so I paid out of pocket to go to the dentist and I kind of thought that I was very unique. But it turns out there's over 10 million Canadians that are in the exact same situation, which is something that shocked me when I became a member of parliament three years ago," said van Koeverden. "The good news is we're there to help Canadians and I'm really glad that we are because I've met quite a few people in my riding whose kids were also having to pay out of pocket … for their children's access to the dentist."

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The Hill Times

Experiences of health care workers during the pandemic

- A total of 95 per cent of health care workers reported that their job was impacted by the pandemic, and 86.5 per cent felt more stressed at work.
- A total of 92 per cent of nurses reported feeling more stressed at work, which was higher than physicians at 83.7 per cent, PSWs, or care aides 83 per cent, and other health care workers 83 per cent.
- Physicians were more likely (68.2 per cent) than people in other occupation groups to report having to change their methods of delivering care, likely reflecting a shift to virtual care.
- There were 126,000 vacancies in the health care sector in the fourth quarter of 2021, which was almost double the number of vacancies seen two years earlier at 64,000.
- Reporting job stress or burnout as a reason for intending to leave their job or change jobs was more prevalent among women (63.9 per cent) than men (59.5 per cent) and among nurses (70.9 per cent) compared with PSWs or care aides (51 per cent), physicians (48.2 per cent) and other health care workers (60.6 per cent).

Source: Experiences of health care workers during the COVID-19 pandemic, September to November 2021, released on June 3, 2022 by Statistics Canada

Accelerating interoperability is key to reducing strain on Canada's health-care system

Michael Green

Opinion

It's no secret that events of the past three years have placed immense strain on Canada's health-care system, with health-care workers past the point of exhaustion. What will it take to address these challenges and restore confidence in our health-care system, among patients and health-care workers?

There is no single answer, but I would argue that accelerating interoperability is one of the key elements that must be prioritized. Interoperability affects every part of the health system. It enables patient health information to flow seamlessly between different solutions and devices. Interoperability improves continuity of care, collaboration between and among health-care providers, and patient access to their health information. By breaking down data silos, it also reduces inefficiencies and redundancies within the health system.

While interoperability continues to improve in Canada, according to two separate surveys recently conducted by Canada Health Infoway (Infoway) and the Commonwealth Fund, there are still opportunities for further growth that will benefit Canadians, clinicians, and our health system.

Infoway's 2022 Canadian Digital Health Survey found that 74 per cent of Canadians said communication among their care providers is always or usually good. However, 24 per cent said their care providers did not have their health information/history prior to or during their visit, and 31 per cent said they experienced at least one gap in communication and co-ordination of their care in the past 12 months. This number is higher for those who have chronic conditions (38 per cent) or many health system encounters (47 per cent).

These gaps are concerning as they can delay care, result in duplicate tests or adverse drug events, or lead to hospital readmissions. The good news, however, is that we have also seen evidence of the effective role that digital health tools, such as electronic medical records (EMRs), can play in improving care.

Historically Canada had lagged behind in EMR use—in 2009, only 37 per cent of primary physicians in Canada were using EMRs, compared to 77 per cent of international peers. But the latest Commonwealth Fund International Health Policy Survey of Primary Care Physicians in 10 countries found that Canada is now on par with the international average, with 93 per cent of primary care physicians using EMRs. Seventy-six per cent of primary-care physicians in Canada have electronic access to regional, provincial, or territorial information systems where they can access patient information outside their practice.

But there are three critical areas of information exchange where Canada remains behind international peers: primary-care physicians' ability to electronically exchange patients' clinical summaries, laboratory and diagnostic test results, and comprehensive patient medication lists. The sharing of patient summaries has been identified as a priority by every jurisdiction in Canada and will help health-care providers save time by accessing patients' complete health information in one place, communicate more efficiently across the health system, have improved confidence in their decision making, and have more time to spend with patients.

Infoway has been leading efforts to create a pan-Canadian interoperable patient summary standard and is collaborating with provinces and territories and solutions vendors to develop and test an initial set of technical requirements.

We were pleased that 2023 federal budget included investments in Infoway to help improve health-care data and interoperability. End-to-end interoperability is a continuous, multi-year journey that requires a coordinated, consensus-driven approach embedded in proactive governance.

Canadians expect a high-performing, world-class health system, even in the face of unprecedented pressures. Harnessing digital health solutions and data will help increase system capacity, improve access, and drive better health outcomes. And interoperability lies at the heart of it.

Michael Green is president and CEO of Canada Health Infoway, an independent, not-for-profit organization funded by the federal government.

The Hill Times

The Hill Times Policy Briefing

Mental Health

Canada does not fund mental health care,
and we are all paying for it

Investing in human resources
is necessary for improving mental health care

Canada must renew leadership
on antimicrobial resistance

The stigma of mental illness,
by Keith Dobson

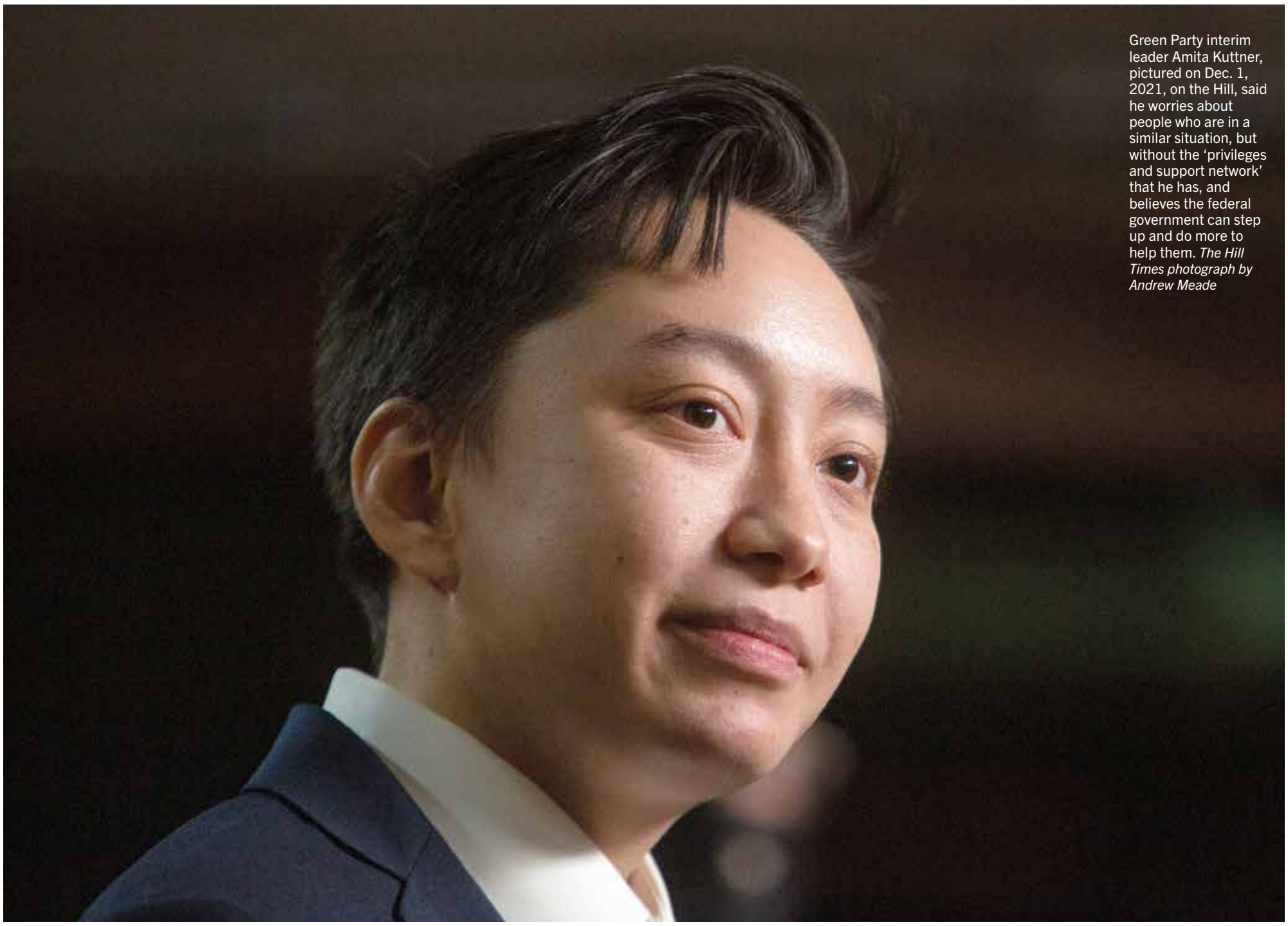
Mental health is health:
it's time act like it

'I'm the interim leader of a federal political party and I'm still thinking about killing myself':
Amita Kuttner

Top public policy experts tackle mental health, in the age of the pandemic. Inside.

Mental Health Policy Briefing

‘I’m the interim leader of a federal political party and I’m still thinking about killing myself’: Amita Kuttner



Green Party interim leader Amita Kuttner, pictured on Dec. 1, 2021, on the Hill, said he worries about people who are in a similar situation, but without the ‘privileges and support network’ that he has, and believes the federal government can step up and do more to help them. *The Hill Times photograph by Andrew Meade*

Thirty-one-year-old Amita Kuttner, the first transgender person to lead a national Canadian political party, lost his mother, Eliza, in 2005 when a mudslide crashed into their North Vancouver family home. Kuttner’s father, Michael, survived, but suffered brain damage and numerous physical injuries, including 23 broken vertebrae. Today, Amita Kuttner struggles with PTSD, including suicidal ideation.

BY CHRISTOPHER GULY

Following the devastating swath Hurricane Fiona recently cut through Atlantic Canada, federal Green Party interim leader Amita Kuttner wrote on Twitter: “I know what it is to lose home and family to extreme weather; my heart is with those dealing with #FionaHurricane.”

Thirty-one-year-old Kuttner, the first transgender person to lead a national Canadian political party who identifies as non-binary and uses the pronouns he/them, lost his mother, Eliza, in 2005 when a mudslide crashed into their North Vancouver family home. Kuttner’s father, Michael, survived, but suffered brain damage and numerous physical injuries, including 23 broken vertebrae.

Kuttner, an only child, was studying at a boarding school in California when the disaster dismantled his family, and left him—as he told *The Hill Times*—with post-traumatic stress disorder (PTSD) that includes suicidal ideation.

Since 2005, Kuttner has undergone therapy, most recently using EMDR (eye movement desensitization and reprocessing), which involves focusing on a traumatic memory while experiencing eye movements to help reduce the emotion associated with the memory.

“I’ve experienced a drop in my PTSD triggers noticeably from having a couple of sessions of that,” he said, adding that he still struggles with suicidal thoughts as recently as a couple of months ago. The feelings, as Kuttner explained, range from “times where I just wanted to rip myself to pieces or throw myself from a building, either because I couldn’t

Continued on page 27

Without adequate numbers of qualified mental health-care providers integrated into primary, secondary, and tertiary sectors, nowhere in Canada can people's needs for rapid access to high quality care be met, writes ISG Senator Stan Kutcher. *Image courtesy of Pixabay*

Investing in human resources is necessary for improving mental health care

Rapid access to quality mental health care depends in great part on the availability of, and access to, appropriately trained health-care providers.

ISG Senator Stan Kutcher

Opinion

Of the thousands of pages written about mental health and COVID, few address one of the key issues that underlies the inability for Canadians to rapidly access high-quality mental health care when needed. That is: the availability of qualified providers with sufficient skill and capacity to meet care needs, and how these providers should be integrated within existing systems of health care.

Without adequate numbers of qualified mental health-care providers integrated into primary, secondary, and tertiary sectors, nowhere in Canada can people's needs for rapid access to high quality care be met. Indeed, it is likely that no location in Canada could do so even before COVID caused additional strains on health-care systems.

This problem can be ameliorated by increasing human resource capacities for mental health care.

Care provision must be linked to need for care. This can be achieved by considering the relationship between need for mental health care and the domains of mental distress, mental health problems and mental disorders. This helps differentiate high volume, low intensity care needs from low-volume, high-intensity care needs, while providing a framework for applying optimal scope of practice considerations. This ensures that the highest trained (and most expensive) providers are not using their time to provide care that can be just as effectively provided by others with less training and at lower cost.

Improving mental health literacy across the nation could also help ease the existing burdens on mental health care. Good mental health literacy helps people understand and know how to manage the stress response and address the existential challenges we all face daily. For example, understanding that mental distress does not require professional interventions. Mental health literacy teaches how to apply effective self-care strategies and how to separate these from unnecessary wellness products. Mental health literacy (such as that found at mentalhealthliteracy.org) can be taught in schools and communities. Canadians could benefit from the scale-up of best available evidence-based mental health literacy interventions. There is good evidence for the positive impact of these interventions, but pre-COVID, national scale-up had not occurred. The federal government can play a role in disseminating and supporting the implementation of these well-researched programs.

In addition, nationally available online interventions, such as Kids Help Phone and Strongest Families, could be directly supported by federal dollars. The Wellness Together electronic platform introduced mid-pandemic could be tweaked to offer best available evidence-based self-care. This, coupled with a transparent data set, could allow independent investigators to research the real-world impact of e-based interventions.

It is also important that those who need care are assigned to a care provider that is best suited to meet their needs. Mental health problems that demonstrate high degrees of emotional/cognitive disturbances are disruptive to life, can be long-standing, and may not resolve with self-care strategies. These occur during substantial life challenges, such as: the loss of a loved one; divorce; social or geographical dislocation; abuse; and so on. With these high-volume low intensity needs, professional intervention can be provided by counsellors and other human service providers who have been trained in best evidence-based psychotherapeutics. Ideally, they should be located in institutions such as schools (a school counsellor provides help for all just down the hall) and in all primary health care locations.

Mental disorders are at the low volume, high intensity end of the needs spectrum. These are the clinical diagnoses that include but are not limited to: major depressive disorder, schizophrenia, bipolar disorder, anorexia nervosa, panic disorder, obsessive compulsive disorder, and so on. Optimal treatment of these often requires the input of highly trained specialty mental health-care providers. For more straightforward conditions, primary-care providers, such as family physicians or clinical nurse practitioners, can provide effective, first-line care, especially if they have access to therapists who can apply evidence-based psychotherapy. For more complicated needs, specialty mental health care services (including psychiatrists, nurses and psychologists) are required and these need to be integrated with primary health care provision. Good examples of how this can be done exist. The shared-care initiative between the College of Family Physicians of Canada and the Canadian Psychiatric Association and CHEO's Project ECHO for example. Psychiatric nurses can provide specialty needs care in communities and in hospitals. Enhancing national capacity to train this currently underutilized resource should be a priority.

While aspects of the training, deployment, regulation, funding, and oversight of these providers may fall under provincial/territorial jurisdiction, the federal government can provide targeted transfer funds to support such innovations, and could provide direct funding to institutions that train such providers so additional training slots are created. This can also provide training to some international medical graduates who already reside in Canada but do not qualify for medical licensure and thus help meet the need for culturally proficient providers. Funding of robust research into the safety and efficacy of online psychological interventions can provide much needed information on what programs are the most helpful and for whom. While acting quickly on these directions will improve rapid access to quality mental health care now, this will also help mitigate the mental health impact of long COVID, a condition that may soon have substantial, and under-recognized demands on health resources

Rapid access to quality mental health care depends in great part on the availability of, and access to, appropriately trained health-care providers. Investing in enhancing the mental health-care workforce will pay dividends now, and in the years to come.

Nova Scotia Senator Stan Kutcher is a psychiatrist and member of the Independent Senators Group.

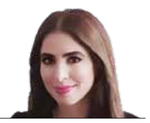
The Hill Times

No more fuel or zest left: burnout

Although not a diagnostic label, burnout can precede or increase the risk of psychological disorders such as clinical depression, anxiety disorders, substance use disorders, and/or trauma and stressor related disorders. Burnout might share similar symptoms with depression or anxiety, but it has found to be a distinct construct from depression and anxiety.

Katy Kamkar

Opinion



The World Health Organization has defined burnout as an 'occupational phenomenon.' Burnout is a work-related hazard caused by cumulative workplace stress, writes Katy Kamkar. *Image courtesy of Pixabay*

Work-related hazard

The World Health Organization has defined burnout as an "occupational phenomenon." Burnout is a work-related hazard caused by cumulative workplace stress.

It can occur when work demands exceed our personal and job resources. In turn, it leads to reduced work productivity, reduced work performance, reduced work morale, and reduced work engagement. It increases the risk for workplace conflicts, accidents and reduced work and life satisfaction.

Health risk factor

Although not a diagnostic label, burnout can precede or increase the risk of psychological disorders such as clinical depression, anxiety disorders, substance use disorders, and/or trauma and stressor related disorders. Burnout might share similar symptoms with depression or anxiety, but it has found to be a distinct construct from depression and anxiety.

Burnout is also associated with physical health problems such as diabetes, cardiovascular disease, musculoskeletal pain, headaches, and gastrointestinal problems. Thus, it is significant health risk factor that cannot be ignored.

Key features

Burnout is marked by exhaustion, depersonalization/cynicism, and reduced professional efficacy.

The exhaustion can be reflected in feeling depressed, high fatigue level and low energy, not feeling restored after sleep, lack of motivation to initiate or engage in activities, as well changes in appetite, sleep, and concentration. You might feel psychologically, emotionally, and/or physically exhausted.

Reduced professional efficacy is the reduced sense of self efficacy when you no longer feel competent or successful. You lose trust in yourself. You start doubting everything you do or the decisions you make. You no longer feel confident.

Psychosocial risks

A host of psychosocial risk factors can contribute to the development of burnout.

When workload surpasses personal or job resources and you no longer feel in control or feel you can cope. There is continuous pressure with timelines and deadlines that you feel you can no longer keep up. There is the feeling of powerlessness and helplessness, in turn, leading to feeling anxious and demoralized.

Continued on page 26

Mental health professionals experiencing burnout

With more Canadians—including health-care providers—accessing mental health services, mental health practitioners are coping with ever-increasing workloads, work demands and compassion fatigue.

Melissa Enmore

Opinion

What is the situation regarding mental health professionals experiencing burnout as increasingly large demands are placed on their services? How can we address the strain being felt by mental health-care providers?

Prior to March 2020, the mental health system in Canada was already under pressure, with one in five Canadians having a mental illness or mental health problem. One year into the pandemic, the Centre for Addiction and Mental Health noted that one-in-five Canadians reported high levels of mental distress. After two-and-a-half years of COVID-related illness and death, social isolation, quarantines, lockdowns and uncertainty, there is and continues to be an increase in the uptake of mental health-care services in Canada.

However, the COVID-19 pandemic also posed unique challenges for health-care providers, who are now struggling with their own mental health. The recent Canadian Medical Association's national physician health survey noted that 53 per cent of physician respondents were experiencing burnout, one-quarter were experiencing severe or moderate anxiety, and almost half were struggling with depression, with many doctors reporting poorer mental health than before the pandemic. The pandemic, coupled with related staffing shortages throughout the Canadian health-care system, is resulting in higher levels of stress and anxiety for health-care providers, including mental health-care professionals.

With more Canadians—including health-care providers—accessing mental health services, mental health practitioners are coping with ever-increasing workloads, work demands and compassion fatigue. They are challenged to come up with effective strategies to help address the concerns of the different population groups they serve, as well as to stay current with the resources that can help their patients, all of which are contributing to caregiver burnout. This can have significant impacts to Canada's mental health system, weakening the system over time.

In efforts to address the strain being felt by front-line health-care providers, the Canadian Psychological Association (CPA) is calling for psychologists registered to practise in Canada to donate some of their time to provide psychological services to these front-line health-care providers? Who may be feeling stressed, overwhelmed or distressed by being on the front lines of the COVID-19 health crisis. But what about the mental health-care providers, who will care for them?

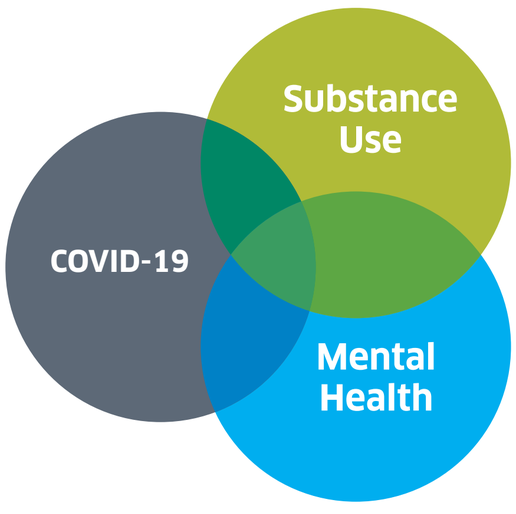
Mental health professionals need to be intentional about practising what they preach. They need to take care of themselves by establishing boundaries (establishing work-life balance), practising self-care, leaning on their own support systems including their families, friends, and colleagues, and reaching out for help and support when needed.

Virtual and online mental health care are innovative ways of more conveniently engaging with patients, yielding similar results as in-person visits, and allowing mental health-care professionals to have more work-life balance. Although it was under-utilized by both patients and mental health professionals prior to the pandemic, tele-health, tele-psychiatry and virtual care are options that more mental health professionals should explore in efforts to address burnout.

Students, new graduates and internationally trained mental health professionals can also play a role in preventing burnout among Canadian mental health professionals. Doctoral students or psychologists in the process of licensure can help to reduce the workload of their supervisors by providing certain services under the supervision of their registered supervisor in each respective jurisdiction. Current mental health professionals can begin filling the mental health pipeline with students and new graduates.

Melissa Enmore is a psychology doctoral student at California Southern University and principal consultant at ME-Consulting Inc., where she works as a consultant with the Government of Manitoba's Mental Health and Community Wellness branch.

The Hill Times



MENTAL HEALTH AND SUBSTANCE USE DURING COVID-19

Mental health and substance use concerns remained elevated in all regions, throughout each wave of the pandemic.

35% Almost 35% of survey respondents reported moderate to severe mental health concerns.

25% About 25% of respondents who used alcohol or cannabis reported problematic use.

The proportion of people accessing mental health and substance use services remained low.

Fewer than **1 in 3 people** with mental health concerns accessed mental health services.

Fewer than **1 in 4 people** with problematic alcohol or cannabis use accessed substance use services.

Mental Health Commission of Canada

www.mentalhealthcommission.ca

Canadian Centre on Substance Use and Addiction

Evidence. Engagement. Impact.

www.ccsa.ca

According to recent surveys conducted by Leger on behalf of the Canadian Centre on Substance Use and Addiction and the Mental Health Commission of Canada, many Canadians still report significant mental health and substance use concerns more than two years into the COVID-19 pandemic.

Minister of Mental Health and Addictions Carolyn Bennett's mandate letter calls for a 'permanent, ongoing Canada Mental Health Transfer to help expand the delivery of high-quality, accessible and free mental health services, including for prevention and treatment.' *The Hill Times photograph by Andrew Meade*

We need to uphold the Canada Health Act

I urge the federal government to follow through on the establishment of a Canada Mental Health Transfer. To ensure it is as impactful as possible, 30 per cent of transfer payments should be allocated towards ensuring timely and equitable access to mental health care for those under the age of 25.

Mark Feldman

Opinion

Last week, as the 101st president of the Canadian Paediatric Society, I chaired a meeting of the presidents of the provincial paediatric societies of Canada. This roundtable of practising paediatricians charged with representing the views of their colleagues and speaking out on crucial child health issues had one clear focus—paediatric mental health.

Without exception, the No. 1 health-care issue identified in each province was the staggering gap between the need for, and the equitable availability of quality, affordable, and accessible mental health care for children and youth.

Unfortunately, this health-care gap existed long before the pandemic and will continue to exist long after unless we do something about it now. Privatization is clearly not the solution. Countries with two-tiered systems, such as the United States, are ranked very poorly when it comes to preventable mortality rates and other measures of a country's health.

In 1985, the Canada Health Act (CHA) was created to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

Statistics from the Mental Health Commission of Canada indicate that 1.2 million Canadian children and youth (that we know of) are suffering with mental health disease. Of these, 80 per cent are languishing without equitable and timely access to care. The result is eroded well-being, unnecessary suffering, and at times even death.

The cost of evidence-based, cognitive behavioural therapy for anxiety and depression is not covered by provincial health insurance plans. Psycho-educational assessments conducted by psychologists for children with developmental or learning problems are only partially covered, with some school funding, in some provinces. Wait-lists for this type of testing typically exceed one to two years.

The CHA has never fully been enacted. Whether a young person has access to the mental health care they need is too often determined by whether their guardians have private insurance or the means to pay for it out of pocket. When class barriers intersect with racial barriers, the challenges are only compounded.

Even for publicly insured mental health care services, there are dangerously long wait-lists. This summer, I had the opportunity to speak with some MPs in my capacity as CPS president. I told them that the children and youth with mental health concerns who are referred to me in Toronto are typically put on a six-month wait-list, despite my feverish work to shorten it. One MP (who happens to be a family doctor) said I was lucky, and that wait-lists in his province are often a full year.

The 2021 Speech from the Throne and subsequent mandate letter of Minister of Mental Health and Addictions Carolyn Bennett, mandated a "permanent, ongoing Canada Mental Health Transfer to help expand the delivery of high-quality, accessible and free mental health services, including for prevention and treatment."

The establishment of a mental health transfer presents an important opportunity to fully enact and uphold the values of the CHA when it comes to mental health care. With adequate and reliable funding, evidence-based mental health diagnostic and treatment services can be scaled up, competencies in paediatric mental health care can be strengthened, wait-lists can be shortened, and, most importantly, we can reduce the number of youth reaching a point of crisis.

I urge the federal government to follow through on the establishment of a Canada Mental Health Transfer. To ensure it is as impactful as possible, 30 per cent of transfer payments should be allocated towards ensuring timely and equitable access to mental health care for those under the age of 25. This would recognize their significant need, the unique barriers to accessing mental health care for children and adolescents, the importance of receiving timely care at a young age for life-long health and well-being, and the proportion youth represent within the Canadian population.

With this targeted funding, the provinces and territories should:

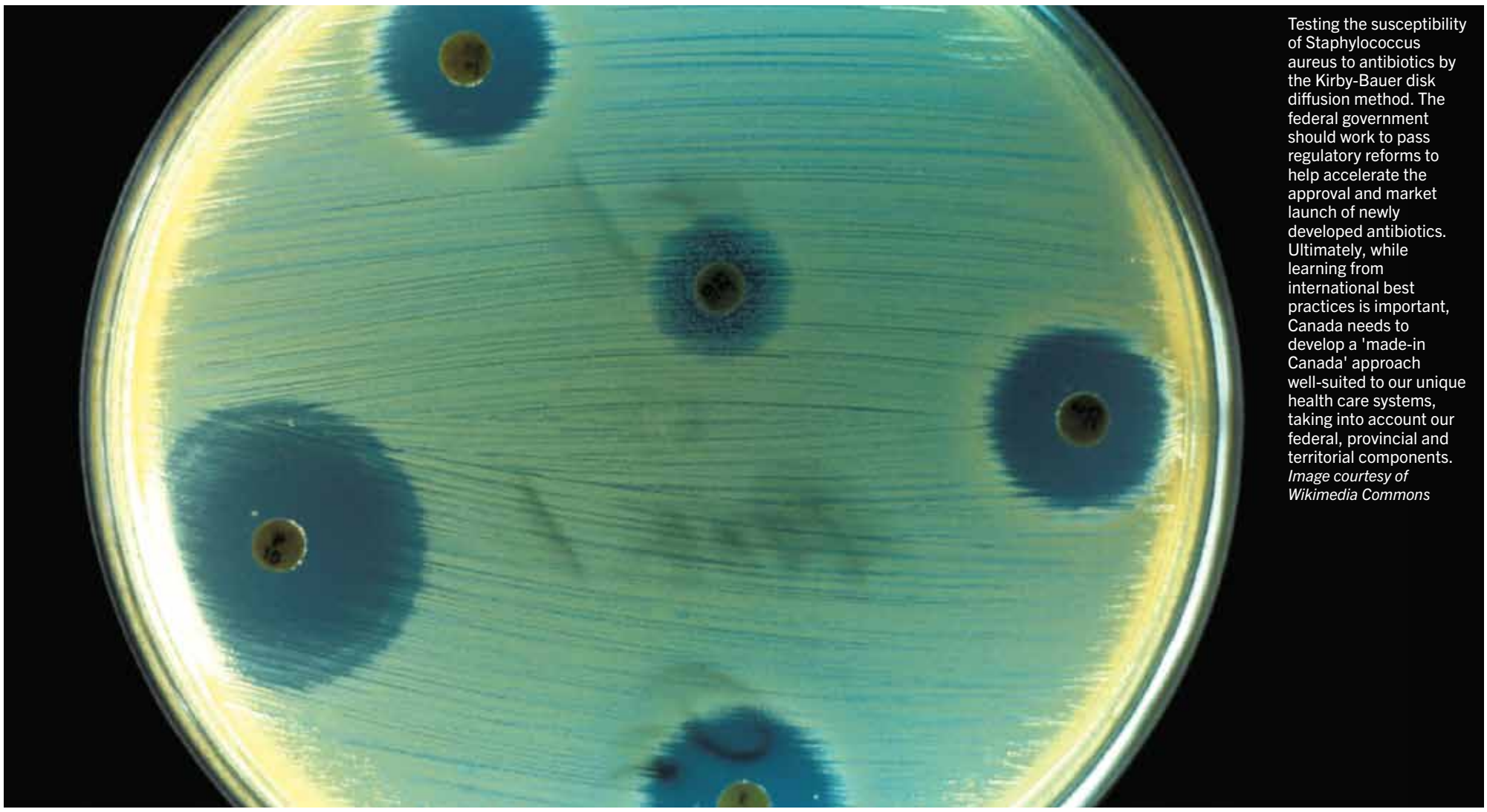
- Ensure assessments by psychologists, and evidence-based cognitive behavioural therapies delivered by psychologists, or by other non-physician mental health care practitioners are publicly funded and regulated;
- Expand the youth-hub model of mental health care delivery, in which the physician is part of a team of non-physician mental health care providers;
- Ensure multidisciplinary mental health care educational tools and navigational resources are available to all those who care for the mental health and well-being of children and youth;
- Fund additional training opportunities (such as 'plus-one', year-long extensions) for family medicine and paediatric trainees to acquire advanced mental health care skills without doing an entire training program in psychiatry;
- Support additional mental health care training programs (such as CanREACH) for practicing general practitioners to upscale and strengthen skills.

Now is the time to fully enact the CHA and ensure that the longstanding mental health care access gap is finally bridged.

Mark Feldman is a professor, department of paediatric, and director of continuing education and community paediatrics at the University of Toronto. He's also a paediatrician at the SickKids Hospital in Toronto and Point-In-Time Youth Hub in Haliburton, Ont. He is also the president of the Canadian Paediatric Society.

The Hill Times

Canada must renew leadership on antimicrobial resistance



Testing the susceptibility of Staphylococcus aureus to antibiotics by the Kirby-Bauer disk diffusion method. The federal government should work to pass regulatory reforms to help accelerate the approval and market launch of newly developed antibiotics. Ultimately, while learning from international best practices is important, Canada needs to develop a 'made-in Canada' approach well-suited to our unique health care systems, taking into account our federal, provincial and territorial components. *Image courtesy of Wikimedia Commons*

AMR is rendering the global antibiotic arsenal ineffective. Left unchecked, it will lead to the collapse of Canadian health systems. Without a final national action plan, Canada will remain ill-prepared to combat this growing threat.

Dani Peters, Pamela Fralick, & Michael Hodin

Opinion

Antimicrobial resistance poses a dire threat not only to the future of public health, but also to the economic prosperity of Canada and the entire world.

Just before COVID-19 hit, the Public Health Agency of Canada sponsored a first-ever national-level study on the socio-economic impact of antimicrobial resistant bacteria, fungi, and other pathogens. The results were alarming. It found that antimicrobial resistance (AMR) already costs us around $3.4-billion each year—an annual toll that could grow to $44-billion by 2050.

And while bacterial resistance to existing antibiotics is steadily increasing, the pipeline for new antibiotics is drying up. Why? There's little incentive to take on the billion-dollar costs of developing new antibiotics.

In fact, across the world, a new class of antibiotics has not been approved in 35 years. Yet current antibiotics are no longer as effective in beating infection as they once were. It is estimated that over 25 per cent of bacterial infections are resistant to first-line antibiotics. According to a new *Lancet* report, AMR kills 1.27 million people worldwide every year; by 2050, this number could be as high as 10 million. Looking ahead, AMR is poised to drain as much as 3.8 per cent of global annual GDP.

Aware of these challenges, our policymakers since 2017 have been planning a robust AMR strategy based on four pillars: Infection Prevention and Control; Stewardship; Surveillance; and Research and Innovation.

The government of Canada has taken numerous other positive steps, but the final consultation on a draft National Action Plan initially scheduled for February 2020 was understandably delayed as our policymakers shifted to COVID-19 response. The delay has been costly, however. A new U.S. Centers for Disease Control report, for example, found that the pandemic in the United States has reversed progress made in combating AMR—and the same is likely true in our country.

In fact, according to the AMR Preparedness Index, Canada ranks lower than its peers in preparing a national strategy for AMR. Thankfully, experts have already identified promising approaches to fighting AMR. We just need to commit to and implement them.

For example, the Public Health Agency of Canada should lead in coordinating AMR efforts across Canada's provincial health systems to avoid over-usage of antibiotics and to encourage vaccinations, which can help avoid the need for antibiotics in the first place.

Ottawa should also collaborate with domestic and international stakeholders in developing economic incentives to revive the pipeline of new antibiotics. Over the past several years, other countries in the G7 and G20—including the United Kingdom, United States, France, Germany, Japan, and Sweden—have explored policies to help incentivize the research and development of new antibiotics. In 2021, the G7 finance ministers committed to partnering with industry leaders to explore "a range of market incentive options"—especially "pull" incentives that encourage firms to invest in new antibiotics, even if they'll only be prescribed in low volumes—along with pilot projects exploring new financial and regulatory structures.

Canadian policy-makers should fully embrace this multilateral effort. The federal government should work to pass regulatory reforms to help accelerate the approval and market launch of newly developed antibiotics. Ultimately, while learning from international best practices is important, Canada needs to develop a "made-in-Canada" approach well-suited to our unique health care systems, taking into account our federal, provincial and territorial components.

To support the development and implementation of incentive policies, it will be crucial to prioritize physician education, public health guidance, and public awareness, which requires additional resources and should be updated with a greater focus on AMR and antimicrobial stewardship. This will help reduce the unnecessary or inappropriate prescription of antibiotics, extending the effectiveness of current treatments. These efforts are especially critical in the wake of a COVID-caused spike in antibiotics usage.

AMR is rendering the global antibiotic arsenal ineffective. Left unchecked, it will lead to the collapse of Canadian health systems. Without a final national action plan, Canada will remain ill-prepared to combat this growing threat.

Now is the time for Canada to renew its vision for leadership toward a future that can far more effectively manage the AMR threat we have today.

Dani Peters is senior adviser to the Canadian Antimicrobial Innovation Coalition. Pamela Fralick is president of Innovative Medicines Canada. Michael Hodin, PhD, is CEO of the Global Coalition on Aging.

The Hill Times

Mental Health Policy Briefing

Mental health is health: it's time we act like it

No more rhetoric. We need urgent action from the federal government now to ensure no one who needs mental health and substance use care and support is left out or left behind.

Paul-Émile Cloutier

Opinion

The availability and accessibility of mental health and substance use services across Canada was severely limited before COVID, but the pandemic has been the equivalent of pouring gasoline on a fire. Mental health needs have exploded during the pandemic, a situation that requires urgent action by the federal government.

Prior to COVID, children could wait up to two and a half years for mental health care in Ontario and adults in Canada could wait up to several months. The average wait time for adult residential substance use treatment is 100 days in Ontario. Wait times for supportive housing can be up to five years in major cities.

The pandemic has hit people with pre-existing mental health and substance use conditions, those with low incomes, the unemployed, youth, and women with younger children particularly hard. There are also higher rates of suicidal ideation among Black and other ethno-racialized groups.

Those working on the front lines of care are not immune. Nearly 87 per cent of health-care workers indicated that they felt more stressed at work during the pandemic, according to data released by Statistics Canada in June 2022. Even before COVID-19, health-care workers were suffering from stress, depression, anxiety, burnout and increased risk of suicide.

Demand for mental health services continues to increase and while it is now well-established that mental health is equally as important as physical health—that mental health is health—we have a long way to go when it comes to providing adequate access to mental health programs and care.

Even though Canadian health-care and health research institutions continue to make tremendous strides in improving mental health care and support programs, those dedicated efforts must be matched by similar commitment from the federal government. That action must include introducing mental health parity legislation guaranteeing timely access to quality, inclusive mental health and substance use care for everyone in Canada.

The guarantee of timely access to quality, inclusive mental health and substance use care across the country Canada will ensure greater and more equitable access to a wide range of publicly funded mental health and substance use services. This will extend beyond the current publicly subsidized services provided in hospital and by physicians.

Finance Minister Chrystia Freeland, pictured. In its platform for the 2021 election, the Liberals committed to permanent, ongoing funding for mental health services under the Canada Mental Health Transfer. It is vital that this money be included in the 2023 federal budget. *The Hill Times photograph by Andrew Meade*

The Liberal government has recognized the importance of the issue. In its platform for the 2021 election, they committed to establishing permanent, ongoing funding for mental health services under the Canada Mental Health Transfer, with an initial investment of $4.5-billion over five years. It is vital that this money be included in the federal government's 2023 budget.

In addition to the need for enhanced access to services, the pandemic also highlighted the need for more affordable and supported housing across Canada, where the federal government could collaborate with provinces and territories to develop an accountability-based funding model for affordable and supported housing.

Supportive housing combines affordable housing and support staff and allows some people dealing with mental illness and substance use concerns to live in the community. Such an approach follows the "right care, in the right place" approach and has proven to lead to with improved health outcomes and reduced use of acute health and emergency services.

A clear funding model developed in collaboration with provinces and territories would facilitate a full array of affordable and supportive housing. It would help create a standardized model across Canada, leverage existing not-for-profit housing development organizations, and support the spread and scale of proven approaches. Most importantly, it would enhance appropriate care being provided at the appropriate time and in the right place.

Enhancing supportive housing would also help reduce the number of patients in acute care hospitals who would be better cared for elsewhere and should not be in hospital, a key factor in Canada's nation-wide emergency care access crisis.

It is heartening to see more awareness and support growing concerning the need to improve access to mental health services and substance use supports across Canada, but awareness of the issues only goes so far. No more rhetoric. We need urgent action from the federal government now to ensure no one who needs mental health and substance use care and support is left out or left behind.

Paul-Émile Cloutier is president & CEO of HealthCareCAN which is the national voice of health-care and health research institutes in Canada.

The Hill Times

Here are some changes that could help turn around the mental health crisis in Canada

Many public health restrictions have eased in communities across Canada. Is there a light at the end of the tunnel where we may see reduced pandemic-related stress, or is the mental health crisis enduring?

Shimi Kang

Opinion

VANCOUVER—The last two years have stressed individuals, institutions, and our communities like never before. As 2022 draws to a close, public health restrictions are easing across Canada, and it feels like the COVID-19 pandemic may be behind us. Still, the question remains, "what will this new normal look like and can we just go back to normal?"

Yes, there will be lasting effects and changes. Many of these changes are necessary. Mental health was a significant topic of concern throughout the pandemic, but it was an issue long before 2020.

The pandemic acted as a catalyst, shining a light on numerous gaps in mental health services around the globe and within Canada. Front-line workers are facing burnout, insomnia, and extreme stress, reducing their ability to care for others. Youth have reported higher levels of depression, anxiety, and Post-Traumatic Stress Disorder. Symptoms of depression have grown from two per cent of the reported population before the pandemic to 14 per cent.

The pandemic disproportionately impacted the mental health of people of colour. The anti-Asian violence that we witnessed throughout the COVID-19 pandemic will have lasting effects on mental health for many. Data shows that Black, Asian, and Indigenous communities were more harshly impacted by the effects of COVID, both physically and mentally.

All these numbers mean it's time to pay attention and take action.

These statistics are scary. It's true. However, the COVID-19 pandemic may ultimately be the push we need for change. In fact, it appears positive change may already be underway. There is a growing destigmatization of mental health subjects. For example, in 2022, there were five million more interactions during #BellLetsTalk day than the previous year.

The current Canadian government also made promises during their last election campaign for an increase in funding for mental health services. Some of this funding is already starting to be seen. There are 57 distress centres in Canada that will receive additional funding. However, it's not enough to just have mental health services available. People are actually using them too. The use of tele-health services was up 40 per cent in 2021.

A shift in how we approach work is also taking place. There is a greater focus on a work-life balance and more opportunities for flexible working hours or remote positions. When utilized well, these changes allow people to reduce their stress, spend time with family, and seek out mental health help when necessary, thanks to a flexible schedule and improved benefits plans.

A significant issue is that many people lack health coverage for mental health services. Currently, there are more mental health-care providers available which means shorter wait-times to speak to someone, but not enough people are taking advantage of these shorter wait-times. Moving forward, mental health needs to be prioritized as a form of health care covered within Canada to make it accessible and affordable.

Virtual and tele-health options allow mental health services to be readily available and more affordable for individuals and communities in need. More practitioners and patients would benefit from finding ways to incorporate technology into their services.

Diversifying the mental health workforce is essential. It's crucial that patients have access to help from someone who can understand their socio-economic situation or how their experiences are impacted by their race, gender, or orientation.

Resiliency skills should be the focus when educating today's youth in our school system. Helping youth develop crucial resiliency skills for dealing with times of uncertainty and stress is essential and can begin in the early years. As more young people struggle to regain their footing after two years of missed academics and social development with peers, it's important that we focus on mental health resources for the young.

These changes could help turn the mental health crisis in Canada around. It's true that we can see some light at the end of the tunnel, but there is still much work to be done. Lastly, and of utmost importance, we all need to be aware of our own mental health and look at creative ways to empower others through professional, personal, and educational channels.

Dr. Shimi Kang is a clinical assistant professor in the department of psychiatry at the University of British Columbia.

The Hill Times

Time to invest in mental health treatments that work

Universal mental health coverage would give Canadians access to the health care services they need, when and where they need them, without financial hardship.

Melanie Badali

Opinion

Mental Health and Addictions Minister Carolyn Bennett, pictured on Oct. 26, 2021, after being sworn in to the cabinet post. With more demand for mental health care services than resources available, we have to be clear about our strategic priorities, writes Melanie Badali. *The Hill Times photograph by Andrew Meade*

With a mental health crisis growing in the shadows of COVID-19 and a health-care system on the brink of collapse, we need to make every dollar invested in mental health care count.

The World Health Organization has already made solid human rights, epidemiological, and economic arguments for universal mental health coverage. If helping to reduce human suffering for millions of people isn't enough of a reason, recent research published in the *Lancet Psychiatry Journal* showed that the return on investment in treatments for anxiety and depression can lead to a fourfold economic return in terms of better health and ability to work.

The question of if we should fund mental health care has been answered over and over again. The clear answer is yes.

It is time to move on to the question of how we should fund mental health. With more demand for mental health care services than resources available, we have to be clear about our strategic priorities to realize a vision of universal health coverage.

So what is universal health coverage anyway?

Simply put, universal mental health coverage would give Canadians access to the health care services they need, when and where they need them, without financial hardship.

Universal health coverage includes universal access as a key component. Since the pandemic began, the government has been investing in initiatives to increase access.

Universal access has three dimensions. First, physical accessibility involves the availability of services in terms of location, timing, and modalities. Second, financial affordability means that people can access the services without financial risk. Third, acceptability relates to people's willingness to seek services. All of these factors are necessary but not sufficient for solving Canadians' mental health care woes.

Good health care is not just about providing access to services—it is about providing access to services that actually help people.

The not-so-secret ingredient of universal mental health coverage is having effective interventions.

Ideally, interventions offered to people have been proven to be effective in real-world conditions, or at least demonstrate efficacy under ideal and controlled circumstances

When it comes to funding mental health services, science-backed effective interventions should be a main ingredient.

Good recipes include not only lists of ingredients, but also steps for making the recipe. Sometimes omitting an ingredient or missing a step is no big deal. Other times, the final product is not worth the cost of ingredients and time. If really poorly executed, the very meal meant to nourish your health could even make you sick.

Taxpayers don't want to fund an undercooked turkey of a mental health service.

Since the COVID-19 pandemic began, the federal government has launched resources to help Canadians access that it says are "immediate, free, and confidential mental health substance use supports," avaialble 24 hours a day, seven days a week. Free, immediate, support. Sounds accessible and amazing, right?

To be sure, it is a great idea. But word on the street is these new services are unhelpful for many people. What does the data show? Are people actually getting treatment that works for them? Or are these new services largely conduits to existing care that may or may not be there? Are people being directed to family doctors that they don't have or emergency rooms that are past capacity?

Band-Aid and revolving-door mental health care solutions only cost more in the long run. Spending money on services that are easy to access but have questionable effectiveness is something we can't afford. Services funded by taxpayer money must provide data to the public to ensure that such expenditures don't end up as portals to nothing.

Strategic investment in mental health care has the power to improve quality of life as well as pay for itself. Or, if done optimally, it could save money in terms of cost offsets related to lost work and other health care. It is time to invest in robust, effective interventions for mental illness.

Dr. Melanie Badali is an award-winning clinical psychologist with over 20 years of experience as a clinician, researcher, educator, and mental health advocate. She currently works at the North Shore Stress and Anxiety Clinic in British Columbia and volunteers as a Scientific Advisor for Anxiety Canada.

The Hill Times

Canada does not fund mental health care and we are all paying for it

A 2022 Angus Reid Institute and University of Ottawa nationwide survey found the mental health needs of Canadians to be even more dire than we had imagined.

Monnica Williams

Opinion

In 2018, Statistics Canada found that 5.3 million Canadians needed mental health services. *Photograph courtesy of Pexels/Daniel Reche*

One in five Canadians will experience a mental health problem in any given year, and half of them will have experienced a diagnosable mental illness by the time they reach 40 years of age. In 2018, Statistics Canada found that 5.3 million Canadians needed mental health services. Although two-fifths of these (three million) had their needs fully met, another fifth (1.2 million) had their needs only partially met, and a staggering 1.7 million people were left with their needs entirely unmet. This situation has only worsened since the COVID-19 pandemic.

In partnership with the Angus Reid Institute, my University of Ottawa research group conducted its own nationwide survey earlier this year and found the needs to be even more dire than we had imagined. Over half of the 1,500 respondents had sought out mental health care but experienced barriers to access. The most common difficulties were largely structural: long waitlists (62 per cent), financial barriers (58 per cent), lack of resources/professionals in the area (47 per cent), difficulty finding specialists (41 per cent), and difficulty accessing in-person care during the pandemic (34 per cent). Many did not realize how long wait-times were until they needed care for themselves or their loved ones. Delaying care for weeks or months when someone is in crisis is inhumane and medically unsound.

We further examined the experiences of more vulnerable groups. People of colour (visible minorities and Indigenous people) had more difficulty accessing care, as did younger adults and those with lower income. Race and ethnicity were related to difficulties as many could not find a clinician of the same ethnic group (25 per cent of Black respondents), someone who spoke their preferred language (22 per cent of South Asian respondents), or they had had prior negative experiences (50 per cent of Indigenous respondents). So, although Canadians from all sectors face difficulty finding care, for the most marginalized, difficulties are compounded.

Provincial health plans do not cover mental health care until a patient's problems become so severe that intensive or inpatient care is needed. However, early outpatient therapy can prevent many of the crises that bring patients to emergency rooms, where last-resort care is the most expensive.

There has been resistance to the idea of spending more taxpayer dollars on health care, given the perceived tax burden already borne by so many Canadians, even if theoretically it will save money in the long run. There are viable models for providing mental health care without increasing costs, but there has not been enough push for implementation. Given the amount of taxes that Canadians already pay, it is hard to understand why so many barriers occur at every level: from finding a family doctor, to having a broken arm set, to getting an MRI. Not to mention that unmet medical needs are stressful and can exacerbate mental health concerns.

Canadians generally believe the United States, our closest neighbour, has a problematic health-care system that leaves the most critically ill unserved. This misperception has created widespread complacency in Canadian consumers,

Continued on page 28

For mental health, talk and walk are not the same thing

Now is the time for the federal government to deliver on its commitment by introducing a Canada Mental Health Transfer as part of the federal government's 2023 budget.

Kim Hollihan, Ellen Cohen, & Glenn Brimacombe

Opinion

The Liberal government promised to create a Canada Mental Health Transfer with an initial investment of $4.5-billion over five years beginning in 2022, but the transfer was not included in Finance Minister Chrystia Freeland's 2022 budget. *The Hill Times photograph by Andrew Meade*

In politics, those who seek our vote talk a lot about what they will do if elected or point to what they have accomplished in terms of getting things done. Both are important as one speaks to the talk of tomorrow, and the other to the walk of yesterday.

In the lead up to and since the 2021 federal election, we saw history in the making with all political parties committed to investing in mental health. This was particularly timely knowing that the COVID-19 global pandemic was, and still is, impacting our collective mental health and substance use health. Clearly, more must be done to ensure that the people of Canada have timely, accessible, and inclusive access to publicly funded mental health programs, services, and supports.

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) strongly applauded the long-overdue talk of such access to mental health and substance use health care has existed largely in the shadows of medicare. For too long, mental health and substance use health programs, services and supports provided by psychologists, social workers, psychotherapists, counselling therapists, and counsellors have not been covered by provincial and territorial health plans. This must change.

Importantly, the Liberal government promised to create a Canada Mental Health Transfer with an initial investment of $4.5-billion over five years beginning in 2022. This was viewed as an important down payment which built on the 2017 10-year agreements with the provinces and territories that set aside $5-billion for mental health and talk, the walk has yet to follow as the transfer was not contained in Budget 2022.

In CAMIMH's view, there can be no health without mental health. Now is the time for the federal government to walk the talk and deliver on its commitment by introducing a Canada Mental Health Transfer as part of Budget 2023.

Such ongoing funding must be tied to appropriate accountabilities (such as national standards, system performance indicators, and guiding principles) which are set out in CAMIMH's proposed piece of legislation called the *Mental Health and Substance Use Health Care For All Parity Act*.

By investing in our mental health, we will provide the people of Canada with expanded as well as reap a number of social and economic dividends that will allow this great country to continue to prosper and flourish.

Notwithstanding the importance of the federal commitment, we know there is much more that the provinces and territories can do to invest in and expand access to mental health and substance use health care. While several are actively implementing innovative models of care at the community-based and primary care level, CAMIMH strongly supports the Royal Society of Canada's recommendation that a minimum of 12 per cent of government health budgets be devoted to mental health and substance use health care.

At the same time, given the results from the recent released 2022 Benefits Canada survey, we also know that employers can do much more in terms of providing their employees with better coverage for mental health and substance use health care programs, services and supports.

As we continue to do all that we can to ensure our families and friends and society-at-large are safe and well, COVID-19 has had—and continues to have—a significant impact on our collective mental health and substance use health. As we emerge from the pandemic, the people of Canada will need improved connections to more accessible and inclusive mental health and substance use health programs, services, and supports—not less.

Each day that passes deepens the impact of COVID-19 on those who need care and continues to hurt those with a pre-existing mental health and/or substance use health problems who are in the queue. Bigger and bolder leadership from the federal government, working in collaboration with the provinces and territories, is needed now—not in 12 months time or beyond.

Given the composition of CAMIMH—which includes organizations representing people with lived and living experience, their families and caregivers, and health care providers—we stand ready to work with all levels of governments, employers, and others to make this a reality.

Our mental health matters. The time for talk is over. It is time to walk together.

Dr. Kim Hollihan (EdD) is co-chair of CAMIMH and CEO of the Canadian Counselling and Psychotherapy Association. Ellen Cohen is co-chair of CAMIMH and CEO of the National Network for Mental Health, which advocates, educates and offers expertise and resources to increase the health and well-being of Canadians with lived and living experience. Glenn Brimacombe is CAMIMH chair of the public affairs committee, and director of policy and public affairs at the Canadian Psychological Association, and past CEO of two National Health Associations.

The Hill Times

No more fuel or zest left: burnout

Continued from page 20

Long working hours and not feeling there is time to take a break to recharge batteries. You cannot sleep or rest properly.

Individual interventions

There is a tendency to use maladaptive coping when we face excessive workload and job strains, which in turn, lead to more stress, exhaustion and negative health outcomes. Thus, setting your own individualized pathway to self care and resiliency is essential.

Attending programs and workshops on stress management and mindfulness can be helpful.

Take a proactive personality approach by changing your circumstances, physical or social environments. Be open to opportunities, set realistic goals, seek support, and reach out to maximize your resources. You might have to seek guidance in regards to your work tasks, work responsibilities and demands. At times, a change in work hours or setting limits can become helpful.

Practice emotional intelligence by identifying your emotions and strategies for better managing and regulating them. When we have emotional intelligence, we feel more tuned in to our own emotions and fatigue level and we are better tuned to others' emotions as well. In turn, we become more proactive in setting goals, seeing support, and making changes needed to better address the problems we are facing.

Set time to recover when you are off work: engage in activities or hobbies, minimize talking about work, try to rest and set time to recharge your batteries when not working.

Practise self-efficacy by breaking down tasks, practising one task at a time, praising yourself when the job is completed (no matter how small) and then gradually mastering more tasks.

Seek professional help if needed. Evidence-based cognitive behavioural therapy can help with getting support, learning skills, and strategies for better coping.

Organizational interventions

Provide resources and help for employees to better manage any clinical symptoms they might be experiencing and to optimize health. It can help towards minimizing presenteeism and absenteeism and reducing relapse related to mental health disability.

Provide leadership training on mental health, empathy in the workplace, and support returning to work after a leave of absence or disability. Help your staff to enhance work autonomy, foster supportive relationships with supervisors, encourage employee participation in work tasks and decisions; and nurture professional worthiness by providing recognition and appreciation.

Dr. Katy Kamkar is a clinical psychologist.

The Hill Times

‘I’m the interim leader of a federal political party and I’m still thinking about killing myself’: Amita Kuttner

Continued from page 18

stand it anymore or because I needed people to understand what it was that I was feeling and felt that I had no other way of expressing it.”

“The worst of it was that I remember—when I was in my mid-20s—being at my Dad’s apartment and gripping the edge of my bed because I would put myself in a dangerous situation,” said Kuttner, who was able to struggle through his life’s stresses and obtain a PhD from the University of California, Santa Cruz, in astronomy and astrophysics, specializing in the study of black holes.

“Look at the positon I’m in now. I’m the interim leader of a federal political party and I’m still thinking about killing myself,” he said.

“We hide these things because we’ve been taught that it’s shameful to admit it. But to me, it’s just part of my life. Obviously it’s an impediment, but isn’t unusual for me to experience it. I just have gotten a lot less intense once I’ve figured out how to get myself out of situations, and have done cognitive behavioural therapy on how to prepare me for situations that will get me to into that space,” Kuttner said.

Kuttner said he worries about those in a similar situation, without the “privileges and support network” that he has, and believes the federal government can step up and help them.

“We’re missing an understanding of the mental health of the entire population,” said Kuttner. “We’re also looking at a worsening crisis where you see the symptoms—such as in the opioid crisis—but not looking at the underlying causes or solutions to it.”

Kuttner is calling on the federal government to implement a national strategy to both tackle the “immediate acute needs” and “figure out how to systemically address everything else causing this.”

New Democrat Member of Parliament Gord Johns (Courtenay-Alberni, B.C.), who serves as his party’s critic for mental health and harm reduction, tabled a motion on Sept. 15 in the House of Commons on the mental health and substance abuse crisis in the country that “has been exacerbated by the COVID-19 pandemic” and that has left “too many Canadians” unable to access “supports in a timely manner,” which in turn has “increase[d] demands on hospital emergency rooms and primary care providers,” resulting in “untreated or inadequately treated mental illness carr[ying] significant social and economic costs.”

Motion M-67 calls on the federal government to, “without delay, develop legislation that will enshrine in law parity between physical and mental health in Canada’s universal public healthcare system, ensure timely access to evidence-based, culturally appropriate, publicly funded mental health and substance use services beyond hospital and physician settings, recognize the importance of investing in the social determinants of health, mental health promotion, and mental illness prevention, and include national performance standards and accountabilities for mental health and substance use services.”

Johns’ motion, seconded by his B.C. NDP colleague and deputy critic for mental health Lisa Marie Barron (Nanaimo-Ladysmith, B.C.), also wants Prime Minister Justin Trudeau’s (Papineau, Que.) government to establish the “Canada Mental Health Transfer,” promised by the Liberals in the 2021 federal election campaign along with their commitment to provide an initial investment of $4.5-billion over five years.

Johns flagged that promise of a transfer in the House on Sept. 22.

“When the government announced its intention to establish a $10-a-day childcare program [in the 2021 federal budget], there were deals with all the provinces and territories in place within a year,” he said.

“Meanwhile, [funding for] the Canada mental health transfer was nowhere to be found in the 2022 budget, and there has been no transparency on when this much-needed investment will be made.”

Liberal MP Élisabeth Brière (Sherbrooke, Que.), parliamentary secretary to Carolyn Bennett (Toronto-St. Paul’s, Ont.), the minister of mental health and addictions and associate minister of health, said in response that the federal government remains committed to that transfer, and noted that Bennett “has also undertaken extensive stakeholder outreach to gather views to inform the development of a comprehensive and evidence-based mental health plan,” which she said, would “also inform the development of the mental health transfer [that] will be established with the benefit of input from the ongoing provincial, territorial and stakeholder engagement.”

In an interview, Johns said that “we need parity with mental and physical health.”

He said that in Ontario alone, Children’s Mental Health Ontario has reported that more than 28,000 children are on waitlists for community-based mental health services that can range from 67 days to more than two-and-a-half years depending on the service, “exceeding clinically appropriate wait-times.”

“A quarter of hospitalizations across Canada for people aged five to 24 were for mental-health issues,” said Johns, adding that “almost one in 10 Canadians who visited emergency rooms for mental health or substance use issues do so at least four times a year and are four times more likely to live in low-income neighbourhoods,” according to data from the Canadian Institute for Health Information.

He also noted that the mental health transfer is the first objective cited in Bennett’s mandate letter from Prime Minister Trudeau.

“We all know somebody struggling with their mental health,” said Johns, who cited statistics from the Canadian Mental Health Association. “One in five Canadians are dealing with mental-health issues, and 50 per cent of those people experience mental illness by the age of 40. It’s a crisis, especially as our country comes to grips with the impact of COVID-19.”

“Managing mental-health concerns often falls on family doctors, most of whom don’t have or might not have the resources or the time needed to treat those patients. And meanwhile, there are about five million Canadians who don’t even have a family doctor.”

The College of Family Physicians of Canada and the Canadian Psychiatric Association have developed a “Shared Care” program, which provides support and ongoing training for primary-care physicians with psychiatrists. “It’s a very, very effective model, but it suffers from scale-up across the country and substantive funding to make it effective” in practice and that’s where the federal government could be involved in collaboration with the provinces and territories, according to Nova Scotia Senator Stan Kutcher, a member of the Independent Senators Group and a psychiatrist by profession.

“The federal government has a role to play in helping develop pan-Canadian health human resources that have the capacity to provide good mental-health care within existing healthcare systems,” Kutcher said.

But adopting nationwide strategies comes with challenges, such as in addressing the opioid crisis, as Kutcher explained.

“This is a tough nut to crack,” he said. “We have a drug supply which is contaminated. We have some models that show promise in terms of helping, but there are differences of opinion politically, across provinces and territories, about how much of those models should be put into place. We have the issue around decriminalization of small amounts of drugs, which I think is a step forward, but which by itself won’t solve the problem.”

“Getting unanimity across the country on what the optimal ways are to address this has proven to be quite difficult,” Kutcher said.

Meanwhile, he said he believes that the pandemic has revealed that Canada has “a paucity of reliable, robust mental-health data across the country.”

“We need better population-level mental-health data and better sharing of administrative data across the country about who’s delivering what service to whom and in what way. And the really problematic piece is that we don’t have consistent outcome data across the country. So we’re not able to say this group of people with these problems are getting this intervention and it’s improving their needs.”

Then there are those Canadians who seek support by accessing online mental-health apps, which Kutcher said should be regulated as a health product.

“There should be a regulatory framework so that people who create these apps can apply to have them evaluated by Health Canada,” he said. “Right now, it’s a wild, wild west out there and we have no idea whether these things are helpful to people.”

Most importantly, in Kutcher’s view, is that mental health should never be viewed separately from physical health, which is “an archaic phenomenon going back centuries when people didn’t understand that the brain was part of the body and the body was part of the brain.”

“It’s high time we looked at integrating every aspect of health together, both physical and mental, because there really is no clear-cut distinction between the two of them.”

The Hill Times

Mental health and substance use health workforce needs policy attention

The impacts of the global pandemic on the mental health and substance use of the Canadian population are proving to be complex—and persistent, write Mary Bartram and Kathleen Leslie. *Image courtesy of Pixabay*

Regulation is a key priority for strengthening the capacity of the mental health and substance-use health workforce. Next up, we need a broader health workforce strategy for Canada.

Mary Bartram & Kathleen Leslie

Opinion

More than one in three Canadians report serious mental health concerns, and one in four report problematic substance use, according to the most recent data from the Mental Health Commission of Canada and the Canadian Centre on Substance Use and Addiction. These are staggering numbers.

The impacts of the global pandemic on the mental health and substance use of the Canadian population are proving to be complex—and persistent. The mental health and substance use health workforce is the backbone of the critical response, but is at risk of being overshadowed by the crisis in the broader health workforce.

Regulation of this field would help provide Canadians with more equitable access and enable needed critical workforce planning. The federal government has an important role streamlining this process in partnership with the provinces and territories—and in creating a new national health workforce registry, which would help the health system as a whole.

Mental health and substance use health counselling in some parts of Canada right now is a bit of a wild west.

If you go to a regulated psychotherapist or counselling therapist in Nova Scotia, New Brunswick, Quebec, Ontario, or Prince Edward Island, you will know what kind of service to expect, who is providing it and what kind of accreditation they've received. You are also more likely to get these regulated services paid for by the province, or at least partially covered by your workplace benefits program if you are fortunate enough to have one.

But if you live elsewhere in Canada, many provinces and territories have yet to move forward with psychotherapy regulation. This means you won't know what you've signed up for.

Some protections are in place through the voluntary certification and competency frameworks of provincial associations, but services from these providers may not qualify for public and private funding. And from a health-planning perspective, understanding the supply of these mental health and substance use providers is more difficult.

In this way, the fragmented regulatory landscape for mental health and substance use health providers across Canada is undermining equitable access to services and inhibiting our capacity to undertake workforce planning.

Our current research, led by Athabasca University in collaboration with the University of Ottawa and the Mental Health Commission of Canada, is zeroing in on both key barriers and facilitators to these critical regulatory reforms.

For example, progress in New Brunswick was helped by a unique approach. Since 1950, regulation for each new health profession in the province has been introduced through a private member's bill rather than through the more complex public legislation used in other provinces.

In Alberta, proposed legislation to regulate the mental health and substance use workforce has been stalled since 2018 due to concerns about the impact on addiction counsellors and Indigenous practitioners, whose training and competencies draw more on lived experience and cultural knowledge.

We hear similar concerns from our partners in the peer support and addiction sectors, who have developed robust competency and certification frameworks, but are wary of regulatory frameworks that privilege graduate-level professional education above other forms of lived knowledge and training.

In 2021, we held a virtual policy dialogue with diverse provider groups, frontline workers, and policy makers. Sixty participants from across the country met and identified a number of other key priorities that need immediate attention in this critical landscape. Firstly, they recommended better mental health and substance use workforce data collection. They also recommend co-ordinated workforce planning that includes employment-based benefit programs and publicly funded services. They also stressed the need for increased diversity and cultural competence and access to regulation that recognizes lived experience and cultural knowledge.

So, what's the solution?

Regulatory reform is needed urgently on two tracks. First, psychotherapy and counselling therapy should be regulated across the country as soon as possible.

Second, policy-makers need to listen to the full range of providers to develop modern, flexible approaches to regulation and certification that work for the workforce as a whole.

A modern regulatory framework will be key for implementing federal commitments to develop mental health and substance use healthcare standards and ensure equitable access to high-quality services for all.

Each province and territory could continue their own approach to workforce regulation. But there is also an opportunity for the federal government to spearhead a less fragmented approach by fully integrating flexible, modern workforce regulation into a new national health workforce registry. This registry would facilitate robust workforce planning to help ensure the future workforce can meet the population's needs.

Regulation is a key priority for strengthening the capacity of the mental health and substance-use health workforce. Next up, we need a broader health workforce strategy for Canada.

Mary Bartram is the director of policy at the Mental Health Commission of Canada. Kathleen Leslie is an assistant professor at Athabasca University.

The Hill Times

Canada does not fund mental health care and we are all paying for it

Continued from page 25

physicians, and policy-makers.

In fact, there are some things the U.S. is doing well. Our southern neighbour actually has an excellent health provisory care system, with relatively short wait times and ample specialists. Over one-third of Americans are covered by a public insurance plan, with lower income Americans having health coverage through Medicaid (fully 25 per cent of the population), eight per cent of Americans remain uninsured for various reasons including personal choice. Further, in 1996 the U.S. passed the Mental Health Parity Act, which was expanded in 2008 and 2010, requiring private and public plans to cover mental health care at the same level as physical health. Insurance costs rose by just a tiny amount as a result of this addition. As a compassionate and progressive nation, Canada should do the same.

Let's compare one U.S. state to one Canadian province—Ontario and Illinois—which have relatively similar populations (15-million in Ontario compared to 12.7-million in Illinois) and GDP ($746-billion for Ontario compared to $775-billion for Illinois in 2021). In Ontario, provincial health care spending was $5,042 per person, plus the federal health transfer of $1,128, for a total of $6,170 in 2021. Critics have noted that health-care spending in Ontario is below other provinces and continues to drop. Meanwhile, in Illinois, the government spends $14,000 per person (federal and state contribution) on Medicaid—over double what is spent on Ontarians. Stop and think about this a moment: the poorest people in Illinois receive better-funded health care than every Canadian living in Ontario. In Illinois they get outpatient mental health care and prescription drug coverage, too. In fact, on average, low income Americans receive government-funded health care that is quicker, higher quality, and more comprehensive than what Canadians receive in general.

But it is not good enough to boost spending if there are no mental health providers to treat people. We also need to increase the capacity of practitioner training programs and reduce barriers to licensure for foreign-trained clinicians. Further, as a nation, Canada owes a generational moral debt to the Indigenous Peoples whose mental health suffers at a higher rate than white Canadians due to historical trauma and ongoing discrimination. In many areas where Indigenous Canadians live there is no clean drinking water, much less any modern mental health care infrastructure or wide-spread training of Indigenous providers.

One must wonder why people who live in one of the world's wealthiest nations tolerate this state of affairs—where nearly everyone suffers from a lack of proper access, with marginalized groups suffering the most.

Monnica Williams is the Canada Research Chair in Mental Health Disparities at the University of Ottawa.

The Hill Times

Cannabis Act needs update to limit legal THC concentration

The task force that studied the legalization of cannabis in 2017-18 had proposed 10 per cent as an upper limit of THC concentration, but when the Cannabis Act was passed, there were no imposed limits, writes Gabriella Gobbi. *Photograph courtesy of Wikimedia Commons*

Our laws need to be updated to reflect the growing evidence about the harmful effects of THC on mental disorders.

Gabriella Gobbi

Opinion

It's a Saturday in August. I'm just back from a restful vacation, where I had the opportunity to immerse myself in the good things in life: family, friends, and nature.

I am on call in a psychiatric Emergency Department (ED) in a large Canadian city. These on-calls are an open window into the suffering of people and families struggling with mental health issues.

The first patient I meet is Johnathan, a 22-year-old man who has been living in Canada for about eight months. He was brought to the ER by his sister, who found him in his room in a dissociated, paranoid state. He is afraid of being killed by his schoolmates, hasn't slept for days, hasn't gone out, and lies motionless in bed. He hears voices telling him to kill himself.

Johnathan was attending college and working at night at his sister's restaurant. Integration has not been easy; he's often bullied for his introverted character and his accent. Jonathan started smoking cannabis to "solve his problems," buying it at first in legal stores and smoking up to once a week, then two to three times a week, and finally two to three joints a day at 35 per cent THC. THC is the addictive ingredient of cannabis, triggering the "high." More recently, he started vaping with THC at 85 per cent.

After careful evaluation and assessment, I diagnosed him with acute psychosis. He will be admitted to the psychiatry ward where he will stay for several weeks.

After Johnathan, I assessed 15 more patients, eight of whom had a problem directly or indirectly linked to cannabis, including patients with schizophrenia or bipolar disorders whose symptoms (i.e. psychosis or mania) were triggered and worsened by cannabis.

The Canadian Cannabis Survey shows that 48 per cent of people who use "recreational" cannabis do so because of mental illness. They use "recreational cannabis" in an attempt to relieve symptoms associated with depression, anxiety and other mental distress. Some studies have demonstrated that short-term cannabis use can relieve anxiety and increase mood. However, chronic cannabis use, especially with high concentrations of THC, can also increase the risk of depression and suicide in young people, even those without a predisposition to mental illness.

Moreover, many studies have also shown that cannabis aggravates the prognosis of schizophrenia and bipolar disorder, two severe mental illnesses affecting around two to three per cent of the population. Cannabis users with a predisposition to schizophrenia or bipolar disorders tend to have more severe and more treatment-resistant symptoms, and the disorder manifests earlier.

The concentration of THC in cannabis has increased exponentially in recent years: from three per cent THC (in Bob Marley's time) to 10 per cent in the early 2010s. The task force that studied the legalization of cannabis in 2017-18 had proposed 10 per cent as an upper limit of THC concentration, but when the Cannabis Act was passed, there were no imposed limits.

In Canada you can now legally buy a joint at 35 per cent and vape at 80 per cent of THC.

There is no evidence that THC has any therapeutic effect on mental disorders. On the contrary, a large corpus of research suggests that high concentrations of THC can trigger psychosis in healthy people and aggravate psychiatric symptoms in already ill people.

In other words, the current regulatory framework is not sufficiently protecting our most vulnerable people and youth. Our laws need to be updated to reflect the growing evidence about the harmful effects of THC on mental disorders.

First, limits should be put on the concentration of THC in the legal market, and the illegal market (still 50 per cent of cannabis sales in Canada) should be better controlled. The maximal concentration of 10 per cent, as initially suggested by the task force working on the Cannabis Act should be reconsidered.

Second, the public should be better informed of the risks associated with the use of THC through educational campaigns, and people with mental health problems who self-medicate with cannabis should be encouraged consult a doctor who can help them to treat the underlying problem

Third, we need a national strategy, outlining ways to monitor the effects of cannabis use on the mental health of Canadians. This could include recording the number of emergency room visits linked to the use of cannabis, testing people who visit the emergency for cannabinoids, and monitoring cannabis intoxication in children and adolescents. Other jurisdictions that have legalized cannabis (i.e. Colorado) have already done this, while in Canada, there is no strategy at all.

Fourth, it is worth noting that one day of hospitalization in a psychiatric ward costs taxpayers about $5,000. A hospitalization to treat a patient with a psychosis or mania triggered by cannabis can last days or weeks. Canadians should be aware of these economic costs, as well as the long-term human cost for young people and the vulnerable population.

Fifth, Canadian physicians need to be better trained about the medical consequences of cannabis, and education in cannabis detox and rehab programs needs to be ramped up. At present, there is no national and/or provincial co-ordination for the training of doctors, specialists, and health personnel.

Current policy is inadequate in dealing with the on-the-ground reality. If we are serious about helping the many Canadians like Jonathan, evidence-based policies are urgently needed, now.

Gabriella Gobbi, MD, PhD, is a psychiatrist, neuroscientist, and professor at McGill University. Based in Montreal, Que., she is the Canada Research Chair in Therapeutics for Mental Health.

The Hill Times

BIOTECHNOLOGY

Rebuilding BIOTECH SECTOR requires diversified *training, say researchers,* by Jesse Cnockaert

p. 16

Reinvestment needed to develop a LAGGING BIOTECH sector, by NDP MP Richard Cannings

p. 18

BIOTECHNOLOGY, *stats, collaboration,* and the pursuit of the future

p. 22

Turning crisis into OPPORTUNITY: a Canadian-made bio-revolution

p. 20

Biotech SOLUTIONS *at a critical time* for Canada

p. 22

GOING BEYOND the search for *biotech unicorns*

p. 19

STOP THE SHIFT to corporate *self-regulation* of GMOs

p. 21

Biotechnology Policy Briefing

Rebuilding biotech sector requires diversified training, say researchers

Health Minister Jean-Yves Duclos announced on April 29 that biotechnology company Moderna will build a manufacturing facility in Quebec with the capacity to produce up to 100 million mRNA vaccine doses annually, as part of the federal government's biomanufacturing and life sciences strategy. *The Hill Times photograph by Andrew Meade*

Canada's bio-economy will need an additional 65,000 workers by 2029, according to a report from BioTalent Canada.

BY JESSE CNOCKAERT

Canada's preparedness to tackle future pandemics will hinge heavily on attracting more talent to the biotech sector, but also on diversifying training to allow researchers to handle different health emergencies, according to health researchers.

"What we're short on right now are trained, skilled workers who have the ability to work in these vaccine manufacturing facilities," said Dr. Volker Gerdts, director and CEO of the Vaccine Infectious Disease Organization (VIDO). "There are various models of national and international training programs. I think the key would be to have training programs that are not only collaborative in nature, but also utilize the many facilities in the country."

Canada's bio-economy—or the organizations concerned with invention, development, production and use of primarily bio-based products and intellectual property—is facing a labour shortage, and is expected to need an additional 65,000 workers by 2029, according to a report released on Oct. 13, 2021 by BioTalent Canada.

Dr. Volker Gerdts, the director and CEO of the Vaccine Infectious Disease Organization, says training health researchers at multiple facilities could help them to work at different manufacturing facilities based on need. *Photograph by David Stobbe / StobbePhoto.ca*

To help build up Canada's biotech sector, the Liberal government announced a biomanufacturing and life sciences strategy on July 28, 2021.

To address the need for biotech research and talent, the strategy launched an integrated Canada Biomedical Research Fund (CBRF) and Biosciences Research Infrastructure Fund (BRIF) competition, which accepted applications until Aug. 11, 2022. The CBRF will invest $250-million over four years to support high-risk, applied research, training and talent development, while the BRIF will invest up to $340-million to support infrastructure needs. Institutions that have applied for funding as a research hub include the University of Alberta, the University of Ottawa, and the University of British Columbia.

Gerdts said that the federal government's biomanufacturing and life sciences strategy is a good one, and it's now a matter of seeing how well it works out. He said the development of research hubs presents an opportunity to prioritize training programs that rotate trainees between multiple facilities to develop different skills. A possible way to help contend with a shortage of labour will be to vary the training of the few available researchers, so that they can be shifted to different vaccine facilities as needed, according to Gerdts. Different health emergencies may require

Continued on page 23

65,000 workers are needed by 2029

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For Canada to capitalize on the biotechnology economy there must be an increase in funding for scientific grants so that post-doctorate students and researchers are paid a living wage, says NDP MP Richard Cannings. *Photograph courtesy of Pixabay*

Reinvestment needed to develop a lagging biotechnology sector

Canada is falling behind when it comes to biotechnology, especially when it comes to training and keeping skilled workers.

NDP MP Richard Cannings

Opinion

The term biotechnology usually conjures up images of medical laboratories, but it has applications beyond human health. Agriculture and forestry use biotechnology to create new products and better crops. The chemical and manufacturing industries use biotechnology to enhance their performance and reduce the cost of their products.

For much of the 20th century, Canada was a world leader in the biotechnology sector. Canada's biotechnology successes include the discovery of insulin, stem cells, and the cystic fibrosis gene; and the development of the Ebola vaccine. More recently, Canadian researchers developed the techniques necessary to develop the mRNA vaccines that have been so successful against COVID-19.

Unfortunately, successive Progressive Conservative and Liberal governments have allowed Canada's position to decline. A prime example is Connaught Laboratories, established in 1917 at the University of Toronto to produce diphtheria and tetanus antitoxins during the First World War. It was there that Frederick Banting and Charles Best discovered insulin in 1923. Connaught Laboratories went on to develop vaccines against pertussis, influenza, measles and smallpox. In 1972, Connaught was sold to the Canada Development Corporation and in 1986, the labs were sold off as part of the Conservative government's privatization program. This left Canada without a domestic vaccine manufacturing facility.

To replace this lost ability, the federal government has spent $1.3-billion in COVID-19 biomanufacturing, vaccines and therapeutics projects.

Agricultural biotechnology has already proven its value with increased yields, reduction in pesticide use, and crops with tolerance to heat and drought. Canola, now the standard cooking oil throughout the world, was developed at the University of Manitoba in the early 1970s. Through more biotechnology research, it is now being developed as a renewable source of fuel, including biodiesel and jet fuel.

The Canadian forest products industry has developed some breakthrough biotech innovations that expand traditional uses of wood fibre to make green bioproducts such as clothing, car parts, cosmetics and construction materials. These technologies create significant new economic opportunities and protect industry jobs. For example, Lignin, the chemical that gives trees their woodiness, has typically been burned for energy at pulp mills. It is now being used as an adhesive resin, provides substrate for 3D printers, can replace carbon black in car tires and has the potential to be used in sporting equipment.

There are also applications in the chemical industry. For example, BioAmber in Sarnia, Ont., uses green chemistry to manufacture succinic acid from renewable agricultural feedstock. Bio-succinic acid is used to make textiles, paints, food additives, and a replacement for petroleum ingredients in personal care products. The environmentally responsible process eliminates greenhouse gas emissions and reduces energy consumption by 60 per cent compared to traditional petroleum-based manufacturing. BioAmber supplies succinic acid to Bayer MaterialScience for its production of bio-based polyurethanes for textile applications.

However, Canada is lagging behind when it comes to biotechnology, especially when it comes to training and keeping skilled workers. A 2021 report by BioTalent Canada found that Canada currently has some 12,000 bio-economy businesses, employing about 200,000 workers. This total is projected to grow to 223,000 workers by the end of the decade.

The workers in these industries require a high level of education, mostly at the postgraduate and postdoctoral level. Current government scholarships to train these workers have remained stagnant since 2003. Since then, housing and tuition costs have skyrocketed, and our best and brightest students have been forced to work at below minimum wage and live below the poverty line. Currently, master's students receive $17,500/year and PhD students receive $21,000/year Postdoctoral fellows, who have completed their doctoral degree, receive $45,000/year.

For Canada to truly capitalize on the biotechnology economy, there must be an increase in funding for scientific grants so that post-doctorate students and researchers are paid a living wage. More broadly, Canada needs to invest more in research and development both within government and the private sector.

Right now, according to UNESCO statistics, Canada only spends 1.7 per cent of its GDP on research. That's well below the world average of 2.4 per cent and only half the level of investment in the United States. The good news is that these Canadian investments have started to rise again after 20 years of decline, but much more needs to be done to ensure we continue to play an important role in the exciting future of biotechnology.

Richard Cannings is an NDP MP representing the riding of South Okanagan-West Kootenay, British Columbia. He is also his party's deputy critic for Innovation, Science and Industry.

The Hill Times

Going beyond the search for biotech unicorns

There is much more Canada can and should do to generate benefits from biotechnology besides just the blockbuster innovations.

Peter W.B. Phillips

Opinion

Canada is one of the global leaders in the application of biotechnology. We invest heavily in research into the technology and have great opportunity to apply new innovations to our economy, our society and our environment. The problem is that we are fixated on blockbuster innovations, the $1-billion-plus opportunities that the venture capital world calls 'unicorns.' There is much more we can and should do to generate benefits from this technology.

By all accounts, we are accomplishing a fair bit. While somewhat dated, studies that compare our efforts to other countries suggest Canada, since 2000, bootstrapped its way into the top five nations in terms of scholarly research and into the top tier of the countries patenting new applications in biotechnology. From there the story is less positive. While Canada has delivered some world firsts—new GM crops, new diagnostic tools, new vaccines and drugs and new biofermentation processes—the number of readily visible commercial successes is relatively small. Unicorns remain mostly mythical in this sector in Canada.

Most commentators suggest we can and should strive for more world-firsts. While this is the conventional wisdom, innovation is more than just world-firsts and successful first adoption of new technologies or ideas. The returns to research come when the insights are adapted and adopted widely. Undoubtedly new startups and first adopters should be celebrated for their efforts, but the greatest gains come when specific innovations become diffused widely through an economy and society. We somehow need to accelerate both types of use.

Getting there is the challenge. There are many hurdles to surmount to get to first-use. The start-up process is fraught with complications. Assuming the research effort generates a clear proof of concept, innovators still need to organize and finance their commercial venture, secure regulatory compliance, reduce to practice and scale up the innovation and proactively market their product. A recent study in the U.S. showed that of 530 bioscience invention disclosures from public research teams in the 2000s, only two successfully entered the market and had sustained revenues. The other 99.6 per cent were mercilessly culled by the rigours of the system.

We should be able to lower the cull somewhat by reducing the costs and time to undertake commercialization. Many of our federal and provincial policies and programs work to lower costs for entrepreneurs and first movers: university tech transfer offices, government business service centres, Superclusters and venture capital programs, each in their own way, helps to lower the cost for firms.

But that effort is somewhat undercut by the rising costs of regulatory compliance. A recent international study of the cost of introducing a new biotechnology product in agriculture reported that research costs fell 29 per cent in the past decade but regulatory costs rose 23 per cent. Constructing and successfully prosecuting a product now makes up about 38 per cent of the total cash costs of a product and takes more than 17 years. While regulation is needed, we should expect that as we gain a familiarity with a technology we could sharpen and improve the system to lower the cost while still maintaining its integrity.

As or more important, we need to shift some of our focus from the problems of first movers to the rest of our economy and society. Patents, licensing revenues and commercial startups are only one way to realize impact. Follow-on use of a technology delivers much higher total returns to society. We need to accelerate uptake and use of new ideas more widely.

Potential users, be they small-, medium- or large-sized businesses, households, or governments, all need to be able to trial a new product to see how it will fit their needs. Too little of our programming is designed to assist potential users to actually do so. This may require accelerating investments in programs like the National Research Council's Industrial Research Assistance Program, which works with firms, but we may also need a rebalancing in other programming to support more market demand. Strategic public procurement and helping larger firms break down their needs to the scale of our enterprise go some way to helping, but more can and should be done to facilitate trialing throughout our economy and society.

In the end innovation is an iterative process, with inventors, users and society ultimately fashioning the tools and products to our economic and social needs. Governments could do a lot more to fashion efficient and effective regulations, policies and programs to mobilize our entire economy in the innovation enterprise.

Peter W.B. Phillips is a distinguished professor of public policy and director of the Centre for the Study of Science and Innovation Policy, Johnson Shoyama Graduate School of Public Policy, University of Saskatchewan.

The Hill Times

A well-supported Canadian life sciences and biotechnology industry requires thoughtful partnerships, much more investment and a transparent regulatory path for novel technologies, says Bettina Hamelin, president and CEO of Ontario Genomics. *Photograph courtesy of Pixabay*

Turning crisis into opportunity: a Canadian-made bio-revolution

Canada has a second chance to build a comprehensive biotech ecosystem as new domestic investment funds and foreign investors take notice of our industry.

Bettina Hamelin

Opinion

Twenty years after the Human Genome Project, we have made significant strides in understanding what "genomics" can do to transform health care. Today, genomics pave the way for a bio-revolution that reaches far beyond human health into crop optimization, food production, and the sustainable manufacturing of products using yeasts and microbes as 'mini-factories.'

A life-threatening and economically challenging pandemic put these genomics advances to the test. Within weeks of the COVID-19 outbreak, the world had a diagnostic test and a vaccine ready for clinical trials.

These breakthroughs thrived outside Canada. Unlike what came to be known as "Operation Warp Speed" south of the border, Canada did not have a life sciences industry at the tipping point for these technologies, nor the apparent ability to mobilize the kind of interagency strategy and funding needed for a similar response.

In the 1990s, Canada's biotech industry flourished with success stories like BioChem Pharma, the inventor of still-used lifesaving AIDS medication 3-TC. Before the pandemic, investment in Canada's biotech start-up industry had all but dried up. Instead, the Canadian government focused on our strong natural resources sector and tech opportunities such as AI and quantum technologies. The pandemic, however, reminded us of the vulnerabilities of supply chains and how important it can be for a country to produce its own, including vaccines, antibodies, personal protective equipment and genomic sequences.

Fortunately, our existing capacities and communities rallied together. Genome Canada, together with a network of six provincially funded Genome Centres and funded by the federal government, rapidly set up a national viral and human genome sequencing initiative to track the evolution of the virus and disease susceptibility.

Even beyond this initiative, the government has become increasingly attuned to the opportunities and needs in this space. An aggregate commitment of more than $2.2 billion over the next five to seven years into the life sciences, bio-manufacturing and the bourgeoning genomics strategy are great gateways; investments into talent development through organizations like MITACs are steps in the right direction. However, we cannot rest there.

We need to futureproof our country.

While we brace for the next inevitable pandemic or global health emergency, we are witnessing a climate crisis raging at home and around the world with unpredictable weather patterns, famines, and disease. According to the World Health Organization, a quarter of a million people will die annually from climate change between 2030 and 2050. Urgent action must address the massive gap between trends and necessary carbon dioxide reduction to limit global warming to below 2°C by 2030.

Canada needs to do its part in providing solutions – in life sciences, agriculture and food production, and sustainable bioproduction of materials. A well-supported Canadian life sciences and biotechnology industry requires thoughtful partnerships, much more investment and a transparent regulatory path for novel technologies. Canada has lagged many jurisdictions when it comes to investing in transformational technology discovery, development and commercialization.

While we are fortunate to have brilliant Canadians who created successful companies like Deep Genomics, AbCellera, Notch, and Noblegen, the pull to move headquarters south of the border continues to be strong—both for investment and talent.

Today, Canada has a second chance to build a comprehensive biotech ecosystem. New domestic investment funds and foreign investors have taken notice of our industry with a 70 per cent year-over-year increase in venture funding in 2021 for a total of over $2-billion. Proving Canadian companies can commercialize when the appropriate support is available.

Canada has a budding biotech industry built on engineering or synthetic biology, an innovation engine that uses biomass rather than petroleum-based inputs and bioengineering to create products we need every day. This transformative and sustainable approach has the power to offset some of the $2-4-billion/per year cost of global climate change as predicted by 2030. This will put Canada in a strong export position for innovative products while creating jobs and prosperity right here at home.

We need to rally more together across academia, federal and provincial governments, and commercialization-focused not-for-profits with the kind of congeniality that attracts Canadian philanthropists, pension funds and big industry players who currently invest elsewhere.

The global bio-revolution makes it feasible to imagine a world where up to 60 per cent of all inputs into our economy could be made biologically. This would herald a global market worth $2-trilliong to $4-trillion annually. If we commit to being a proactive part of this, our economy and jobs will shift towards an innovation-based economy. It will either happen to Canada or in Canada. I hope we opt for the latter.

Bettina Hamelin, PharmD, EMBA, is the president and CEO of Ontario Genomics, an Ontario-based not-for-profit organization that catalyzes and supports the development of genomics-based technologies across multiple economic sectors for a genomics and engineering biology-driven bioeconomy. Dr. Hamelin has over 30 years of experience in academia, industry, and not-for-profit organizations across Canada, the U.S. and Europe.

The Hill Times

Stop the shift to corporate self-regulation of GMOs

Instead of ensuring government oversight, the federal government has handed responsibility for determining the safety of some products over to the companies that develop them, says Lucy Sharratt, coordinator of the Canadian Biotechnology Action Network. *Photograph courtesy of Pixabay*

Biotechnology companies have an open door to the Canadian market for some genetically engineered foods produced with new gene editing techniques.

Lucy Sharratt

Opinion

The minister of health recently allowed Health Canada to give up its role as independent regulator when it comes to the safety of many future genetically engineered (genetically modified or GM) foods, and the minister of agriculture and agri-food is contemplating a similar set of proposals on seeds from the Canadian Food Inspection Agency.

This is a profound shift away from independent science and transparency to corporate self-regulation, and it will limit future regulation and policy options on genetic engineering.

As it stands, the health minister's decision means that Canadians could soon be eating some unreported, unknown genetically modified organisms (GMOs) that have not been assessed for safety by Health Canada's regulators. The decision will have wide-reaching impacts across our food system, and begins a cascade of changes that now include forthcoming proposals from Health Canada to amend the regulations themselves.

Biotechnology companies have long lobbied for less regulation, and now they have an open door to the Canadian market for some genetically engineered foods produced with new gene editing techniques. If a new food comes from a plant that was genetically engineered without incorporating DNA from other species (it has no foreign DNA), then the product developer alone can determine if that food is safe.

The presence of foreign DNA is one of five categories of novel characteristics that Health Canada asks product developers to assess. The problem is that Health Canada will no longer verify that developers have, in fact, assessed these safety questions, or check how well they have examined them. Health Canada won't review these gene-edited foods for safety because they will not fit the definition of a "novel food."

Instead of ensuring government oversight, the federal government has handed responsibility for determining the safety of some products over to the companies that develop them. Critically, by exempting them from the *Novel Foods Regulations*, Health Canada has surrendered its authority over these new GM products. The government won't have the ability to ask companies for their safety data, or for any other information about these foods.

This means that companies can put these gene-edited foods on the market without even notifying the government that they exist. The federal government will lose the ability to track GM foods and seeds, if it wanted to. It will leave Canadians dependent on product developers for information about the role and prevalence of GM in our food system.

Yet, Canadians do not want to give up public oversight of GM food safety. In fact, expressions of concern to the federal government were brought by more than 100 groups of environmentalists, health advocates, farmers, and small businesses. Further, the regulatory exemptions are opposed by Canadians by a margin of nearly two to one (46 per cent to 24 per cent), according to opinion research conducted by Pollara Strategic Insights.

Critically, this important change was made via updates to the regulatory guidance on novel foods. Health Canada took full advantage of the flexibility and power it has in making changes to this technical document. However, now Health Canada also says that it will propose changes to the regulations, to "reflect the interpretation reflected in the guidance." This is shocking management of the regulatory change process and of stakeholders who commented in 2021 public consultations. Soon, the minister of agriculture and agri-food could allow similar corporate self-regulation for gene-edited seeds, via regulatory guidance.

If gene editing is the future of genetic engineering, and the future of our food system as promised, then Canadians and our government will be entirely dependent on voluntary corporate information about this new reality, even as we grow and eat gene-edited foods.

This is unacceptable. It is incumbent upon the ministers to end these moves to corporate self-regulation.

Lucy Sharratt is coordinator of the Canadian Biotechnology Action Network (CBAN) that brings together 15 groups to research, monitor and raise awareness about issues relating to genetic engineering in food and farming. CBAN members include farmer associations, environmental and social justice organizations, and regional coalitions of grassroots groups, and is a project of MakeWay's shared platform. www.cban.ca/NoExemptions.

The Hill Times

Biotech solutions at a critical time for Canada

Canada has a strong biotech foundation upon which to build, but there remain some headwinds to be addressed.

Andrew Casey

Opinion

The central value of the biotechnology sector has always been the solutions it brings to the challenge of a global population moving quickly to ten billion people and the imperative of finding ways to fundamentally alter how we grow, manufacture, cure, and fuel our economies and societies. Not surprisingly, the pandemic's economic, social, and health impact has effectively focused the attention of policymakers and the public on the strategic importance of building a competitive domestic life sciences industry and biomanufacturing capacity. Importantly, Canada is building this capacity from a position of strength.

Prior to the pandemic, Canada was already home to two large-scale, multinational facilities belonging to Sanofi (Toronto) and GSK (Québec City), as well as several established Canadian biomanufacturing facilities including those of Resilience, Vido Intervac, Medicago, and BioVectra. The existing capacity coupled with a national biotech ecosystem comprised of nearly one thousand companies, and globally recognized expertise in regenerative medicine, artificial intelligence, vaccines, clinical trials, and genomics, (and the soon to be added Moderna mRNA facility in Quebec) all represent a formative and competitive foundation upon which to build Canada's biomanufacturing capacity. Investing in this foundation will both prepare for a future pandemic-like health challenge and drive the competitiveness of the biotech ecosystem more broadly.

While Canada is certainly fortunate to have a strong biotech foundation upon which to build, there remain some headwinds to be addressed, namely:

• **Attract and reward investment**: Canada still needs to be more competitive with respect to attracting and rewarding investment capital. Other countries are using strategic tax initiatives such as R&D tax credits and patent boxes to attract investment and support company growth. Canada needs to keep pace with these. Moreover, a significant and long-term commitment to enhancing the federal life sciences venture fund would accelerate the availability of venture capital investment dollars for early-stage Canadian biotech companies.

• **Attract and retain talent**: the attraction and retention of top tier talent might be the most pressing hurdles before the industry. Canada is not alone in grappling with this. Other nations' biotech sectors are equally challenged. But this simply makes for a hyper competitive landscape for the very mobile asset that is talent. Importantly, there are some initiatives led by adMare BioInnovations and the Canadian Alliance for Skills and Training in Life Sciences (CASTL) which will certainly help address gaps, but more needs to be done to retain the talent we have and attract new talent.

• **Regulatory efficiency**: With remarkable health and environment technologies both on our doorstep and on the not-so-distant horizon, Canada needs to ensure its regulatory capacity is effective, modern, and agile.

The 2021 federal budget dedicated significant funds (over $2-billion) and launched a Biomanufacturing and Life Sciences Strategy to grow the life sciences sector in Canada and develop domestic biomanufacturing capacity. This makes good public policy sense with respect to building Canada's ability to address a future pandemic. The investments and strategy also represent an important and timely opportunity to accelerate the growth and global competitiveness of Canada's biotech sector beyond just a crisis response.

Yet, there remains significant work ahead to address the challenges noted, strategically deploy the budget's investments, and deliver the Biomanufacturing and Life Sciences Strategy. As the country begins to emerge from under the pandemic and return to some sort of normal, there will always be the risk of new priorities and challenges (e.g.: inflation) drawing attention from finishing the important investments and work already underway. Accordingly, the government should establish a dedicated, senior level official and corresponding team tasked with strategically deploying the investments and following through on the delivery of the Biomanufacturing and Life Sciences Strategy.

Not all should fall solely on the shoulders of government. This is an important moment for industry and government to partner constructively to deliver on diverse but connected objectives relating to the entire life sciences sector. Accordingly, in 2020, BIOTECanada developed the BIONATION initiative to bring policymakers and the industry together to chart a course for the future of Canada's biotech and biomanufacturing sector. The inaugural 2020 BIONATION in-person event was to take place in Ottawa in April 2020, but those plans were quickly derailed for obvious reasons. After a two year wait, the in-person BIONATION summit will take place in Ottawa on Sept. 28 and Sept. 29. Policymakers and the industry will gather on Parliament Hill to celebrate the Canadian biotech industry, and look to the future and the important role it can play in addressing economic, environmental, and social challenges both in Canada and the world more broadly. To learn more about BIONATION and how you can participate, visit https://www.biotech.ca/bionation/

Andrew Casey is president and CEO of BIOTECanada, the national industry association representing biotechnology companies in Canada. For more than 25 years Andrew has provided government relations and communications advice to various trade associations.

The Hill Times

Biotechnology, statistics, collaboration, and the pursuit of the future

Capitalizing on investments in biotechnology is challenging due to the complexity of the biosystems being created.

Donald Estep

Opinion

Canada has embraced the potential for biotechnology to revolutionize modern life. Substantial investments are being made in biotechnology in a range of fields including health care, the environment, agriculture, aquaculture, and sustainable development. Biotechnology is a strong contributor to the Canadian innovation economy and Canada places highly in international rankings of biotechnology development.

However, capitalizing on investments in biotechnology is challenging due to the complexity of the biosystems being created. Biotechnology depends critically on analyzing massive streams of complex data arising from new technologies to gain knowledge, make predictions, and evaluate risk and uncertainty. These data analysis problems arise in all areas of biotechnology, e.g., from gene sequencing to GPS data to chemical properties to health outcomes, and at every step of the biotechnology process from initial investigation to end-product evaluation.

Biotechnology data analysis problems require development of new statistical methodologies. They cannot be solved using brute-force computational methods and traditional analytics. Indeed, using those approaches plays a substantial role in the growing crisis of non-reproducible research, whereby findings cannot be replicated or are not robust with respect to realistic operating conditions. Negative consequences of non-reproducibility include raising questions about the value of biotechnology and wasted investment.

The solution to the challenges inherent to biotechnology data analysis is to foster interdisciplinary collaborations between statistical scientists and biotechnology researchers that lead to the creation of cross-disciplinary scientific innovations. The success of such an approach is demonstrated by the Canadian Statistical Sciences Institute (CANSSI). Headquartered at Simon Fraser University, CANSSI is a national institute supported primarily by the Natural Sciences and Engineering Research Council. CANSSI is Canada's catalyst for discovery and innovation in statistical sciences and application of statistical sciences in other fields.

CANSSI programs support the pursuit of cutting-edge collaborative research involving statistical sciences along with the communication and application of the results to science, engineering, and society. For example, the Collaborative Research Teams (CRT) program fosters statistical sciences research and training interactions that span disciplines and institutions. The CRT program emphasizes the co-creation of knowledge, the leveraging of Canada's expertise in statistical sciences, and the synergy achieved by embedding partnership into interdisciplinary projects at their inception.

CRT projects have initiated significant advances in research across a swath of applications and have had a direct impact on Canadian society in several areas. Some CRT projects tackle the development and application of statistical methodology important to biotechnology, including:

• Analyzing whole-genome sequencing to better predict drug resistance, phylogenetic or epidemiological relatedness, and identifying genomic variants.

• Using massive data streams related to the movement, behavior and health of humans and animals to make better health predictions.

• Combining biological and fisheries data into models to assess the condition of stock and predict the response to varying levels of fishing pressures.

• Determining and describing familial dependence structures in DNA sequence data for the investigation of rare genetic mutations involved in complex diseases.

• Quantifying and mapping severe fire risk, with a focus on wildland-urban interface.

The success of the CANSSI model shows that interdisciplinary partnerships between statistical scientists and biotechnology researchers provide the best approach to tackle the complex data analysis problems endemic to biotechnology. Unfortunately, CANSSI is the sole Canadian national institute in statistical sciences with the mandate to interface across the entire spectrum of science and engineering. CANSSI simply does not have sufficient resources to fulfill the interdisciplinary capacity of the Canadian statistical science community with respect to biotechnology. Finding the resources to foster more interdisciplinary collaborations with statistical sciences is essential for capitalizing on Canada's investment in biotechnology.

Donald Estep is the director of the Canadian Statistical Sciences Institute and a Canada Research Chair in Computational Probability and Uncertainty Quantification at Simon Fraser University in Burnaby, B.C. He has served on scientific advisory panels for the U.S. National Science Foundation and Department of Energy and on the Sandia National Laboratories CISE External Review Board and has co-authored several reports.

The Hill Times

Rebuilding biotech sector requires diversified training, say researchers

Continued from page 16

different types of vaccines, such as Messenger RNA (mRNA) vaccines, viral vector vaccines, or toxoid vaccines.

"If that was a mRNA vaccine manufacturing facility, those skilled workers essentially would only know how to make mRNA vaccines. What you really want is to train them in different facilities, for different technologies, for different product lines, so that you have more universal trainees who could be potentially used in whatever facilities are chosen to rapidly make vaccines," said Gerdts. "Let's say the next virus comes and we all figure that a mRNA vaccine is no good, and we need a viral vector for it. Maybe McMaster [University], at their viral vector facility, doesn't have enough personnel, and then personnel could be flown from Saskatoon or from Alberta to McMaster to help there to manufacture those vaccines."

Gerdts also recommended that Ottawa's strategy should be to put more investment towards One Health research. One Health is an approach to fighting infectious disease "not only by looking at the health of humans, but also animals and the environment, as well.

"[One Health] is a recognition that what we do in humans is no different from what we do in animals, and in fact, most of these emerging diseases are zoonotic in nature, and they have either jumped from animals into humans or from humans into animals," said Gerdts. "As a country, we should have done more One Health research in the past. As we move forward, we need to recognize, through our funding mechanisms … that One Health is an important solution to many of these problems."

The 2021 federal budget included a promise of $59.2-million over three years for VIDO to develop its vaccine candidates and expand its facility in Saskatoon.

The biomanufacturing and life sciences strategy, launched with a promise of more than $2.2-billion over seven years from the 2021 federal budget, promises investments in bio-innovation research, including $500-million over four years for the Canada Foundation for Innovation for a bio-science research infrastructure fund, to support the bio-science infrastructure needs of post-secondary institutions and research hospitals. The strategy also promises $92-million over four years towards adMare BioInnovations to support company creation, scale up, and training activities in the life sciences sector.

Actions taken by the federal government to advance the strategy include an announcement on April 29 by Prime Minister Justin Trudeau (Papineau, Que.) that biotechnology company Moderna will build a manufacturing facility in Quebec with the capacity to produce up to 100 million mRNA vaccine doses annually. The facility is expected to be operational in 2024 at the earliest, subject to planning and regulatory approvals, according to a press release from the Prime Minister's Office.

"One of our government's top priorities is to protect the health and safety of people in Canada. Moderna's new facility will strengthen domestic health security and pandemic preparedness through timely access to innovative, cutting-edge vaccines that help us save lives. Moderna's presence will also further establish Canada as a global leader in mRNA technology, leading a new era of domestic health innovation," said Health Minister Jean-Yves Duclos (Québec, Que.) in the press release.

Dr. Michael Strong, president of the Canadian Institutes of Health Research (CIHR), agreed that diversifying training in the biotech sector is an important concept, and said that CIHR is doing more to increase training opportunities.

"Science today cannot be in one lab as we're moving things forward," said Strong. "Increasingly, with the new [health training programs] that we're bringing forward, we are actually expressing … an experiential component to it, so that individuals can leave the milieu in which they are in."

The CIHR is a federal agency responsible for funding health and medical research in Canada.

To help health researchers develop interdisciplinary skills, CIHR launched a Health Research Training Platform (HRTP) pilot program on Jan. 8, 2021. CIHR will take stock of lessons learned from the HRTP Pilot funding opportunity to improve its career development and training support offerings to the health research community, according to the CIHR website.

"The skill sets on everything from how do you run that as a business, all the way through to the actual production finish … those all require that individuals have defined skill sets, but to work as a cohesive group they have to understand what each other's doing," said Strong.

Dr. Earl Brown, a professor emeritus at the University of Ottawa's school of medicine and an expert in immunology and microbiology, told *The Hill Times* that when it comes to vaccine research and production, "you can't put all your eggs in one basket." He said that vaccine production has entered the age of synthetic biology, which is a field of research involving the creation of biological parts in a lab.

"The way vaccines are made has changed dramatically, just seeing this mRNA technology come out and be successful in the world, that changes the game," he said. "Now with synthetic biology, you can make any of the components of life in a laboratory … but we're in the age when you can make DNA, you can make RNA, [and] you can make proteins in a number of different ways, and so we're not as restricted."

Brown said that the federal government's investments have covered the bases in terms of support for facilities with synthetic biology and classical vaccinology approaches, but he estimates that Canada's ability to handle a hypothetical future pandemic could still be about three to five years off.

"I think they've covered it. If those things actually turn into brick-and-mortar companies that actually do that thing with their staff, we should be in a position to have achieved the objective," he said.

Developing a strong biotech sector in Canada will also involve passing legislation that supports the vaccine industry, he added. Canada's major competitor in attracting biotech companies and talent is the United States, and an advantage the U.S. has is a lack of price control on drugs, which means many drugs can be sold in the U.S. for higher prices, according to Brown.

Canada's Patented Medicine Process Review Board is responsible for ensuring that prices charged by manufacturers of patented drugs are not excessive. Making Canada an attractive country in which to manufacture and sell prescription drugs involves striking a reasonable balance, according to Brown.

"Host countries have to nurture their vaccine producers. It comes down to supporting them in their infrastructure and supporting them in developing their product and selling the product. I think there has to be an eyes-open approach to it," he said. "I think it comes down to tax incentives and non-tax incentives … for producing and having a facility."

Dr. Jennifer Gommerman, a professor and associate chair of graduate studies in the department of Immunology at the University of Toronto, told *The Hill Times* that Canada's capacity for vaccine production is better than it was two years ago, but that "we have some ways to go."

"It's going to take time, but we've got to start, right? It's important to not just think in terms of COVID-19. There are going to be other pandemics, and there are going to be other situations where we have to ramp up quickly," she said. "Whether it's true or not, [Canadians] have this reputation of being a little cautious, and maybe not really throwing ourselves in front of a problem. I hope that's not what we do here. I hope that we approach … future problems with a determination to be a world leader."

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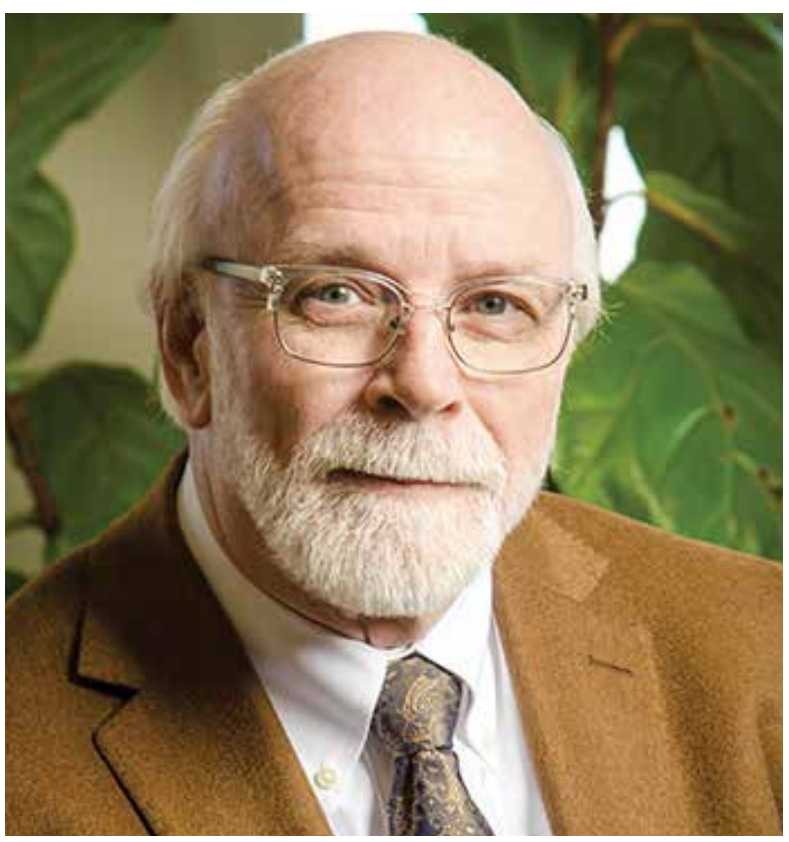
The Hill Times



Dr. Michael Strong, president of the Canadian Institutes of Health Research, says that science today cannot be "in one lab." *Photograph courtesy of CIHR*

Liberal government support for the biotechnology sector

- Since the onset of the pandemic, the Liberal government has committed more than $1.8 billion in 32 projects in the biomanufacturing, vaccine, and therapeutics sector to support the domestic development and production vaccines and therapies to respond to COVID-19, future pandemics, and other health priorities.
- In Ontario, these investments include an announcement on March 31, 2021, of up to $415-million to support Sanofi Pasteur Limited in building an end-to-end influenza vaccine manufacturing facility, and an announcement on May 12, 2022, of more than $19.5-million through the Stem Cell Network for 32 research projects and clinical trials across Canada focused on rare and chronic diseases.
- Other recent funding announcements include a $92-million investment in adMare BioInnovations, announced on March 30, 2022, intended to drive company innovation, scale-up and training activities in Canada's life sciences sector.

Source: Innovation, Science and Economic Development Canada

Canada bio-economy statistics

- Roughly 12,000 organizations in Canada's bio-economy collectively employed about 200,000 people in 2019. The overwhelming majority of bio-economy companies are small- or medium-sized businesses.
- Canada's bio-economy is expected to require 65,000 additional workers by 2029.
- Canada's bio-economy is rooted in research and development (R&D), with 69 per cent of companies engaged in some form of R&D activities.
- Bio-economy employers rank human resources among their top five obstacles to company development. More than half (56 per cent) report management-level skills and labour shortages (up from 43 per cent in 2013), while 61 per cent report skills and labour shortages in research and technical areas — up 24 per cent from 2013.
- In 2016–2017, nearly 200,000 students were enrolled in university programs specifically related to the bio-economy. In 2018–2019, more than 156,000 students were enrolled in college-level STEM and health programs
- While exact numbers are not yet known, it is estimated the COVID-19 pandemic resulted in 65,000 fewer international students enrolled at Canadian post-secondary institutions for the 2019–2020 and 2020–2021 school years. This drop of 20 to 30 per cent may have a negative impact on research activities in STEM labs, as graduate students — including significant numbers of international students — often play key roles in these activities.

Source: Close-up on the bio-economy: National report, by BioTalent Canada, released on Oct. 13, 2021

HEALTH

Canada's NURSING RETENTION crisis

By Jesse Cnockaert

Post-pandemic HEALTH AND SCIENCE: *preparing for the next one*

No health care without HEALTH-CARE WORKERS

Long-term care: *no longer an* AFTERTHOUGHT

Canada can't afford to tackle ONE DISEASE at a time

How feds can address MENTAL HEALTH *epidemic*

Timely access to mental HEALTH CARE must be top priority

Where is our 'CAN-DO' SPIRIT?

A holding pattern *for mental health:* WHAT ARE WE WAITING FOR?

Drop-in programs care for our MOST VULNERABLE, *but can they afford to continue?*

Nurse retention crisis requires action plan to address workplace violence, says nursing organizations

Canada is in need of a pan-Canadian health human resource action plan to address a workforce crisis in the health-care sector, according to health and nursing organizations.

BY JESSE CNOCKAERT

Health-care organizations are pushing for the federal government to step in with an action plan to address a workforce retention crisis, which has been worsened by escalating verbal and physical abuse directed towards health-care providers during the global pandemic.

"Unfortunately, workplace harassment and violence is not a new issue for health-care professionals. It's something that people have had to deal with for a long time. But what's changed, I think, is the scale of it during the pandemic," said Dr. Katharine Smart, a pediatrician in Whitehorse, Yukon, and president of the Canadian Medical Association (CMA). "I think it's no surprise to anyone that everyone is more stressed from the pandemic. Naturally, some of that is coming out in health-care environments where people are particularly stressed … and that is being expressed as verbal abuse and sometimes physical abuse at health-care providers."

The CMA is advocating for the federal government to take the lead in developing a pan-Canadian health human resource action plan to address a workforce crisis in the health-care sector. The COVID-19 pandemic has exacerbated existing health-care challenges, including the risk of health-care workers leaving their professions due to burnout, according to Smart. Burnout is a syndrome resulting from unmanaged, chronic workplace stress characterized by feelings of exhaustion, increased mental distance from one's job, and reduced professional efficacy, according to the World Health Organization.

A contributor to stress, and therefore burnout, in the workplace for health-care professionals is the increased instances of violence and harassment during the COVID-19 pandemic, according to Smart. Some of the harassment facing health-care workers has come from people who don't believe in vaccinations, she said.

"When they get COVID and end up in the hospital, they can be very belligerent and combative," said Smart. "Their mental model is 'this doesn't exist.' When they have the health-care professionals trying to treat them and communicate with them about what's going on, it's confronting their belief system and that can often result in aggressive behavior from both the patient and sometimes their family."

Addressing workplace violence needs to be an "institutional value" incorporated into any plan by the federal government that addresses the workforce crisis, according to Smart. During the pandemic, some health-care workers have been followed to their cars or to their homes by screaming protestors, she said.

"This is really, deeply concerning that you can't feel safe in your workplace. You can imagine when you're already dealing with all these other issues, and then on top of it you're experiencing that harassment and that type of violent behavior towards you … I imagined it was the straw that broke the camel's back," she said.

A positive step in addressing violence facing health-care workers was achieved on Dec. 17, 2021 when the former Bill C-3 was given royal assent in the Senate, according to Smart. The legislation, sponsored by Labour Minister Seamus O'Regan (St. John's South—Mount Pearl, N.L.), is intended to enhance protections for health-care workers, those who assist them, and patients.

Going forward, the success of the legislation will depend on how well it is enforced, according to Smart.

"If a person is yelling and screaming or blocking you from doing your job, that's probably an easier thing to pursue than, say, someone who's harassing you significantly online from an anonymous account," said Smart. "I think [Bill C-3] was a step in the right direction, but I think it's going to need to be supported with resources from law enforcement to make sure that when people are experiencing those things, there is a timely response … and that people that are doing those behaviors actually meet with the consequences for it, because otherwise, it's just a piece of paper."

A cultural shift will be needed to improve working conditions for health-care providers, and that will include staff in hospitals and health-care institutions stepping up to communicate what behaviours are not acceptable, she said.

"This is not behavior we would tolerate in any other workplace," said Smart. "I think it just needs to be a value that we hold that's clearly communicated to the public, and that the health-care workers who are experiencing that are supported when they report it; to know that it's not okay."

Health Minister Jean-Yves Duclos announced on March 25 a $2-billion one-time top-up to provinces and territories through the Canada Health Transfer. The announcement was intended to address a backlog of nearly 700,000 medical procedures that were cancelled or delayed during the pandemic. *The Hill Times photographs by Andrew Meade*

Linda Silas, president of the Canadian Federation of Nurses Unions (CFNU), told *The Hill Times* that the workforce crisis facing the health-care sector is the worst she has seen in almost 30 years. Data collected by the CFNU indicates that as many as one in two nurses want to either change jobs within the health-care sector, or leave the health-care system altogether, she said.

A report released by the CFNU on Dec. 7, 2020, showed that 21 per cent of nurses experience verbal abuse every day from patients or their families. The report was based on a pre-COVID survey conducted between late October 2019 and March 17, 2020, by Dr. Linda McGillis Hall and Dr. Sanja Visekruna at the University of Toronto. The survey also found that 37.8 per cent of nurses surveyed experienced work-related physical injuries on a monthly basis.

"Prior to the COVID-19 pandemic, the nursing workforce was aging, with many nurses on the cusp of retirement. Many new nurses were choosing to work part time, sometimes because of excessive overtime and unsustainable workloads. As a result, shortages have been experienced in the nursing workforce," said the report.

Preventing burnout will involve improving working conditions, according to Silas. Measures to improve job satisfaction in the health-care sector could include more flexible working hours, and introducing phased-in retirement, she said.

"Right now, phased-in retirement for nursing is just available in New Brunswick. Instead of retiring, you go work part-time, so you're still committed to your employer, and part of your salary comes out of your pension plan. You kind of 'early retire,' but you're still working. You're still a resource to your employer," she said.

To address workplace violence and minimize burnout, one avenue to consider would be implementation of 'nurse-patient ratios,' which could be legislated by the federal government, according to Silas.

Some jurisdictions around the world have mandated staffing ratios as a way of addressing nursing workloads, according to A CFNU paper released on Sept. 29, 2012.

In 2015, Australia's state of Victoria set a requirement for a minimum number of nurses or midwives per number of patients in specified wards or beds.

"The federal government needs to start talking about patient safety and linking it to nurse-patient ratios," said Silas. "If we want to guarantee safe and quality care, we have to guarantee safe numbers in the health-care workforce. We believe that a good step, and we've seen it in other countries, would be to have legislated nurse-patient ratios."

Canada could benefit from an organization that examines workforce trends in the health-care sector, similar to an existing organization, BuildForce Canada, which is related to the construction industry, according to Silas.

BuildForce Canada, originally created in 2001 as the Construction Sector Council, is a national industry-led organization that works with contractors, labour providers and governments to identify supply and demand trends that will impact the labour force.

"You can literally tell how many plumbers you will need in X number of years, [or] how many carpenters you are going to need in X number of years. The list goes on, and then programs are able to be modified, and honestly, it's a success," said Silas. "That's exactly what we're looking for in healthcare. It is embarrassing that in a country like ours we do not know how many nurses we will need in 10 years. We do not know how many nurses we have now that are working casually who would want to work full time, or are working full time and feel the need to quit because they want to work part time."

The CFNU is Canada's largest nurses' organization, representing nearly 200,000 nurses and student nurses. The organization is also advocating for the federal government to fund an action plan to address the workforce crisis in the healthcare sector, which would include collaboration with the provinces, territories and health-care experts.

Continued on page 32

Cancer Impacts Everyone

Tracey Ramsay
Vice-President & General Manager,
AbbVie Canada

When you are living with cancer, rapid access to medication is critical. Cancer remains the leading cause of death in Canada, accounting for 30% of all deaths in the country.[3] According to the Canadian Cancer Society's Advisory Committee on Cancer Statistics, nearly half of all Canadians will develop cancer during their lifetime, and about one quarter of Canadians are expected to die from the disease.[4] Developing innovative medicines for cancer is essential to improve the quality of life and health of Canadians. As a research-based biopharmaceutical company, our priority is to ensure Canadians can access our treatments. This includes all aspects of the innovation process including manufacturing, distribution, and ensuring healthcare professionals and patients across Canada have timely reimbursement for lifesaving and life-changing therapies.

Canadians wait an average of 22-months for access to new medicines once approved by Health Canada. This is two times longer than most OECD countries, contributing to Canada's rank of 19 out of 20 OECD countries with respect to treatment access time.[5]

Thinking about a person's journey with cancer puts everything into perspective. According to a recent study, a one-month delay in cancer treatment resulted in a 6%-13% higher risk of death across all common forms of cancer. This risk increases with further delays.[6] For a Canadian living with cancer, time is everything.

Mark Silverstein is a chronic lymphocytic leukemia (CLL) survivor. Through his journey, Mark found a new purpose in life. He changed careers and returned to school to become a psychotherapist. He helps people throughout his community and shares his experience with cancer openly through written stories, speaking at leukemia and lymphoma conferences, co-facilitating patient survivor groups, and advocating for better access to the same kind of treatments that have allowed him to keep doing the things he loves. Like so many cancer survivors, he inspires and leads by example, but a growing and real need remains to ensure all Canadians have timely access to cancer care to live their best lives.

COVID-19 Impact on Cancer Care

As a result of public health restrictions postponing crucial medical services, including cancer screenings, surgeries, and essential interventions, healthcare experts are expecting to see delayed cancer diagnoses and treatment plans.[1]

A survey from the Canadian Cancer Society in July 2020 found that almost half of cancer patients in Canada reported having their care appointments cancelled or postponed.[2] Cancer care requires early diagnosis and intervention – which are crucial to treatment success.

We must continue to develop innovative solutions to address this clinical backlog, as well as advocate for equitable access to cancer medications.

Improving Outcomes

AbbVie Canada is committed to being a leader in oncology by advancing the science, research, development, and delivery of therapies to make a remarkable impact on Canadians living with cancer. A significant feature of this commitment involves working with payers and providers to ensure patients have access to the medicines they need to treat their conditions.

Access to innovative treatments is one of our top priorities, and we continuously work to leverage all available accelerated pathways to obtain expedited, fair, and equitable patient access.

Opportunity for Innovation

At AbbVie, we are striving to meet the need for faster scientific discoveries in oncology and making advances in areas of greatest unmet medical need. We are confident that innovative science powers discovery and have seen incredible advances in science and access to treatments over the past two years from the scientific community's global response to COVID-19.

We have also witnessed the positive acceleration of approvals of innovative oncology medications through Health Canada with innovative regulatory pathways such as Project Orbis, which allows for the simultaneous filing and review of oncology medicines among international partners, reducing the review time by several months.

However, despite this accelerated approval pathway, access to these approved oncology products by Canadians continue to lag as compared to other OECD countries.

The Power of Partnerships

We continue to foster meaningful, reciprocal partnerships with patient and physician associations, government policymakers, and payers to advocate on behalf of improved care and timely, equitable access to treatment for Canadians.

Together, with a focus on patient outcomes, innovation, and the strength of our partnerships, we will continue our efforts to ensure timely access to innovative oncology treatments to deliver on our commitment to make a remarkable impact on people living with cancer.

Every Canadian should have timely access to the medicines they need.

For more information on understanding the value of breakthrough Cancer Treatments in Canada, visit the Conference Board of Canada – Tomorrow Can't Wait.

About AbbVie

AbbVie's mission is to discover and deliver innovative medicines that solve serious health issues today and address the medical challenges of tomorrow across several key therapeutic areas: immunology, oncology, neuroscience, eye care, virology, women's health and gastroenterology, in addition to products and services across its Allergan Aesthetics portfolio. www.abbvie.ca, @abbviecanada on Twitter and Instagram.

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Health Policy Briefing

Post-pandemic health and science: preparing for the next one now

Dr. Theresa Tam, Canada's chief public health office, and Howard Njoo, Canada's deputy public health officer, pictured on the Hill after a presser on Dec. 15, 2020. 'We must not listen to calls that demand inquiries on what went wrong and who is to blame, but rather focus our attention on what has been learned and how this can inform policy-makers going forward,' write Stan Kutcher and Abraham Fuks. 'The Public Health Agency and Health Canada still need to produce a cogent and thorough plan to address these threats, recognizing long-standing concerns raised by infectious disease physicians.' *The Hill Times photograph by Sam Garcia*

Let's not miss this opportunity to plan ahead. Our lives and those of Canadians that follow us will depend on our communal foresight and wisdom.

Senator Stanley Kutcher & Abraham Fuks

Opinion

As Canada moves out of the COVID-19 pandemic and into a COVID-19 endemic mitigation state, it would be wise to take into account some highly regarded and sober advice. Writing in the medical journal *The Lancet*, a panel of international experts recently recommended that all countries conduct "urgent and comprehensive risk assessments" of the current functioning of their health systems. Dealing with upcoming crises will require a commitment to "open science and the rapid deployment of the best scientific responses, [that] are essential to reduce the spread, morbidity, and mortality of future emerging outbreaks."

For Canada, this advice has two essential components that should be a focus for the new Parliament.

First, we must not listen to calls that demand inquiries on what went wrong and who is to blame, but rather focus our attention on what has been learned and how this can inform policy-makers going forward. To this end, establishing an independent group of experts to conduct a national risk assessment of Canada's current state of health system preparedness for imminent threats of new pathogens and emerging outbreaks is essential. This must include a consideration of where we stand regarding anti-microbial resistant organisms.

The Public Health Agency and Health Canada still need to produce a cogent and thorough plan to address these threats, recognizing long-standing concerns raised by infectious disease physicians. A strategic assessment was identified as an urgent necessity in the auditor general's report of 2015 that concluded that: "the Public Health Agency of Canada and Health Canada have not fulfilled key responsibilities to mitigate the public health risks posed by the emergence and spread of antimicrobial resistance in Canada."

Once this risk assessment has been completed and its results reported, governments must take action. Political leaders and policy-makers can no longer play the ostrich. Incidentally, we note a recent call for a US COVID-19 commission by the Nobel laureate Harold Varmus and colleagues. Perhaps this may be a useful model for Canada.

Second, Canada requires a dramatic increase in its investment in basic science research and related disciplines, including research in social science, communications, and the humanities as we reflect on the imperative of understanding human behaviours, both individual and collective in coping with the exigencies of pandemic resilience. Canada's ability to cope with the current pandemic was based on following solid public health advice and taking advantage of new vaccines that were rapidly developed in response to this existential threat. However, without a preceeding robust basic science research enterprise the ability to produce these effective interventions would not have existed. More recently, effective anti-COVID-19 medications that can be used to mitigate many of the negative outcomes of infection have brought further encouragement to a population tired of slogging through the many months of this pandemic. These hopeful developments did not spring forth from nowhere, but were based on prior decades of basic science research. Discussions regarding innovation and economic development in response to the pandemic have suggested that Canada enhance its biomanufacturing capacities to mitigate future crises. This is valid and necessary, but policy planners must understand that without having a definitive and proven product, this capacity will sit idle, even as illness and death spin out of control. Simply put, no increase in investment in basic and health science research now, equals no innovative product with which to protect ourselves and others from the ravages of future diseases.

It's really that simple.

So as Parliament plans for our future and as the federal government, provinces, and territories move into a better space regarding the management and control of this pandemic, we really need to take a moment to consider what needs to happen next. So let's not miss this opportunity to plan ahead. Our lives and those of Canadians that follow us will depend on our communal foresight and wisdom.

Senator Stanley Kutcher, who is also a psychiatrist and professor, is an Independent Senator for Nova Scotia and Dr. Abraham Fuks is a professor in the faculty of medicine at McGill University in Montreal.

The Hill Times

CDA WELCOMES FEDERAL INVESTMENT IN DENTAL CARE

Canadian dentists support efforts to improve Canadians' oral health

CANADIAN DENTAL ASSOCIATION

This funding can make a huge difference in strengthening chronically underfunded provincial and territorial programs that meet the oral health needs of those who need it most:

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- **Racialized Canadians**
- **Low-income families**

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It is critical that the federal government work with provinces on improving health care, which would require Prime Minister Trudeau, pictured, to show leadership and be willing to meet with the provinces to talk about their health-care needs, writes Conservative MP Michael Barrett. *The Hill Times photograph by Sam Garcia*

Liberals can't delay on post-COVID recovery in health care

Provinces were experiencing health care capacity challenges long before today and before the extent of COVID.

Conservative MP Michael Barrett

Opinion

The pattern from the Liberals to delay until things reach a breaking point before taking any action has proven ineffective at managing the pressures on Canada's health system.

Since the start of the pandemic, whether it was ensuring our health-care workers had proper personal protective equipment, securing vaccines, and now last to lift unscientific mandates, the Liberals have been slow to act and even unwilling to take responsibility for their failure and Canadians have paid the price.

The mental health crisis in our country is facing added pressures from the loss, isolation and uncertainty, and the ongoing restrictions that have impacted the mental health of so many Canadians. Even before COVID there were far too many people dying from opioid related deaths in Canada, which has worsened significantly in two years, yet treatment resources are lacking to address the crisis that it is.

Provinces were experiencing health-care capacity challenges long before today and before the extent of COVID. But instead of addressing increasing medical backlogs, the Trudeau government is adding to the burdens on our health-care system by launching new programs amid a health-care human resource shortage.

This will have a negative impact on people's quality of life and health outcomes on otherwise treatable and curable illnesses, as well as the harm it will have on mental health. That is why it's irresponsible for the Liberals to prioritize promises made in the coalition agreement with the NDP over their obligation to address the existing health-care needs of the provinces.

The Liberals also have no reason to drag out something as necessary as creating a national three-digit suicide prevention hotline. The Conservatives had brought in a motion that called on the government to consolidate all suicide crisis numbers into a simple three-digit number that would be easier to remember for Canadians who need to access life saving help quickly.

That motion to create a national suicide crisis line received the unanimous support of Parliament more than 16 months ago. The Liberal government's failure to streamline that help is inexcusable.

It is also critical that the federal government work with provinces on improving health care, which would require Prime Minister Justin Trudeau showing leadership and being willing to meet with the provinces to talk about their existing healthcare needs. Instead, he maintains he won't discuss these challenges with the provinces until he decides that COVID is over. Meanwhile, the Trudeau Liberals impose new programs on the provinces to deliver with an already cash- and resource-strapped health-care system.

From the start of the pandemic the Liberal government's missteps and their refusal to take responsibility has downloaded immense pressure on the provinces and forced Canadians to have to wait longer for the care they need, like medical procedures, screening appointments, and testing.

The lack of accountability from the Liberals has also hampered the lessons that could be learned for a full post-COVID recovery and a plan for pandemic proofing Canada.

We need transparency from the Liberals on their decision to keep in place unscientific mandates and what their metrics are for reopening and restoring lost employment, on the surveillance tools used for monitoring COVID and having an effective health reporting network, in managing the National Emergency Strategic Stockpile to ensure supplies are there, and a detailed preparedness plan in place for any eventual outbreak.

The Liberal government must pitch in their federal responsibility with predictable and stable health transfers, not expensive new programs, so Canadians can have access to reasonable health care, while knowing that the federal government is prepared to respond to any future health emergencies.

Conservative MP Michael Barrett, who represents Leeds-Grenville-Thousand Islands and Rideau Lakes, Ont., is his party's health critic.

The Hill Times


Did you know 75% of all emerging infectious diseases over the past 30 years originated from animals, principally wildlife? Between 2014 and 2019, Canada allowed the import of at least 1.8 million wild animals from 76 countries, including known disease hotspots.
It's time we put a stop to this destructive trade.
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PANDEMIC
RISK
WHAT'S IT
GOING TO TAKE?
DESTINATION:
CANADA
The time for change is now.
Our health depends on it.
Canada plays a huge role in supporting the commercial wildlife trade, importing unchecked numbers of animals with very little oversight. How can we be sure we're not at risk for another pandemic? It's time the government takes responsibility.
WORLD
ANIMAL
PROTECTION
The world can't wait

Health Policy Briefing

Long-term care can no longer be an afterthought

Hundreds of members of the Canadian Armed Forces were called in to help out in at least two dozen Ontario and Quebec long-term care homes in April and May 2020, hit hard by COVID-19, including at this one pictured. There were allegations of elder abuse and neglect in at least five long-term care homes in Ontario. *Photograph courtesy of Department of National Defence*

It is unacceptable that it took the death of nearly 16,000 LTC residents to make long term care a priority.

Senator Jane Cordy

Opinion

Much has been said and much has been written about how the COVID-19 pandemic has brought very public attention to the state of long-term care homes across the country.

The 2020 Canadian Armed Forces report, which followed their deployment to some of the hardest hit care facilities in Ontario, painted a very grim and disturbing picture of the conditions within these long-term care homes. As shocking as this report was, these conditions have been known to advocacy groups and families of residents, who have been pushing governments to make changes for years.

Health care has always been a top priority for Canadians, yet until recently, long-term care seems to have been an afterthought far too often. Inadequate funding has led to under staffing, lack of services—both for residents and staff—and critical shortage of available spaces for those waiting to get into a long-term care home. Overworked staff feel unsupported, leading them to leave, and resulting in deteriorating quality of care.

It is unacceptable that it took the death of nearly 16,000 LTC residents to make long-term care a priority.

At the time of the CAF report, there were calls for the federal government to establish a national inquiry into conditions in Canada's long-term care homes. We need more than that. We need clear, strong leadership to make meaningful and substantial change to improve the lives of long-term care residents across the country.

My province of Nova Scotia recently committed resources to renovate and build 2,500 new single-bed rooms over the next three years, as well as funding recruitment initiatives with a goal of hiring 600 nurses and 1,400 Continuing Care Assistants.

Provinces and territories can't do it alone because the gap is far too large to bring our LTC systems up to the standards of care we need. The federal government must make a substantial investment and provide the necessary leadership to make the required changes happen.

The administration and delivery of healthcare is under the jurisdiction of the provinces and territories. Historically, those governments bristle when the federal government is seen as interfering, especially when it comes to how money is spent. But we need national standards, and we need a transparent mechanism to hold everyone accountable.

The 2004 Health Accord saw the federal government play a leadership role and successfully bring together First Ministers to a consensus on a path forward for renewal of health care in Canada. The same can be done now for LTC.

The Standards Council of Canada, Health Standards Organization, and Canadian Standards Association have been working together to develop new national standards for LTC. The plan is to use these new national standards as the foundation for a new Safe Long-Term Care Act.

The federal government clearly has a role to play in long-term care, and it does seem to be taking that responsibility seriously. In the health minister's mandate letter, wage increases and 50,000 new personal support workers, are specific targets. In the mandate letter to both the minister of health and the minister of seniors, the prime minster instructed them to negotiate agreements with provinces and territories to support efforts to improve the quality and availability of long-term care homes and beds and the implementation of the Safe Long-Term Care Act.

These goals cannot be downloaded onto the provinces to fund alone. The federal government will have to commit funding to these initiatives.

As we are hopefully seeing an end to the pandemic and a shift in focus by our governments to economic recovery, there is a real concern that the state of our long-term health care systems will fade from the public's attention.

The pandemic has been a reality check for many Canadians, and particularly for us Parliamentarians. We must find solutions to ensure quality care for some of Canada's most vulnerable, and to ensure they are treated with dignity and respect. We need federal leadership here, in this moment, to ensure lasting and systemic change.

Jane Cordy is a Senator for Nova Scotia and Leader of the Progressive Senate Group.

The Hill Times

Health-care systems
are stretched thin.

WHAT'S NEXT?

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Who cares: drop-in programs care for our most vulnerable, but can they afford to continue?

A man sits against a wall outside the National Arts Centre in Ottawa on April 22, 2020. The federal government has an important role providing direct financial support to charities and non-profits—particularly in these ongoing pandemic years. *The Hill Times photograph by Andrew Meade*

The federal government has an important role providing direct financial support to charities and non-profits— particularly in these ongoing pandemic years.

Sharmini Fernando

Opinion

In the northwest corner of Toronto, every morning, seven days a week, two women, front-line staff at the Syme Woolner Neighbourhood Centre, enter through a side door and head towards their carefully organized kitchen. They sort through food items, donated or bought, and begin their daily task of preparing and serving delicious and nutritious meals for those in need.

By 11 a.m., lone individuals, women with children, some LGTBQ+, sometimes entire families, many racialized and Indigenous, the unhoused or precariously housed, begin to wait outside the front door. By 1 p.m., more than 80 individuals will have received what is often their only hot meal of the day.

Before March 2020, Syme used to provide meals for 30 participants enrolled in our daily Community Drop-In program. But when Toronto entered the pandemic's first lockdown, our community's needs exploded beyond anything our small organization had anticipated. Our staff noticed, with great alarm, how vulnerable individuals, already marginalized by deeply systemic inequities, got pushed even further into precariousness as their basic human necessities—food, housing, clothing, harm-reduction supplies and medical and service referrals—became both urgent, yet more difficult to access.

How can we continue to provide this care? With difficulty.

City of Toronto-funded drop-ins are among the few easily accessible physical spaces in this city that provide trauma-informed and low-barrier services to people living in precariousness—with no questions asked. Yet drop-ins themselves are struggling with a number of challenges including low wages for staff, sky-rocketing rents, staff burnout and inflationary food prices.

One of the key services drop-ins provide is a warm meal. On our shoestring budget, we have to find ways of feeding 80 people on a daily basis. While relying heavily on the food bank system, many drop-ins, including Syme Woolner, raise funds to ensure that no one goes hungry. The food that is provided through the food bank system has to also meet the needs of an ever-increasing line of families who use the food bank weekly.

The Syme Woolner Neighbourhood Centre in Toronto, pictured. On our shoestring budget, we have to find ways of feeding 80 people on a daily basis. While relying heavily on the food bank system, many drop-ins, including Syme Woolner, raise funds to ensure that no one goes hungry. The food that is provided through the food bank system has to also meet the needs of an ever-increasing line of families who use the food bank weekly, writes Shamini Fernando. *Photograph handout*

In 2021, we served 5,109 households which is a 45 per cent increase from the previous year. This number translates to 450 households that are food insecure every month—just in our tiny neighbourhood. The working poor make up these households, some are the very frontline staff who work at drop-ins and other front-line services throughout the city; they are, for the most part, racialized women, underpaid, with an average hourly wage between $18-$22.

As a primarily gendered and racialized sector of the care economy, community drop-ins occupy the bottom of the care hierarchy.

The hard emotional and physical labour, and the ability to support and manage a range of people with mental health and addiction issues, while concurrently creating an environment that is trauma-informed, safe and caring for people experiencing social isolation, requires skills and competencies with a highly nuanced and compassionate approach. Without a living wage, our staff leave the work or burn out.

Wages must be increased to harmonize with inflation and build the respect required for the people who hold our social safety nets together.

The housing crisis in this city is now well known, including skyrocketing rental costs for people, small businesses—and for non-profit organizations. People and places are being displaced with dire consequences.

People are literally dying on the streets of Toronto. Syme Woolner recently lost five people who were regular participants at our drop-in program despite our efforts to keep in touch—just a fraction of the almost 150 people who died on the streets in the city in 2020.

The uncertainty of our clients is also reflected in the organizations that serve them, as front-line organizations also brace for rent hikes. How much, do we as a society, value this labour of care?

The City of Toronto budget was debated and passed in February. The drop-in sector is now bracing for another poor allocation of funding. We are concerned that we will not have the funding to raise salaries beyond the $18-$22/hour with benefits. We are worried that we will not have the funds for our hot meal program, which is usually one of the first programs to be cut when purse strings tighten, and we are concerned that rents will increase for our agencies.

As the city proclaims yet another celebratory day for front-line workers, such words need to be translated into material improvement for our labour and for our programs so that we can work with dignity and provide the dignity and respect to our communities—a symmetrical recovery for all.

Food poverty and homelessness in Toronto are not just municipal or provincial issues. Neither are the challenges charities and non-profits face to fund the critical services they provide only a matter for one level of government. All levels of government must give them top priority and work together collaboratively for meaningful and lasting solutions.

The federal government has an important role providing direct financial support to charities and non-profits— particularly in these ongoing pandemic years. Charities and non-profits need urgent help to retain staff, pay rent and keep our doors open. Without such support, we may see a shuttering of essential services provided by these front-line organizations like ours, with programs ceasing suddenly, and communities left destitute.

The pandemic is not over; federal government supports must continue.

Sharmini Fernando is the executive director of the Syme Woolner Neighbourhood and Family Centre.

The Hill Times

There is no health care without health-care workers

Canada's health-care system is on life support and on the verge of collapse.

Linda Silas

Opinion

Like many nurses in Canada, I welcomed last week's announcement that Prime Minister Justin Trudeau and NDP Leader Jagmeet Singh had reached an agreement with health care at its heart. As nurses, we have long advocated for national pharmacare, long-term care standards and dental care, and we recognize affordable housing as an essential social determinant of health.

While these measures will most certainly improve Canadians' health outcomes, the deal fails to recognize the perilous state of our health-care system. A decades-long health-care worker shortage continues to grow unabated and has left our health system on life support and on the verge of collapse.

Nurses are now hinging their hopes on the agreement's promise of immediate "additional ongoing investments" in Canada's health system, including more nurses. They are desperately hoping to see significant, targeted funding aimed at proven retention and recruitment initiatives, reinforced by real accountability measures.

Yes, we need more health-care workers, nurses, and doctors. At the same time, we also need to keep the nurses we have in their jobs to train, mentor, and retain a new generation of nurses. Retention and recruitment are two sides of the same coin.

In the fourth quarter of 2021, Statistics Canada reported 126,000 vacancies in the health-care and social assistance sector, an all-time high. Nationally, the number of vacant nursing positions surpassed 34,000, a 133 per cent increase over a two-year period.

Late-career nurses are revising their retirement plans. Meanwhile, new nurses are shocked by the untenable working conditions on the front lines and are reassessing their career choices.

Gruelling workloads and staffing shortfalls have taken their toll. A national Viewpoints Research Poll commissioned by the CFNU found that severe burnout among nurses had risen to 45 per cent. Nurses are grappling with high levels of stress. Polling indicates that just over half of nurses are considering leaving their jobs this year. Of those, one in five may leave nursing altogether. Even if nurses don't leave immediately, over 20 per cent of health-care workers are eligible to retire by 2026.

Along with more than 60 other health-care organizations, the CFNU also supports the agreement's commitment to better data, which we hope will inform a robust approach to health human resources planning. To this end, the federal government must establish a dedicated coordinating body to address critical health workforce data gaps.

Without a commitment to better data collection, coordination, analysis and planning tools, we can expect inadequate planning to continue now and in the future.

Health workers represent a significant public investment. In 2019, this amounted to nearly eight per cent of GDP. More than 10 per cent of all employed Canadians work in health care. And yet, we know very little about our health workforce. We lack the most basic data and tools needed for planning. To plan for the future and build a responsive health-care system, we need the ability to forecast how the workforce will change.

The federal government must assume a leadership role by collecting better and more complete data. Meanwhile, the provinces, territories, and regions will benefit from a more strategic and holistic approach to health workforce planning.

Throughout this pandemic, nurses have shouldered the burden of a short-staffed and under-funded health care sector. It's time to do right by health care workers and invest in a stronger health-care system.

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

The Hill Times

Prime Minister Justin Trudeau, pictured in Ottawa. As countries divert resources to stem the impact of COVID-19, the fight against other serious diseases like HIV, tuberculosis, and malaria where we were seeing progress previous to 2020 are losing hard fought gains, writes Julia Anderson, chief executive officer for the Canadian Partnership for Women and Children's Health. *The Hill Times photograph by Andrew Meade*

Where is our 'can-do' spirit? The world needs Canada to step up and stem the lasting health impacts of the COVID-19 pandemic

The scientific community has made it clear that low vaccination rates will increase the risk of new emerging variants.

Julia Anderson

Opinion

Early in the pandemic, collaboration was our first line of defence. We witnessed individuals and institutions working together—across divergent political parties, provincial, municipal, federal jurisdictions, and across a research community that spanned the entire planet.

This collaboration brought us four vaccines endorsed for emergency use by the World Health Organization less than one year into the pandemic, in comparison to the 10 to 15 years it can take to develop a vaccine under normal circumstances. It is incredible to consider where we were in March of 2020 and just how quickly we have arrived here. The now well-worn term 'unprecedented' seems the only word fitting. Unfortunately, for low- and middle-income countries, the collaborative spirit dissipated when it came to fair and equitable access to vaccines and other life-saving commodities.

In a world capable of so much, how is it that one continent (North America) has 74 per cent and another continent (Africa) only has 15 per cent of its population fully vaccinated? And it's no secret that many wealthy countries, including Canada, contributed directly to this inequity through its winner-takes-all procurement strategy, later dubbed vaccine hoarding. At one point in the pandemic Canada in fact had contracts that would have provided 10 doses for every Canadian, long before many countries received adequate supplies of personal protective equipment (PPE).

The scientific community has made it clear that low vaccination rates will increase the risk of new emerging variants, and contribute to the ongoing COVID-19 pandemic. In other words, as every G7 leader has said, until the entire world beats COVID-19, we will never be safe here at home. Yet, the rhetoric has not driven the level of support, innovation and thinking required to deliver a global strategy for vaccine equity.

This crisis of political energy sets the backdrop for the collapse of already fragile health systems. As countries divert resources to stem the impact of COVID-19, the fight against other serious diseases like HIV, tuberculosis, and malaria where we were seeing progress previous to 2020 are losing hard fought gains. Not to mention that for the first time in a decade, we are seeing key health indicators, including maternal and newborn mortality, slide backwards.

With the release of 2022 federal budget, we saw Canada positioning itself as a leader in the fight against COVID-19 which included a contribution to date of more than $1.3-billion to the Access to COVID-19 Tools Accelerator (ACT-A)—a global effort to improve equitable access to COVID-19 vaccines, tests, and treatments. Budget 2022 also proposed to provide $732-million in 2022-23 to Global Affairs Canada to further support the efforts of the Access to COVID-19 Tools Accelerator.

While this is a step in the right direction, to move forward on an equitable global response to COVID-19, Canada needs to bring back the collaborative spirit that infused its initial response. This means going above and beyond our current aid budget and recalibrating our global resources to meet the demand of this moment. It also means pushing companies and the World Trade Organization to lift the intellectual property protections that are slowing down the manufacturing and distribution of COVID-19 vaccines around the world. Many rich nations poured billions of dollars into a collaborative private-public partnerships that got us viable vaccines but this formula does not work for poor nations unable to bring such research dollars to the table, a collaborative approach that sees the end of COVID-19 would see lives put before profits and Canada has a role to play in making this happen.

In October 2021, a proposal tabled at the World Trade Organization's Council for Trade Related Aspects of Intellectual Property (TRIPs) asked members to waive the intellectual property rights on COVID-19 tools, including ventilators, drugs, and vaccines. Since then, over 100 countries, mostly low-income nations, have voiced their support for this waiver. Canada needs to listen to what is being asked of us and support this proposal. If we fail to act, economic and public health recovery are going to be slowed not by months, but years.

It is critical that we continue to ask ourselves if Canada is doing its fair share both to address the impacts of COVID-19 as well as maintaining its existing global health commitments—the two are intrinsically connected. Contributions to vaccine equity and increasing access to lifesaving commodities must not be at the expense of Canada's previous commitments to advance the health and rights of women and children around the world. The burden of need is higher than ever.

When the world came together to create a vaccine, we saw what we were capable of. We need to see this same kind of collaborative effort to ensure an equitable global response to COVID-19. To safeguard progress, it is critical that Canada maintains previous commitments and simultaneously steps up to help balance other global health priorities. Only together will we stop this tide.

Julia Anderson is the chief executive officer for the Canadian Partnership for Women and Children's Health (CanWaCH).

The Hill Times

Catching up on the next pandemic: how the government can address the mental health epidemic in Canada

Two years of lockdowns, isolation, uncertainty, and stress in the face of COVID-19 means that more Canadians are struggling with their mental health.

Dave Gallson

Opinion

To address the mental health crisis, the federal government needs to work with the provinces to develop a pan-Canadian funding strategy, writes Dave Gallson, the national executive director of the Mood Disorders Society of Canada. *The Hill Times photograph by Andrew Meade*

It's no secret that there is a brewing mental health crisis in Canada, and governments at all levels need to be prepared to meet the increased needs of the millions of Canadians who are seeking mental health supports. Two years of lockdowns, isolation, uncertainty, and stress in the face of COVID-19 means that more Canadians are struggling with their mental health, and it is incumbent upon our governments to make sure that the healthcare system is able to meet this increased demand to help Canadians.

At present, our primary health-care system is not supporting Canadians' mental health needs adequately. We know that many face unacceptable long wait times, inadequate person-centric care and inaccessible services. Many Canadians have to pay out of pocket for their mental health care, either because their employee benefits only cover a small amount, or they are without benefits programs entirely.

Mood Disorders Society of Canada (MDSC) knows first-hand the gaps that exist in the health-care system for Canadians seeking mental health treatment. As a non-profit organization offering support and resources for Canadians with depression, bipolar disorder, and other mood disorders, we are often the first stop for those looking to find supports and treatment. So many different community mental health organizations work hard to offer services to patients who might otherwise not be able to get treatment elsewhere. However, without greater support from the provincial and federal governments, these community mental health organizations are severely limited in their abilities to provide support.

In 2021, MDSC initiated a dialogue with community-based patient mental health organizations across the country to: learn more about the programs and services they offer; advance networking; listen to the challenges that these organizations face on a daily basis in attempting to delivery high-quality, accessible and impactful mental health programs; and discuss opportunities for collaboration and shared efforts in proposing solutions to the barriers that they face.

Our roundtable meetings with these community mental health organizations identified a set of key findings that were consistent among all the groups that we spoke with. Across the board, we found:

1. Community M/H organizations are strong innovators in developing new programs and services.
2. Community M/H organizations struggle to secure *core*, *operational*, and *sustained* funding.
3. Community M/H organizations face structural difficulties when recruiting and retaining talent.
4. Coordination and improved engagement between primary care and community organizations strengthen mental health care and improve accessibility.
5. Community organizations want to work together and strengthen available programs and services.

While all of these findings are critical, the biggest issue stems from the fact that these organizations are often overlooked when it comes to receiving funding from either the provincial or federal government. For the most part, these organizations rely heavily on fundraising activities or donations to pay for rent, staff and operational costs—with some receiving partial government grants. The inconsistent nature of this funding and non-existing core operational funding means that it's near impossible for organizations to focus on providing the much-needed services, because they spend too much time coming up with fundraising plans to hold yard sales, car washes and bake sales so they can raise money to pay their bills, rent and staff to do their work.

If governments are serious about making sound investments in mental health, and improve community services, then we implore them to put some of OUR money where the need is. Without providing support to these crucial community mental health organizations, the Canadian healthcare system is woefully unable to support the needs of families impacted by mental illness and mental health issues that will be seeking treatment as we move out of the COVID-19 pandemic. In order to address the ongoing mental health crisis, the federal government needs to work with the provinces to develop a pan-Canadian funding strategy for community organizations to drive programming and alleviate burdens they face in doing their work.

Dave Gallson is the national executive director of the Mood Disorders Society of Canada and has worked in the mental health and disability sector for more than 20 years.

The Hill Times

Federal transfers to provinces and territories for mental health and addictions are inadequate, representing only seven per cent of overall healthcare budgets, writes Margaret Eaton, the national CEO of the Canadian Mental Health Association. *Photograph courtesy of Pexels*

A holding pattern for mental health: what are we waiting for?

Canada is entering an era of national childcare, dental, and pharmacare. But where is mental health?

Margaret Eaton

Opinion

Budgets 2021 and 2022 made great strides in filling the gaps in our universal health-care system and recognizing the social determinants of health. We are now entering an era of national childcare, dental, and pharmacare. Those programs, along with investments in housing, will reduce health and social inequities and improve people's health and well-being.

But where is mental health care in all of this?

All major political parties campaigned on significant mental health promises in the 2021 federal election. Post-election, the government created a ministerial portfolio for mental health and addictions and upgraded campaign promises to mandate-letter commitments, including the creation of a Canada Mental Health Transfer. Since then, however, the government has stalled on clarifying how—and how soon—they will deliver on this commitment.

There is now broad recognition of the impact COVID-19 has had on mental health. Research, including that done by the Canadian Mental Health Association in collaboration with UBC researchers, shows that the pandemic has taken a terrible toll on Canadians' well-being. Are we now just paying lip service to improving mental health supports, without ensuring Canadians have the mental health care they need?

We need to remember that our mental health system was inadequate long before the pandemic.

The Canadian Institute for Health Information reported that in 2019-2020 half of Canadians seeking ongoing mental health counselling had to wait up to a month, while one in 10 people waited four months or longer. Already grave, this data requires us to ask how our system can meet the increasing need for mental healthcare that the pandemic has spurred.

Piecemeal actions on mental health like lumpsum health transfers to provinces and territories, small pots of short-term restricted funding, or charitable donations won't fix our mental health system. We can't just hope that Canadians will have enough cash or insurance benefits to cover the private counseling they need.

Mental health services that are delivered in the community, by community organizations, are not part of medicare. This is a long-standing legislative gap in the Canada Health Act, which excludes all mental health services except those provided in hospitals and by psychiatrists and family doctors.

Federal transfers to provinces and territories for mental health and addictions are inadequate, representing only seven per cent of overall healthcare budgets. These transfers also aren't tracked or directed to specific areas of care. That's why so many Canadians must pay out of pocket or rely on limited insurance benefits to scratch together mental health services. Those of us who don't have these financial resources often turn to community organizations and charities for mental health care. And yet, these community-based non-profits and charities receive only a small portion of the federal transfers and are funded, often insufficiently, through a patchwork of systems. They rely on restricted single or multi-year government and charitable grants, individual and private sector donations, and fundraising events.

Our system was built on these Band-Aid solutions.

A parliamentarian once told me our health-care system is really good at looking after everyone below the neck. When dental, eye, and mental health care are excluded, the system cannot truly be universal. We can no longer continue to praise a 'universal' health-care system that cherry picks which health conditions are worth treating. We can no longer prop up a system that forces people to choose between counseling for anxiety and paying their rent.

The time has come to make real universal mental health care happen.

So how will this happen? In concrete terms, it will mean first setting a timeline to establish the Canada Mental Health Transfer. Then, "strings" or accountability mechanisms (such as standards) must be built in, creating a framework for how and where mental health dollars can be spent by provinces and territories. Similar to the agreements on childcare, provincial and territorial advisory committees—with stakeholders including community mental health organizations and people with lived experience of a mental illness—must guide how this funding is spent. Finally, we need to see federal, provincial and territorial governments negotiate the integration of counseling and psychotherapy into provincial and territorial health plans. All of this must be underpinned by legislation, such as "Mental Health and Substance Use Health Care Act For All Parity Act," making the investment and policy framework permanent and accountable.

If politics is the art of the possible, we've seen masterful cross-party collaboration that has driven progress on long-awaited social policies. Mental health system transformation is appearing possible, and the time is now. What are we waiting for?

Since January 2020, Margaret Eaton has served as national CEO of the Canadian Mental Health Association (CMHA). Prior to joining the CMHA, Eaton served for seven years as executive director of the Toronto Region Immigrant Employment Council (TRIEC). Previously, she served as president of ABC Life Literacy and held leadership roles with the Association of Canadian Publishers and Magazines Canada.

The Hill Times

Bigger and bolder leadership from the federal government working in collaboration with the provinces and territories is needed now, writes representatives of the Canadian Alliance on Mental Illness and Mental Health. *Photograph courtesy of Pixabay*

Timely access to mental health care must be a top priority

Coming out of the pandemic, Canada will need improved connections to more accessible and inclusive mental health and substance use health programs, services and supports.

Kim Hollihan, Ellen Cohen, & Glenn Brimacombe

Opinion

While we provide our comments in a post-federal government budget world, it is clear that we still have some way to go before we can say we are living in a post-pandemic world. As we continue to do all that we can to ensure our families and friends and society-at-large are safe and well, we know that COVID-19 has had, and continues to have, a significant impact on our collective mental health and substance use health. In short, coming out of the pandemic the people of Canada will need improved connections to more accessible and inclusive mental health and substance use health programs, services and supports, not less.

While the recent federal government budget provides a mixture of important investments for mental health, substance use health and affordable housing for priority populations, they have postponed a key commitment made in their election platform; and that is the introduction of a Canada Mental Health Transfer coupled with an initial five-year investment of $4.5-billion, including $625-million in 2022/23.

In the view of the 15 national organizations that comprise CAMIMH, to defer such a critical investment is to delay, and in some cases, to deny timely access to care. Each day that passes deepens the impact of COVID-19 on those who need care and continues to hurt those with a pre-existing mental health and/or substance use health problem who are in the queue. Bigger and bolder leadership from the federal government working in collaboration with the provinces and territories is needed now, not in twelve months time or beyond.

Improving timely access to mental health and substance use health care services contributes to taking care of our loved ones, a quicker return to work, resuming of our volunteer and social activities and re-engaging as active members of society. In our view, the health, social and economic dividends that come from investing in mental health and substance use health programs, services and supports are life-saving and financially substantial … yet we continue to drag our feet on such an important societal issue.

Moving forward, CAMIMH continues to call on the federal government to introduce a new piece of legislation called the Mental Health and Substance Use Health Care For All Parity Act. The intent of this legislation is to align appropriate and sustainable federal funding and the creation of national standards with provincial and territorial health system accountabilities. It will also bring mental health and substance use health from out of the shadows and into the light to ensure that it is no longer neglected by medicare.

For too long, mental health and substance use health programs, services and supports provided by psychologists, social workers, psychotherapists, counselling therapists and counsellors have not been covered by provincial and territorial health plans. This must change.

This proposed legislation will also support and actively build on innovative delivery models of care—of which, some are focused at the primary care and community-based level—that the provinces and territories are actively pursuing to expand and improve timely access to mental health and substance use health problems.

Given the composition of CAMIMH—which includes organizations representing people with lived and living experience, their families and caregivers, and health care providers—we stand ready to work with all levels of governments and others to make this a reality.

Our mental health matters.

Investing in mental health care is a form of paying ourselves first.

There can be no health without our mental health.

The time to act is now.

Dr. Kim Hollihan (EdD) is co-chair of CAMIMH and CEO of the Canadian Counselling and Psychotherapy Association. Ellen Cohen is co-chair of CAMIMH and CEO of the National Network for Mental Health, which advocates, educates and offers expertise and resources to increase the health and well-being of Canadians with lived and living experience. Glenn Brimacombe is CAMIMH chair, Public Affairs Committee, and director of policy & public Affairs at the Canadian Psychological Association, and past CEO of two National Health Associations.

The Hill Times

For other preventable diseases, we can get back on track if we increase investments to tackle more than one disease at a time, writes Justin McAuley and Elise Legault. *Photograph courtesy of Pixabay*

We cannot afford to tackle one disease at a time

While we must continue to fight COVID-19, we cannot afford to neglect other diseases, such as AIDS, TB, malaria and polio.

Justin McAuley & Elise Legault

Opinion

It should not come as a surprise to anyone that COVID-19 has interrupted the fight against other major diseases. The pandemic has thoroughly and completely disrupted so much over the last two and a half years, that of course it has directly impacted efforts to combat other preventable diseases.

However, we cannot afford to tackle one disease at a time. While we must continue to fight COVID-19, we cannot afford to neglect other diseases, such as AIDS, TB, malaria and polio. To tackle all these crises at the same time, we need to increase funding to global health in its entirety, rather than just focusing on COVID-19.

In the most recent federal budget, the government again made a small increase to Canada's investments in development. We can celebrate that as a step in the right direction, especially since they specifically identified global health as an area for expanded investment. However, the context is key: Canada still invests only 32 cents out of every $100 of gross national income. This is well below the average of 39 cents from our "rich country" peers and even further below the 70 cents some of our G7 peers invest.

Now is the time for Canada to rise above that average: especially as we are facing a convergence of crises across multiple diseases.

While the COVID-19 pandemic raged on, existing diseases that were already plaguing global health systems have worsened or reappeared. A new case of wild polio has been found in Malawi, 30 years after the last reported case in Africa.

2020 was the first year in a while that saw an increase in deaths from malaria and tuberculosis (TB). HIV testing also fell by 22 per cent. Since people living with HIV and without access to treatment are severely immunocompromised, COVID-19 hits them hard. We're also seeing reports of increased COVID-19 mutations when the virus interacts with HIV.

To put the fight against these three deadly diseases back on track, Canada will need to re-invest in the Global Fund to Fight AIDS, TB, and Malaria. The Global Fund is one of the most effective global health organizations in the world and helped save 44 million lives since its creation in 2002. The economic argument is also clear and strong: for every $1 invested in the Global Fund, countries see $31 in health and economic returns.

The rapid development of vaccines, tests, and treatments during the pandemic has led to further innovations in science and research that can transform global health. By looking ahead and investing in the future, we can harness new technology, such as mRNA vaccines, that could finally beat these diseases after decades and centuries of fighting them. This progress will only be possible with immediate and significant investments in global health.

President Biden already set the tone by asking the U.S. Congress to increase the American investment by 30 per cent, and Canada should follow suit. With this new investment, Canada will help reduce the incidence rate of these diseases by up to 58 per cent. That means 20 million more lives could be saved between 2024 and 2026!

Investing in better global health to beat COVID-19 and diseases like HIV and TB is not just about charity, it is about making the world a safer and more prosperous place. As COVID-19 has shown, until a disease is brought under control everywhere, new variants and outbreaks will remain a threat to everyone everywhere.

For COVID-19, we can end the pandemic by getting tests, treatments, and vaccines to those who need them and continue to invest in new and better tools against future variants and pandemics. The rapid development we've seen on this front to date shows that when scientists are properly funded and backed by governments and regulators, we can tackle the world's most threatening diseases.

For other preventable diseases, we can get back on track, but only if we increase investments to tackle more than one disease at a time. By continuing to fund innovation and technology we can develop vaccines against other major diseases, from flu to malaria and HIV, saving millions of lives around the world and unlocking even more economic growth world-wide.

Justin McAuley is the DEI Council and media manager at ONE Canada and a former staff to the minister of development. Elise Legault is the policy and advocacy manager at ONE Canada and a former policy advisor at UNICEF.

The Hill Times

Health Minister Jean-Yves Duclos, Minister of Mental Health and Addictions Carolyn Bennett, and Seniors Minister Kamal Khera, pictured March 25, 2022, making a health funding announcement in Ottawa. The pandemic has caused remarkable increases in rates of burnout and other mental health concerns, already prevalent among nurses and doctors before the pandemic, due to health and safety concerns and unsustainable workloads. Health workers have faced 16-plus hour days, cancelled vacations and forced redeployment, writes Ivy Lynn Bourgeault. *The Hill Times photograph by Sam Garcia*

Canadians are concerned about the mental health of health workers; they should be

The status quo must be seen for what it is: the most expensive and least tenable option going forward.

Ivy Lynn Bourgeault

Opinion

If the health workforce was a patient, it would be in critical condition. The public seems to get it.

New results of a nation-wide survey by the University of Ottawa, conducted among members of the Angus Reid Forum from March 4-8, 2022, paint a troubling picture of how we feel about health workers. Overall, nine out of 10 Canadians (87 per cent) say they are concerned about the mental health of health-care workers.

This level of concern is even higher than ratings of our own worsening mental and physical health. When asked how things have changed since March 2020, 54 per cent of Canadians say their own mental health has worsened. After two years of pandemic stress, we are much more likely to express concern about the mental health of health workers than to say we've experienced a worsening of our own health.

People are not only concerned about how health workers are doing; they also express concern about what this means for their access to, and quality of, health care. Overall, four out of five Canadians (79 per cent) say they are concerned about being able to access health-care services because of the shortage of health workers. Slightly more (84 per cent) say they are concerned about the quality of health care services.

Women are significantly more likely than men to express concern about the mental health of health workers, health access and quality of care. Perhaps this is because the health system is primarily a women's workforce, with more than three quarters identifying as women, and growing, each year.

Regionally, half of those in Atlantic Canada (53 per cent) expressed strong agreement that they are concerned about being able to access health care services because of labor shortages—by far the highest rate in the country. Perhaps the importance of health care to provincial elections is most salient in this region.

If the public gets it, why doesn't it seem to be the case for our politicians? The recent federal budget was like crickets about these growing concerns.

The pandemic has caused remarkable increases in rates of burnout and other mental health concerns, already prevalent among nurses and doctors before the pandemic, due to health and safety concerns and unsustainable workloads. Health workers have faced 16-plus hour days, cancelled vacations and forced redeployment.

And then there is the violence.

We were warned pre-pandemic of the increasing violence nurses experience in health care, caused by understaffing, inadequate security and increased patient numbers, and how even in medicine, women faced incivility, bullying and harassment.Few of the critical recommendations from the report have ever been implemented. We are still waiting for the recommended public awareness campaign about the violence faced by health care worker or the pan-Canadian prevention framework. We are also still waiting for the much-needed update to the Pan-Canadian Health Human Resources Strategy to address staffing shortages and reflect the well-being of health care providers.

While health-care workers care for us, they have not received the support and care they need from our governments through supportive public policy.

As more than 65 health-care organizations and 300 health workforce experts and organizational leaders stated in an open Call to Action we began last year, the time is now for the federal government to take the lead in supporting provinces, territories, regions, hospitals, health authorities and training programs with an investment in better health workforce data and decision-making tools.

Canada needs to make informed staffing decisions, optimize contributions of the available workforce and enable safer workplaces. Right now, we are working in the dark.

There is both a sound economic argument for such an investment—with the health workforce making up eight per cent of Canada's GDP, or over $175-billion in 2019—and a sound humanistic argument in support of health workers.

The status quo must be seen for what it is—the most expensive and least tenable option going forward.

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

The Hill Times

Nurse retention crisis requires action plan to address workplace violence, says nursing organizations

Linda Silas, president of the Canadian Federation of Nurses Unions, pictured at a press conference on the Hill on Nov. 26, 2021, says shortages have been experienced in nursing because of an aging workforce. *The Hill Times photograph by Andrew Meade*

Continued from page 16

"We were hoping with the federal budget to see a little bit of a light at the end of the tunnel, because it won't be a quick fix, and it won't be a one-solution-fits-all. It'll be very multifaceted, but we need to work together to ensure Canadians that we're able to deliver health care," said Silas. "Our ask to the federal government was clear since last spring, that the federal government needed to bring the experts in, collect the appropriate data, look at the best practice across the world on how we retain and recruit into nursing [and] into health care, and to do this immediately."

The Hill Times asked Health Minister Jean-Yves Duclos (Québec, Que.) how the federal government is addressing the issue of worker retention in health-care. The request was passed along to Health Canada, and spokesperson Mark Johnson responded in an email on April 14 that, in addition to the former Bill C-3, the federal government addressed the workforce crisis in health-care with funding promises in the 2022 federal budget, which was tabled on April 7.

The 2022 budget proposed $26.2-million in funding to increase the forgivable amount of student loans for doctors and nurses who practice in rural and remote communities, which will mean up to $30,000 in loan forgiveness for nurses and up to $60,000 in loan forgiveness for doctors working in underserved rural or remote communities. The 2022 budget also proposed $115-million over five years, with $30-million ongoing, to expand the Foreign Credential Recognition Program and help up to 11,000 internationally-trained health-care professionals per year get their credentials recognized and find work in their field.

Dr. Katharine Smart, president of the Canadian Medical Association, says the scale of workplace harassment and violence in health-care has increased during the COVID-19 pandemic. *Photograph courtesy of Dr. Katharine Smart*

"Supporting the incredible contribution that health-care workers have made and continue to make in Canada's response to the pandemic is a priority for the Government of Canada. The Government of Canada works alongside provinces and territories, who have the responsibility for matters related to the administration and delivery of health services, including health workforce planning and management, to address pressing health workforce challenges," said Johnson in the emailed statement. "A safe working environment is critical to support the retention of health-care workers."

Sylvain Brousseau, president of Canadian Nurses Association (CNA), told *The Hill Times* that the federal budget does not go far enough to address the health workforce crisis. He argued that the measures proposed in the budget prioritize the recruitment of health-care workers, but don't do enough to address retention of existing workers.

"Workloads of health-care workers need to be reduced in order to make sure that people will stay and make sure that everyone will be able to practice in the full scope of the practice, and that means investment," said Brousseau. "The quality of work life in some healthcare facilities must be addressed, and we need to add actions in order to improve retention. That means that we must make sure that our healthcare professionals will be … able to self-schedule their own work day, [and] have more staff, because the nurses are not working at their full scope of practice in some areas."

Between the start of February and April 7, the CNA was one of the most active advocacy organizations on the Hill, and posted 57 communication reports related to the federal budget, according to the federal lobbyists' registry. This included communication with Liberal MP Greg Fergus (Hull-Aylmer, Que.), the parliamentary secretary to Prime Minister Justin Trudeau (Papineau, Que.) on Feb. 28, and Liberal MP Sean Casey (Charlottetown, P.E.I.), chair of the House Health Committee, on March 1.

Prior to the release of the budget, the federal government also addressed the issue of an overworked health-care sector by announcing it will provide the provinces and territories with an additional $2-billion through a top-up of the Canada Health Transfer. The top-up, announced on March 25, is intended to help address a backlog of nearly 700,000 medical procedures that were cancelled or delayed during the pandemic.

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The Hill Times

INFO BOX:

The 2022 budget proposed $26.2-million in funding to increase the forgivable amount of student loans for doctors and nurses who practice in rural and remote communities, which will mean up to $30,000 in loan forgiveness for nurses and up to $60,000 in loan forgiveness for doctors working in underserved rural or remote communities. The 2022 budget also proposed $115-million over five years, with $30-million ongoing, to expand the Foreign Credential Recognition Program and help up to 11,000 internationally trained health-care professionals per year get their credentials recognized and find work in their field.

Canada Nursing Shortage Statistics

- A study released on Jan. 23, 2018, predicted a shortage of 117,600 nurses in Canada by 2030. (*Scheffler and Arnold*)
- About 50 per cent of the personal support worker workforce in the health-care sector in Ontario are between 35 and 54 years old. (*Long-term care staffing study, July 30, 2020*)
- A survey of nurses conducted by the Canadian Federation of Nurses with researchers from the University of Regina, released on June 16, 2020, showed that 83 per cent of nurses felt that their institution's core health care staff was insufficient to meet patient needs. (*Mental Disorder Symptoms Among Nurses in Canada*)
- At least 13 per cent of RNs aged 26-35 reported they were very likely to leave the profession after the pandemic, and a total of 4.5 per cent of respondents said they planned to retire now or immediately after the pandemic. (*Work and Wellbeing survey, March 2021, Registered Nurses' Association of Ontario*)

Mental Health Among Health-Care Workers in Canada (2021)

- Eight months into the global pandemic, 33 per cent of 18,000 health care workers from the provinces and territories surveyed reported fair or poor mental health.
- Most participating health care workers (70 per cent) reported that their mental health was "somewhat worse now" or "much worse now" compared with before March 2020.
- When asked to choose between five levels indicating how stressful most days were, 56 per cent chose one of the two highest levels, reporting that most days were "quite a bit stressful" or "extremely stressful."

Source: Statistics Canada

HEALTH

Canada's premiers are united in calling for the federal government to increase its share of health funding through the Canada Health Transfer to 35 per cent and maintain this share of funding. This is aspirational and will no doubt take time, but an important starting point for negotiations. The proposed '25 per cent by 2025' federal contribution pitch by Canada's major health-care stakeholders is a realistic and achievable short-term goal. What is clear is the federal government must re-commit itself as a full funding partner to renew Canada's public healthcare system for the 21st century. *The Hill Times photograph by Andrew Meade*

It's time to renew Canada's public health-care partnership

Canada has just 1.95 acute care hospital beds per 1,000 people, which is fourth worst among the 27 OECD countries.

Don Davies

Opinion

It is now a truism that while COVID-19 caused many problems, it exposed others already there. One of the latter is the dangerous erosion of capacity in our public health-care system which began long before the pandemic struck.

Decades of underfunding and neglect have impeded access to care and undermined our ability to respond to an emergency like COVID-19. This has placed tremendous strain on our health-care system, resulted in millions of delayed surgeries and diagnostic procedures, and pushed frontline workers to the edge of their capacities.

Yet, clear warnings were ignored for years prior to the outbreak of this virus. A review of Canada's critical care capacity conducted following H1N1 found that intensive care unit resources vary widely across Canadian provinces, and cautioned that during times of crisis this could result in geographic differences in the ability to care for critically ill patients.

The comparative numbers tell the real story.

Canada has just 1.95 acute care hospital beds per 1,000 people, fourth worst among the 27 OECD countries. The number of hospital beds in Canada is similarly near the OECD bottom, and has dropped dramatically from 6.9 beds per 1,000 in 1976 to 2.5 beds today. As a result, our country's pre-pandemic acute care bed occupancy rate of 91.6 per cent ranked far higher than the OECD average of 75.7 per cent. The internationally accepted standard for safe hospital capacity is 85 per cent.

Canada ranks 21st of 27 in the per capita number of MRI and CT scanners and 10th out of 10 among similar countries in wait times for surgeries and procedures. While general health outcomes are still fairly good in Canada, that is due more to the skills and talents of Canada's health-care workforce than to the resources we provide them.

Our health-care fiscal framework is a foundational part of the problem.

When medicare was first established in Canada, the federal government agreed to assume half the costs incurred by provinces and territories. However, at a first ministers meeting in 1976, prime minister Pierre Trudeau put forward a plan to replace the 50-50 cost sharing agreement with a new regime of block grants that exposed the provinces and territories to unilateral federal cuts over the subsequent decades.

Today, the federal share of overall health-care spending in Canada has plummeted from the original 50 per cent to 21.7 per cent. Without immediate action, the federal contribution to provincial and territorial health expenditures is projected to decline even further over the coming years.

When seeking re-election in 2011, Stephen Harper pledged to negotiate a Health Accord with the provinces and territories—but no discussions ensued. Instead, then-finance minister Jim Flaherty simply announced that the Canada Health Transfer escalator effectively would be cut from six per cent to three per cent.

In its 2015 election platform, the Liberal Party pledged to negotiate a new Health Accord with the provinces and territories—but instead adopted the Harper cuts. This decision has deprived our health-care system of an estimated $36-billion over a decade.

The long-term impact of the Harper/Trudeau funding formula is clear. Because health-care costs across the country are rising at an average of five per cent per year, if the federal government is only increasing spending at three per cent, that is a recipe for fiscal imbalance and cuts. In addition, the Conference Board of Canada estimates that the impacts of the COVID-19 pandemic will result in a further $80-billion to $161-billion in health-care expenditures over the next ten years.

Instead of deferring discussions on health transfers to an unspecified date in the future, the federal government should step up now with the long-term funding needed to protect our health-care system. Federal-provincial-territorial negotiations should begin without further delay so that an agreement can be finalized early this year, ahead of federal, provincial and territorial budgets.

And there is a historic consensus. Canada's premiers are united in calling for the federal government to increase its share of health funding through the Canada Health Transfer to 35 per cent and maintain this share of funding. This is aspirational and will no doubt take time, but an important starting point for negotiations. The proposed "25 per cent by 2025" federal contribution pitch by Canada's major health-care stakeholders is a realistic and achievable short-term goal. What is clear is the federal government must re-commit itself as a full funding partner to renew Canada's public health-care system for the 21st century.

Through federal leadership and collaboration, we can ensure the sustainability of our existing public health-care system, while expanding it to provide desperately needed services and treatments such as better long-term care, pharmacare, dental care, and mental health care.

In doing so, we can emerge from the COVID-19 pandemic with a stronger and more equitable public healthcare system for all Canadians.

NDP MP Don Davies represents Vancouver Kingsway, B.C. He was first elected in 2008, and re-elected in 2011, 2015, 2019 and 2021. He serves as the NDP critic for health and deputy critic for global affairs and international development. Prior to that, he served as official opposition critic for international trade, citizenship and immigration and multiculturalism, and public safety and national security.

The Hill Times

HOPE IS HARD WORK

For somebody living with lung cancer, like Sarah, it wasn't always easy to stay hopeful.

But thanks to advancements in oncology treatments and innovative therapies, Sarah's cancer is now in remission.

Find out how Canada's research-based pharmaceutical sector works to improve the quality of life for all Canadians.

HopeIsHardWork.ca

INNOVATIVE MEDICINES CANADA

What will it take to change long-term care in Canada?

Canada has spent millions for reports on long-term care over two decades with the same basic recommendations.

Trina Thorne & Carole A. Estabrooks

Opinion

The global pandemic marked Canada as an outlier in one significant, tragic way. While seniors in most countries were hit hard, in Canada, a whopping 81 per cent of all deaths in the initial months of the pandemic happened in long-term care, compared to a mean of 42 per cent in other OECD countries. A more recent, independent assessment has found that of Canada's 30,420 deaths from COVID-19, 18,800 deaths have occurred in 1,871 residential facilities (as of Jan. 9, 2022).

Why were seniors in Canada's long-term care facilities so hard hit compared to elsewhere?

Poor pandemic preparedness, lower daily care hours for residents, poor funding and resources, inconsistent inspections and inadequate integration of health and hospital services are among many factors at play. Most of these problems long predate the pandemic. Governments at all levels have known about the problems in long-term care for decades and have done little to address them.

In a recent study published in F1000 Research, along with our colleagues, we identify more than 80 reports from governments, unions, non-profit organizations and professional societies commissioned to examine the state of long-term care in Canada from 1998 to 2020. The reports range from a few pages to almost 1500 pages; most identify the same basic problems and repeat the same basic recommendations.

What will it take to make changes to long-term care in Canada?

Our study found the report recommendations over the last two decades have been consistent, evidence-based and would have, undoubtedly, saved many lives had they been implemented prior to the pandemic. Inaction set the stage for increased deaths during COVID-19 and contributed to lower quality of life in long-term care homes.

What recommendations have been made recurrently that have been ignored by successive provincial and federal governments?

The three main recommendations across reports spanning over two decades include increasing or redistributing funding to improve staffing, increase direct care and capacity; standardizing, regulating and auditing quality of care; and reforming, standardizing, and regulating education and training for long-term care staff. Improving staff education and training and increasing behavioural supports and modernizing infection control measures were universally recommended in the reports.

Why did these repeated pleas for change in long-term care go unheeded? Issues of understaffing, under-training and the negative impact of for-profit long-term care homes are repeatedly mentioned in the reports. Countless media articles have also highlighted the findings of these reports over two decades.

In the aftermath of the pandemic's first waves, some changes have happened in long-term care. Several provinces have modestly increased wages and provide more full-time employment to stabilize the workforce. Ontario committed four hours of direct care per day for each resident by 2024, an increase on the national average of 3.3 hours. Alberta's Facility-Based Continuing Care report recommended among other things, 4.5 hours of care, establishing full-time employment benchmarks for the workforce and prioritizing quality of life for residents. The Quebec ombudsman's final report also prioritized full-time jobs to enable a single-site format and limit the use of workers from employment agencies.

Although highly relevant infection control deficiencies are noted and specifics of some recommendations such as hours of care may vary, many of the recommendations have been made many times over. These are solid steps in the right direction, but much more needs to be done, particularly on resident quality of life and staff quality of work life.

While much good could potentially come if the recommendations of the new pandemic reports are implemented, it remains the case that duplicative investigations of known findings have far less value than implementation of the solid existing recommendations. Had the recurring recommendations been implemented, we would undoubtedly have improved working conditions, quality of care and quality of life in Canada's long-term care homes, as well as, prevented unnecessary deaths due to COVID-19.

Now we must try to introduce increased hours of care amid a growing and increasingly severe shortage of all levels of workers in long-term care.

Now is the time for action. Our governments need to move forward, prioritize recommendations—it cannot all be done at once—and begin the hard work of figuring out implementation, resourcing, and evaluation. This must include identifying and resourcing areas where gaps in knowledge make coherent decision-making impossible and are too major to ignore.

Trina Thorne is a nurse practitioner working in long-term care who is completing her PhD with Dr. Estabrooks and the Translating Research in Elder Care (TREC) program at the University of Alberta. Dr. Carole A. Estabrooks is scientific director of the pan-Canadian Translating Research in Elder Care (TREC) program and professor and Canada Research Chair, College of Health Sciences at the University of Alberta.

The Hill Times

Let's aim higher for the health care we deserve

As we know from history, major disasters are the impetus for important change because they expose the fallacies of sacred cows. After the disaster of COVID, we have a unique opportunity now to make the new investments needed to build the health-care system Canadians want, need and can afford.

Bill VanGorder

Opinion

HALIFAX—COVID-19 has done many things to us individually and collectively. Perhaps the biggest lesson from the pandemic is the importance of a well-run health system that not only meets our everyday needs but can also rise to unexpected challenges.

Canada's health-care system in its current state failed to meet the challenges of COVID and we all paid a very high price. We continue to pay, as Canadian health-care struggles to catch up with hundreds of thousands postponed surgeries, tests and procedures, including for lethal diseases such as cancer. We are discovering the cost of having neglected to meet some basic needs.

For example, in the year before the pandemic began, Statistics Canada reported that 4.6 million Canadians over age 12 (14.5 per cent of us) did not have access to "a regular health-care provider they see or talk to when they need care or advice for their health." That's a basic gap and recipe for a lack of prevention and care for problems when they could be most simply dealt with, and at the least cost.

And when health problems do escalate, we are ill-equipped. Compared to other major wealthy countries, we have among the fewest hospital beds per capita and lowest amounts modern equipment such as MRI scanners.

This issue is most vital for Canada's rapidly increasing population of seniors, who not only face the most health challenges but have been disproportionately impacted by the pandemic from deaths, serious illness and confinement, either in their own homes or long-term care facilities, many of which also failed to meet basic needs during the pandemic.

Even more than we did when the pandemic started over two years ago, we need dramatic and innovative changes in our health-care system. Rather than dwell on what we missed or lost, it's time to aim for the health care we deserve—based on increased investments and innovation.

For example, we can do far more now to prevent major health issues and to care for people at home. Yet our current system is built around providing sick-care treatment—not health care—after the fact, in large, centralized institutions. We need to deliver health care in totally different ways, facilitated by the types of technology we suddenly had to count on during the pandemic so we can prevent health problems as well as treat them.

One positive outcome from the pandemic was the clear demonstration that constructive change is possible when we have the will to make it happen. For example, doctors quickly adopted virtual visits and even hospitals began caring for some of their patients while they remained at home. COVID testing and vaccine programs were rolled out in multiple settings, beyond formal clinics and hospitals including pop-ups where they were most needed. Why not do that to regularly provide things like blood pressure and diabetes testing or healthy eating counselling?

We must also take note that the COVID vaccines and medicines that are our ticket out of the pandemic became available in record time because governments removed the unnecessary roadblocks that delay other treatments and vaccines from getting to patients for many years. This included an exemption from the proposed federal price controls on new drugs. Let's make those speedy processes the norm for all medicines.

Contrary to what many politicians believe, Canadians see the need and are willing—indeed desperate—for important changes to our health system because the current model has been tested and found very wanting. In a recent survey of CARP members, there was near unanimity that innovative treatments should be available to Canadians at the same time as in other major countries and that applying the model used for COVID vaccines and treatments would be a good way to achieve that.

As we know from history, major disasters are the impetus for important change because they expose the fallacies of sacred cows. After the disaster of COVID, we have a unique opportunity now to make the new investments needed to build the health-care system Canadians want, need and can afford.

We require action now: immediate and specific changes that are made for the 21st century, based on increased investments and embracing new technology and innovation to create new and efficient ways to deliver the care we all deserve.

Bill VanGorder is chief operations officer of CARP, the Canadian Association of Retired Persons. He has been involved in health advocacy for over 30 years both in his present position and as president and CEO of the Lung Association of Nova Scotia, 28 years with the YMCA, and for the final 12 years as the Atlantic area director for the YMCA. VanGorder 'retired' as CEO of The Lung Association of Nova Scotia almost 15 years ago, but has continued to be an advocate for seniors' issues and a speaker on retirement planning.

The Hill Times

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Liberals 'dragging their heels' on pharmacare as COVID ups the need for affordable meds, says labour union, NDP

The Canadian Labour Congress and the NDP health critic argue the Liberal government has stalled on universal pharmacare, which would benefit many Canadians by making medications more affordable during the COVID-19 pandemic, thereby reducing the strain on hospitals.

BY JESSE CNOCKAERT

With yet another pandemic federal budget on the horizon, organized labour is pushing for universal pharmacare to help workers who have lost their workplace benefits due to COVID-19 work disruptions.

The prospect of a universal pharmacare program has become all the more important during the COVID-19 pandemic, according to Canada's largest labour organization, which is hoping the upcoming federal budget will focus on the many Canadians struggling to afford their medications to help reduce the strain on hospitals.

"I don't think the government is prioritizing it in the same way as they would have prior to the pandemic," said Bea Bruske, president of the Canadian Labour Congress (CLC), an umbrella organization with a membership of dozens of unions, which together, represent more than three million workers. "We know that when people don't take their medications, they end up in doctors' offices [and] they end up in hospitals. Right now, we don't have the capacity to manage these things, so it's even more critical to get this thing done."

The CLC and other stakeholders like the Canadian Doctors for Medicare and the Canadian Federation of Nurses Unions are awaiting the implementation of a universal pharmacare program that would help manage the cost of prescription drugs. Implementation of pharmacare was a 2019 election promise for the federal Liberals, but with no universal pharmacare program yet in place almost three years since then, Bruske said the Liberal government is "dragging its heels."

The Liberals' 2021 election platform mentioned the party had been "moving forward on pharmacare," but did not include a specific renewed commitment towards implementation.

"With everything else that's been going on, we think the eye has been taken off the ball of pharmacare and it's no longer as much of a priority as it might have been a few years ago, and that's a problem," she said. "We definitely need them to focus on it again and put it into the budget discussions this year. It has a place in our arsenal to keep Canadians healthy, and to keep Canadians out of hospital rooms."

Bruske said it was appropriate during the pandemic for the health conversation to shift towards issues such as vaccine production, but it is still important for the government to retain attention towards pharmacare. During the last two years of the pandemic, workplace disruptions have made it twice as likely for a worker to lose their prescription drug coverage because of a loss of workplace benefits, according to Bruske.

"We know that workplaces have not yet returned to normal. We know that in the service sector [and] in the hospitality sector, many workers, even though they may be working, are not back to their full hours. If they're not back to their full hours, many of them don't meet the threshold set by their employers to be actually eligible for benefits," she said. "That means that they've lost those benefits, and can no longer count on them at a time when they have even more fiscal challenges, in terms of making their household budgets work."

Bruske cited a study by the Angus Reid Institute (ARI) which stated that millions of Canadians

Bea Bruske, president of the Canadian Labour Congress, says the Liberal government is not prioritizing pharmacare 'in the same way as they would have prior to the pandemic.' *Photograph courtesy of LinkedIn*

are struggling to access needed prescription medicines. During the first year of the pandemic 23 per cent of Canadians decided not to fill or renew a prescription because of high costs, according to the ARI study released on Oct. 29, 2020.

During the first year of the pandemic, Canadians were twice as likely to have lost prescription drug coverage (14 per cent) as to have gained it (seven per cent), and about 26 per cent of Canadians paid for half or more than half of the cost of their prescription drugs, according to the study.

The ARI study was conducted in partnership with the University of British Columbia's School of Population and Public Health; St. Michael's Hospital and University of Toronto; the Carleton University Faculty of Public Affairs and School of Public Policy and Administration; and, the Women's College Hospital in Toronto.

"We know with inflation and everything else going on Canadians are struggling. Workers are struggling with the cost of living, and [pharmacare] is one way that our federal government could assist," said Bruske. "Anytime that we have an opportunity to speak with a government minister, we have a whole slew of priorities that we speak about. Pharmacare is always one of the many priorities that we've set. It's an ongoing push for us."

Former Ontario health minister Dr. Eric Hoskins led an advisory council appointed by the Liberal government in 2018 that examined possible models for implementing a national pharmacare program. The council's final report, released in June 2019, recommended the federal government opt for a "single-payer" system, which would move all Canadians onto one national public drug plan. This is contrasted with a "mixed-payer" model, which would provide drug coverage through a combination of existing private insurance plans and public plans.

The advisory council report included an estimated cost of $3.5-billion to launch national pharmacare, starting with universal coverage for essential medicines. The report further estimated that, as the national formulary grows to cover a comprehensive list of drugs, annual incremental costs would reach $15.3-billion in 2027.

The CLC is pushing for support for implementation of pharmacare in the 2022 federal budget that aligns with the estimates provided in the advisory council report, according to Bruske.

Health Minister Jean-Yves Duclos, pictured at a Hill press conference on Jan. 7, 2022, was directed to engage with willing provinces and territories towards implementation of national universal pharmacare in his mandate letter on Dec. 16. *The Hill Times photograph by Andrew Meade*

Implementation of national pharmacare has currently exceeded the timeline originally recommended in the Hoskins report. The report suggested that federal, provincial and territorial governments should launch national pharmacare by offering universal coverage for a list of essential medicines by Jan. 1, 2022, which has not occurred.

NDP health critic Don Davies (Vancouver Kingsway, B.C.) told *The Hill Times* that exceeding the timeline in the Hoskins report is an indication that the Liberal government is not committed to implementing universal pharmacare.

"[Pharmacare] is not a new idea. It's been recommended for decades. There's been blueprints and studies and task force recommendations and the Hoskins report, which not only gave the Liberals a blueprint, but a timeline, and the Liberal government has ignored both of those things," said Davies. "Frankly, I think the issue is completely stalled."

In terms of developing a budget for pharmacare, Davies said to look at universal child care for an example. In the spring of 2021, the federal government announced $30-billion over five years to help provinces offset the costs of a national child care system. Nunavut became the latest territory to sign a child-care deal with the federal government on Jan. 24. Under the deal, the federal government will provide $66-million to the territory over five years, with parent fees for licensed child care expected to be reduced by 50 per cent on average by the end of this year. Ontario is the only province that hasn't yet reached a deal with Ottawa.

"It's a very apt comparator, because both of these programs have to be delivered by the provinces, both of them require federal leadership, [and] both of them require federal contributions of funding," said Davies. "The first thing is, we need a fiscal commitment and a fiscal framework by the federal government. And then, from a programmatic point of view, I think one of the first things to do is to nail down a formulary. That would be the basis for the act."

Davies said that he views pharmacare as an expansion of the basket of services provided by the public health system.

"What you need in pharmacare is to set out that formulary of covered drugs that you're asking the provinces and territories to cover according to the principles of universality and comprehensiveness," said Davies. "I think that's the next and most important thing. That's not hard to do because formularies exist all over the place. Insurance companies use them all the time. It's not that difficult to come up with an acceptable formulary."

Davies and Bruske both support implementation of the "single-payer" model for pharmacare, in accordance with the Hoskins report. An organization that supports the "mixed-payer" model is the Canadian Life and Health Insurance Association (CLHIA), a trade organization representing life insurance and health insurance providers across Canada.

The Hill Times reached out to the CLHIA for comment about pharmacare, and was directed to its pre-budget submission for the 2022 federal budget, which was released on Aug. 6, 2021.

More than 26 million Canadians currently have access to a wide-range of prescription drugs and other health supports through extended health care plans, and any reforms should ensure "the continued viability of the health benefit plans that the majority of Canadians rely upon and value today," according to the CLHIA pre-budget submission.

Former Ontario Health minister Dr. Eric Hoskins led an advisory council, whose final report in 2019 recommended Canada adopt a 'single-payer' pharmacare model. *The Hill Times photograph by Andrew Meade*

"Patients want access to the same standard coverage no matter where they live and no matter what kind of plan they have. Federal, provincial and territorial governments and private insurers should work together to jointly develop a standard list of medicines that all Canadians can access. It is important that private payers are able to participate in this process to ensure the list meets the needs of Canadians covered through private plans," said the CLHIA pre-budget submission.

The Hill Times reached out to Health Minister Jean-Yves Duclos (Québec, Que.) to ask where the Trudeau government is currently in regards to implementation of universal pharmacare. An emailed response from Anne Génier, the senior media relations advisor at Health Canada and the Public Health Agency of Canada, said the mandate letter Duclos received on Dec. 16 reiterated the Liberal government's commitment to engaging with provinces and territories towards national universal pharmacare, while proceeding with a national strategy for drugs for rare diseases and advancing the establishment of the Canadian Drug Agency.

"No Canadian should have to choose between paying for prescription drugs and putting food on the table," said the emailed statement. "The government of Canada is committed to working with provinces, territories and stakeholders to continue to implement national universal pharmacare so that Canadians have the drug coverage they need."

As an example of the progress towards the implementation of universal pharmacare, the emailed statement cited an agreement that was signed on Aug. 11, 2021 between the Liberal government and the government of Prince Edward Island (PEI) intended to improve access to and affordability of medications to island residents. The agreement, announced by then-health minister Patty Hajdu, states that the province will receive $35-million over four years in federal funding to add new drugs to its list of covered drugs, and lower the out-of-pocket costs for drugs covered under existing public plans for Island residents.

In a press release accompanying the signed agreement, the Liberal government stated it would "use early lessons from PEI's efforts to inform its ongoing work to advance national universal pharmacare."

The 2019 federal budget set aside $35-million to establish a Canadian Drug Agency Transition Office to advance discussions surrounding pharmacare and to engage provinces, territories and stakeholders in discussions on the creation of a new Canadian Drug Agency. Susan Fitzpatrick was announced as the head of the Canadian Drug Agency Transition Office on April 1, 2021. Fitzpatrick's more than three decades of experience in the health-care sector includes serving as the former interim CEO of Ontario Health, and as the former CEO of the Toronto Central Local Health Integration Network. She currently serves as an advisor for Santis Health, a health consultancy in Toronto.

NDP health critic Don Davies says the Liberal government has 'completely stalled' on implementing universal pharmacare. *The Hill Times photograph by Andrew Meade*

"In addition, work is underway with partners to develop a national formulary. In July 2021, an arms-length organization, the Canadian Agency for Drugs and Technologies in Health (CADTH), established a multidisciplinary national panel to develop a draft formulary framework for consultation this winter. Consultations are currently underway," said Génier's emailed statement. "The government remains firmly committed to improving the access to and affordability of quality medicines for Canadians."

The 2019 federal budget also listed lowering drug prices as part of the groundwork in moving towards implementation of a national pharmacare plan.

The Patented Medicines Pricing Review Board (PMPRB), the agency that regulates drug prices in Canada, is currently awaiting the implementation of new regulations intended to provide better protection to Canadian consumers from excessive prices for patented medicines. The proposed updates include new price regulatory factors that would need to be considered by the board, and a revised list of countries that should be referenced for setting drug prices.

The updates to the PMPRB, the first substantive updates to the board in more than 30 years, were proposed on July 15, 2021. Duclos announced in a Dec. 23, 2021 press release that the coming-into-force of the new regulations will be delayed by six months and implemented on July 1, 2022.

The Health Canada press release stated the delay is in response to the COVID-19 pandemic, and the spread of new variants of concern that require urgent action.

"This delay provides additional time for impacted stakeholders, including industry, governments, and other parties within the drug reimbursement and distribution system to continue to focus their efforts on responding to the unprecedented challenges presented by the COVID-19 pandemic," stated Génier's email, repeating a statement from the Dec. 23 press release.

jcnockaert@hilltimes.com
The Hill Times

Canada prescription drugs statistics (as of June, 2019):

- A total of 7.5 million Canadians either don't have prescription drug insurance or have inadequate insurance to cover their medication needs
- One in five households reported a family member who had not taken a prescribed medicine due to its cost
- Nearly three million Canadians said they were not able to afford one or more of their prescription drugs
- Almost one million Canadians cut back on food or home heating in order to pay for their medication
- About 60 per cent of Canadians are enrolled in private drug plans (primarily employer-sponsored benefit plans), but these plans cover only 36 per cent of total system-wide spending on prescription drugs

Source: Final Report of the Advisory Council on the Implementation of National Pharmacare, released on June 12, 2019.

Canada prescription drug statistics (as of October, 2020)

- Between 2019 and 2020, nine-in-ten Canadian households (89 per cent) have been prescribed medications by a doctor, and one-in-three (32 per cent) have filled a prescription six or more times
- About 72 per cent of Canadians have most or all of the cost of their prescriptions covered by insurance and government support, but 26 per cent must find money for at least half the cost – or more – on their own
- Lower income households are more than twice as likely as those with household incomes over $100,000 to have paid more than half of the cost for their prescription(s) out of their own pocket (37 per cent to 15 per cent)
- Among Canadians who received prescriptions, 26 per cent of Canadian households found themselves having to pay $500 or more for them between 2019 and 2020
- A total of 44 per cent of Canadians say they are at least "somewhat worried" about their ability to afford prescription drugs in 10 years, while 24 per cent say they feel "very confident" that they will always be able to pay for them

Source: A study about prescription drug costs and pharmacare from the Angus Reid Institute released on Oct. 29, 2020.

New openness to decolonization also needed in Inuit climate-health research

Let us move forward in the right direction and seek to answer the call articulated for 'Inuit self-determination in climate-health research, response, and governance, with a focus on Inuit knowledge, Inuit-led approaches, and Inuit research leadership to support a climate-resilient and health Inuit Nunaat.'

Monica Ell-Kanayuk

Opinion

Shortly after the new year, a major press conference was held in Ottawa to announce a $40-billion settlement over the systemic underfunding of child welfare services to Indigenous children. It struck me as critical that this settlement had finally been made, but also vital was the tone in which Indigenous Crown Relations Minister Marc Miller, and Indigenous Services Minister Patty Hajdu spoke.

In their statements and responses to reporters, they articulated what Indigenous peoples have known for decades: there is systemic racism within the halls of government, and the colonial structures built up over the last 100 years still exist and will take time to dismantle.

So it is in many areas we have had to engage in over the years, such as in the fields of health and climate change, and in the context of both government and research. This point is highlighted in a recent commentary piece that our international ICC Chair, Dalee Sambo Dorough, and our climate change officer, Joanna Petrasek MacDonald, co-authored. Along with fellow authors Sherilee L. Harper, Ashlee Consolo, and Nia King, they argue, in part, that colonial mentalities and structures are, unfortunately, alive and well in the Arctic climate-health research community.

The commentary, published in the journal *One Earth* is titled, 'Climate Change and Inuit Health: Research Does Not Match Risks Posed'. The paper asks the question, "If climate change is the 'biggest health threat of the century,' what does this mean for regions experiencing the fastest warming on the planet?" Seven key risks to Inuit health caused by climate change are identified. Responding to these seven risks, the authors "call for Inuit self-determination in climate-health research, underpinned by Inuit knowledge, Inuit-led approaches, and decolonization of research processes."

Minister of Crown-Indigenous Relations Marc Miller and Indigenous Services Minister Patty Hajdu, pictured on Jan. 4, 2022, at a Hill press conference, held to provide an update on the negotiations related to compensation and long-term reform of First Nations Child and Family Services concerning the Moushoom and Trout class actions. *The Hill Times photograph by Andrew Meade*

Let me unpack this a bit more and focus on four of the seven key health risks identified as being affected by climate change: nutrition, foodborne illness, mental health, and heat morbidity. These risks interplay with the rapidly changing water, sea ice, and snow conditions.

Changes to our lands and water have impacted migration patterns and the availability of country foods. Across Inuit Nunangat, our Canadian Arctic homelands, Inuit have reported a decline in the availability of fish, whale, ringed seals, and birds. This has a direct effect on our essential nutrient intake.

Warming oceans has meant an increase in foodborne pathogens in seafood. Vibrio—a water borne pathogen—was unheard of in the Arctic until recently because the Arctic ocean was previously too cold for this pathogen to survive.

In terms of mental health, the ability to regularly and reliably connect to the land through hunting, fishing, and harvesting is fundamental to our health and well-being. Chronic weather events have resulted in negative mental health impacts for Inuit because they reduce our ability to engage in cultural and livelihood activities.

You likely wouldn't associate the Arctic with heatwaves, however the authors identified "heat morbidity" as one of the seven key risks noting that "increases in heatwave intensity challenges Inuit health." Our northern buildings were built to keep the cold out. The thought of needing air conditioning in the summer was laughable. Now, just as heatwaves in the south render elders extremely vulnerable in old age homes, we are experiencing similar situations in our Arctic homes and buildings.

In response to the identified health risks to Inuit caused by climate change, the authors expressed concern with the lack of research but, more importantly, with the lack of Inuit partnership, participation, and inclusion in climate decision-making processes. They argue that Inuit are in the best position to develop climate-health research, policies, and actions that affect them.

Returning to the words of Miller and Hajdu, I hope that their acknowledgements of the colonial structures in our past and present, and calls for changes in government are heard around the cabinet table. I hope the messages are also heard by bureaucrats at all levels, and by extension, at Crown corporations and throughout the research community linked to our government structures.

This paper is an example where this new openness to change can by applied. Let us move forward in the right direction and seek to answer the call articulated in this paper for "Inuit self-determination in climate-health research, response, and governance, with a focus on Inuit knowledge, Inuit-led approaches, and Inuit research leadership to support a climate-resilient and health Inuit Nunaat."

Monica Ell-Kanayuk is president of the Inuit Circumpolar Council—Canada.

The Hill Times

Peeling back the layers: the over-regulation of long-term care

Layers upon layers of rules, reporting requirements and prohibitions have seemingly paralyzed a workforce whose sole function is to care for our seniors.

Joanna Carroll

Opinion

There are countless problems plaguing long-term care in Canada, but near the top is regulation. Not a lack of regulation, rather an overabundance.

For decades, our response to any crisis, complication or elementary inconvenience in long-term care has been to add more regulation in a misguided attempt to minimize risk, justify funding and protect against perceived threats to resident and staff safety. The result? Layers upon layers of, at times unnecessary, and at others contradictory, rules, reporting requirements and prohibitions which are not only devoid of good public and health policy, but which have seemingly paralyzed a workforce whose sole function is to care for our seniors near and at the end of their lives.

Consider that in order for any long-term care home to be compliant with applicable regulation, its staff must ensure that all residents are present for breakfast in a prescribed eating area during a mandated, determined and limited period of time. The regulation fails to account for numerous resident complexities, including those arising from dementia let alone individual resident preference and choice.

It has been argued that the current long-term care regulatory scheme has de-prioritized resident individuality and choice. That is to suggest of course that it was ever in its purview. Avoidance of risk (regulation) and freedom of choice are most often always at odds. If we are to truly make strides in improving resident quality of life in long-term care we must, in part, trade rules for risk. Allow residents the freedom to choose the risk of a fall for the freedom to walk unassisted into the arms of a spouse or loved one; to forgo breakfast in favour of fatigue or the time to reflect on a photograph.

Among the many observations and conclusions that can and should be drawn from any over-regulation are the overwhelmingly inescapable ones, which are that the regulators long ago lost sight of that which they were seeking to regulate, and the risk they were seeking to mitigate against. In long-term care, the result of this potentially crushing effect is, as referenced above, the crippling of workers who are required to spend more time on compliance than they are on care.

I am hopeful, as we all must be, that the work the federal government is undertaking in establishing nationally recognized standards in long-term care will not only be resident-centred and based on compassion, respect, dignity and quality of life, but will necessarily entail the peeling back of years and layers of regulations that no longer are—or ever were—necessary or relevant. Moreover, they must be focused on the people and system they ostensibly seek to protect.

In defining and implementing national standards in long-term care, let us truly seize the opportunity to put our seniors and the people who are devoted to caring for them at the centre of those standards. As we move upward beyond the recent pandemic, may we also grow comfortable with the acceptance of certain risks in favour of quality of life. And in so doing, avoid regulation for regulation's sake.

Joanna Carroll is a lawyer, the chief administrative officer of Think Research, a company focused on transforming health care through integrated digital software solutions and the executive sponsor of the company's work in seniors care.

The Hill Times

Pharmacare in Canada: one step forward, two steps back

If Canada did like every other OECD country, except the U.S., universal pharmacare would provide better access to prescription drugs for Canadians, says associate professor Marc-André Gagnon of Carleton University.

Marc-André Gagnon

Opinion

Canadians pay 42 per cent more per capita for prescription drugs than the OECD average. A whopping nine per cent of Canadians do not fill their prescriptions for financial reasons.

Twelve years ago, I wrote a report making the economic case for universal pharmacare in Canada. In a nutshell, if Canada did like every other OECD country (except the United States), universal pharmacare would provide better access to prescription drugs for Canadians while allowing saving up to 40 per cent in drug costs per capita. Peer-reviewed research and the Parliamentary Budget Office have confirmed these claims.

The House Health Committee studied the issue for two years and published its report in 2018, confirming that universal pharmacare would save money and improve access to prescription drugs. However, every dollar saved by Canadians is a dollar lost by drug companies, insurance companies or pharmacy chains. Unsurprisingly, these stakeholders massively lobby to oppose any rational reform in drug coverage.

In 2018, the Liberal government announced the creation of an Advisory Council on the Implementation of National Pharmacare (ACINP). Revealing the divide among Liberals on this issue, minister of finance Bill Morneau, who chaired the largest benefits consulting company in Canada for many years, made clear that universal pharmacare was not on the table and ACINP had to focus on preserving current private drug benefits. Nevertheless, ACINP published its final report in 2019 insisting instead on the need to implement universal pharmacare and defining a prudent step-by-step strategy to ensure that the transition could be done smoothly for all stakeholders. In particular, the ACINP report proposes the creation of a Canadian Drug Agency that would manage a national formulary of reimbursed drugs, as well as the development of a national strategy for expensive drugs for rare diseases.

The report builds on cooperation with provinces and territories. Each province would continue providing its own public drug coverage (mostly for seniors and people on social assistance), but coverage of drugs listed on the national formulary would be expanded to the whole population and the federal government would pay for all additional public costs. Provinces and employers could continue providing additional drug benefits in supplement of the national drug formulary if they wanted to. Nobody would lose their current coverage.

Prime Minister Justin Trudeau accepted the recommendations of the report and more or less committed to implementing it. The Liberals did create the Canadian Drug Agency that will manage the national drug formulary, but did not provide a substantial budget for the initiative. Instead, they simply arrived at an offer to provinces based on the ACINP report, but did nothing to promote a change in the current structures. In the 2021 election, the Liberals acted as if they had already delivered on pharmacare since the offer to provinces was still on the table.

The mandate letter to the new minister of health instructs the minister to "continue engaging with willing provinces and territories towards national universal pharmacare," but it is clearly not a priority anymore. COVID-19 currently has Canada under the thumb of drug companies that can create a political crisis by delaying deliveries of drugs or vaccines. Because of this, Canada has also postponed the implementation of the new patented drug price regulations four times already, and opposes technology transfer for covid-19 vaccines to lower income countries.

However, while most people were already giving up on the idea that Canada would finally enter the 21st Century by implementing rational drug coverage for its population, Prince-Edward-Island recently accepted the offer of the Federal Government. The province currently manages more than 25 public drug plans mostly offering coverage based on which disease you get. Prince Edward Island's move is forcing the federal government to almost reluctantly go forward with the whole initiative of developing a national formulary.

Unfortunately, Prince Edward Island alone is not a sufficient market to develop substantial bargaining capacity to reduce drug prices and lock in the development of the necessary institutional capacities for better drug coverage in Canada. Other provinces must follow. However, in times where foreign drug companies hold unprecedented power, it seems difficult for any policymaker to stand up for their constituents, who will be the ones to pay that price instead.

Marc-André Gagnon is associate professor with the School of Public Policy and Administration at Carleton University (Ottawa). He holds a PhD in political science from York University and a master's of advanced study in economics from Paris-1 Sorbonne and École Normale Supérieure de Fontenay/St-Cloud.

The Hill Times

Canada needs a national aging strategy that includes older women

The world has given us a template to build our own roadmap. We need to apply these lessons and develop a path forward to address the unique needs of Canadians and build our own age-friendly communities. We need a strategy.

Paula Rochon & Surbhi Kalia

Opinion

There are now more than 6.8 million older adults in Canada. By 2026, we expect our country to become a super-aged society, where 20 per cent of the population will be 65 and over.

Yet Canada is facing a major policy gap: the lack of a national plan to support our aging population.

The impact of the pandemic on older adults, specifically long-term care homes, calls for critical action. Along with long-term care reform, we need a plan to meet the health needs of older Canadians in the community where 93 per cent of older adults live.

Canada has about 304 geriatricians, for example—one geriatrician per 100,000—and a lack of access to primary care, not nearly enough to meet the demand of our older population, particularly in rural areas.

It's time we had a national aging strategy.

This strategy needs to be inclusive. A one-size-fits-all approach to support healthy aging will leave many Canadians behind, mainly women. Older women comprise the majority of the aging population.

Healthy aging is a major global priority—it's on the top of the United Nations and the World Health Organization's agenda. Countries like Japan and Singapore have made major investments to support their older population such as promoting life-long learning and social integration, as well as building age-friendly home care and assisted living and designing age-friendly technology, write Paula Rochon and Surbhi Kalia.

Photograph courtesy of Pixabay

Women have specific and unique health needs that are often unacknowledged by our health system and its care providers. Certain medical conditions such as osteoporosis, thyroid problems, and headaches, for example, present more often in women, and other conditions, like heart disease, present differently and are not always recognized by clinicians. Older women are also more likely to experience side-effects from medications and may require lower doses of some medications than men.

These health issues are further compounded by the socio-cultural and economic inequities women face throughout life. Older adults, especially older women, do not always have access to non-insured health services, such as dental, vision and hearing care. They are more likely than men to face poverty, and not able to afford proper care options to live in their communities.

An effective aging strategy would enable older adults to actively participate and contribute within their communities, provide affordable options to health care and social services and address systemic inequities based on sex and age.

Healthy aging is a major global priority—it's on the top of the United Nations and the World Health Organization's agenda. Countries like Japan and Singapore have made major investments to support their older population such as promoting life-long learning and social integration, as well as building age-friendly home care and assisted living and designing age-friendly technology.

In Arnsberg, Germany, deemed one of the most age-friendly cities in the world, older adults can access affordable housing and care options, contribute and participate in social life and feel connected to their communities.

The world has given us a template to build our own roadmap. We need to apply these lessons and develop a path forward to address the unique needs of Canadians and build our own age-friendly communities.

We need a strategy.

Dr. Paula Rochon is a geriatrician and the founding director and Surbhi Kalia is the strategy lead, of the Women's Age Lab at Women's College Hospital.

The Hill Times

Will 2022 be the dawn of a new era for long-term care in Canada? Yes, with federal leadership

The demand for more care, as our population ages, must be met by an adequate supply of health human resources.

Amy Hsu

Opinion

Like a category five hurricane, the trail of devastation left by COVID-19 is clearly illustrated by the all-too-familiar epidemic curves and graphs of the cumulative deaths from COVID-19 in Canada. Yet, even amid another wave brought on by Omicron, many of us are cautiously optimistic about the pandemic's end and have started to plan our path to recovery.

Those who work and live in long-term care homes are perhaps the most eager among us to see the pandemic end. COVID-19 has not only highlighted the vulnerability of the people who need long-term care but also the vulnerability of a sector within our healthcare system that has long been overlooked.

The issues facing long-term care extend beyond infrastructure, although there is an indisputable lack of beds and facilities. A 2017 Conference Board of Canada report suggests that the need for long-term care beds will be double our current capacity by 2035. The demand for more care, as our population ages, must also be met by an adequate supply of health human resources. Even before the pandemic, the sector has experienced a persistent shortage of healthcare workers needed to meet the care required by residents in long-term care homes.

There is, however, a silver lining to the fateful impact of the pandemic on long-term care. The pandemic has prompted the development of new national standards on long-term care; an investment of $1-billion from the federal government through the Safe Long-term Care Fund to address the immediate needs of the sector; as well as a commitment of $3-billion over the next five years to ensure provinces and territories can meet the national standards set out for long-term care. Provincially, new legislations and infrastructure funding programs have also been introduced to address deficiencies, including staffing levels, that have existed for at least a decade before the pandemic.

While provincial and territorial governments hold jurisdiction over how long-term care should be administered and decide how the committed funding should be used to meet the needs of their constituents, we need federal leadership to ensure all Canadians needing support in long-term care receive the same high-quality service. Along with the proposition of new federal legislation for long-term care to hold provinces and territories accountable to the national standards, we need to consider the option of amending the Canada Health Act to bring long-term care under its definition of insured health services. Although an amendment to the Canada Health Act would not provide the federal government opportunities to enforce the national standards on care, it offers defence against two-tiered care that currently exists within long-term care. For example, recent research has found that residents who can afford accommodation in a private room within long-term care experienced less fatal outcomes over the pandemic than residents in shared accommodation.

There is an undeniable need for more beds. A key barrier to entry, especially for independent and non-profit operators, is the capital required to plan, purchase and develop land to build a facility. On top of the current commitments to enforce the newly formed national standards, the federal government—in partnership with the provinces and territories—could provide infrastructure funding or create low-cost capital financing options for non-profit, charitable and municipal or health authority operators, which have demonstrated superior outcomes for residents in their care in comparison to their for-profit counterparts.

Recognizing that current investments in infrastructure and the labour force may not yield positive returns for the sector in the next three to five years, the federal government can also leverage existing initiatives to engender immediate impact. Within our National Dementia Strategy and the Framework on Palliative Care, several actionable recommendations and promising practices exist to improve the health and quality of life for persons living with dementia in Canada and those at the end of life in long-term care. Federal support for these frameworks through the Common Statement of Principles on Shared Health Priorities, and the recent $3-billion commitment in the 2021 budget, can be leveraged to develop new performance indicators specific to long-term care that align with our new national standards. For example, indicators on access to behavioural support services to enhance care for residents living with dementia, reduction in the use of antipsychotic medication in residents not living with psychosis, and adequate pain and symptom management for residents approaching the end of life are a few of the quality indicators that have been used and reported at provincial and regional levels to inform health system planning.

Even with the uncertainty of when this pandemic will end, we can be confident that the time for action to fix long-term care is now.

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The Hill Times

Investing in long-term care will alleviate pressures on the hospital system

Canada's health system performance lags when compared to France, Sweden, Australia, and the United Kingdom.

Lisa Halpern & Allan Maslove

Opinion

As it has in other countries, COVID has exposed weaknesses in Canadian health care, especially relating to staffing and capacity issues. The experience of the last two years has prompted calls for more money to be spent on health care in general and on more hospital beds in particular. There may well be a case for both more money and hospital beds given the continued aging of the population in coming years, but more money alone will not solve the deficiencies in the health care system. We also need to address where and how resources should be allocated.

Canada is already one of the highest per capita spenders in the developed world. Based on OECD Health Statistics 2021, Canada's health spending as a percentage of gross domestic product (GDP) was 10.8 per cent, roughly equivalent to health spending in France (11.1 per cent of GDP), Sweden (10.9 per cent of GDP), Australia (9.4 per cent of GDP), and the United Kingdom (10.2 per cent of GDP).

Yet, Canada's health system performance lags when compared to these countries. The Commonwealth Fund 2021 health-care system performance rankings for Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States, places Canada tenth out of 11 countries. So, based on international comparisons there is not a strong argument to be made for significantly more spending.

Also, more money often makes it easier, at least for a time, to paper over the systemic issues that require reform. Meaningful reforms in health care can be contentious and hard to accomplish given the incredibly complex organizational interactions and the diffusion of decision-making authorities.

There are a number of structural changes in terms of re-allocation of resources and improved access to specialized services that would likely improve health care outcomes. To illustrate one, consider the interface between acute hospital care and long-term residential or home care. Hospitals are struggling with capacity limits in large part because of "alternative level of care (ALC)" patients. These are people who are not ill enough to be hospital inpatients, but not well enough to be discharged without some level of care available to them. Because of shortages of long-term care (LTC) beds and/or home care resources they must remain in hospitals occupying valuable acute care beds.

Aside from the human toll, this is very expensive. These patients are occupying beds, staff time, and medical equipment that could be used by people waiting to be admitted from the emergency department (ED) or who have had their surgeries delayed due to lack of hospital space. The average per diem cost of caring for someone in a LTC residence is $126/day, which is a fraction of the cost of caring for them in a hospital bed at $842/day. Home care is even less costly at $42/day. Every ALC patient transferred to a more appropriate care setting effectively frees up a hospital bed and saves money for the health care system at the same time.

Health Quality Ontario reported that in 2015 about 14 per cent of hospital beds were occupied by ALC patients. Current estimates of the ALC patient population vary by province; however policy, industry, and academic leaders are increasingly calling attention to the linkages between long-term care investment and acute care hospitals as an area for positive structural health systems change.

A related issue is leveraging ways to decrease ED visits for seniors living in long-term care settings. That would reduce crowding in the emergency waiting rooms, reduce wait times for care, and reduce numbers of people waiting for inpatient admission. With better health maintenance and improved access to specialized services in the LTC residences themselves, many ambulatory hospital visits from LTC homes' residents may become preventable and unnecessary. Again, improving the LTC sector benefits the residents of these homes, and can lead to significant savings throughout the hospital system.

We do not minimize the issues that need to be faced in the long-term care sector, most importantly around adequate staffing. The COVID experience has devastatingly revealed these problems. We suggest however, that attention to reducing the use of acute care beds for people who should be in alternative forms of long-term care and reducing the need for LTC residents to visit EDs are reforms that will go a long way towards alleviating pressures on Canada's hospital system.

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