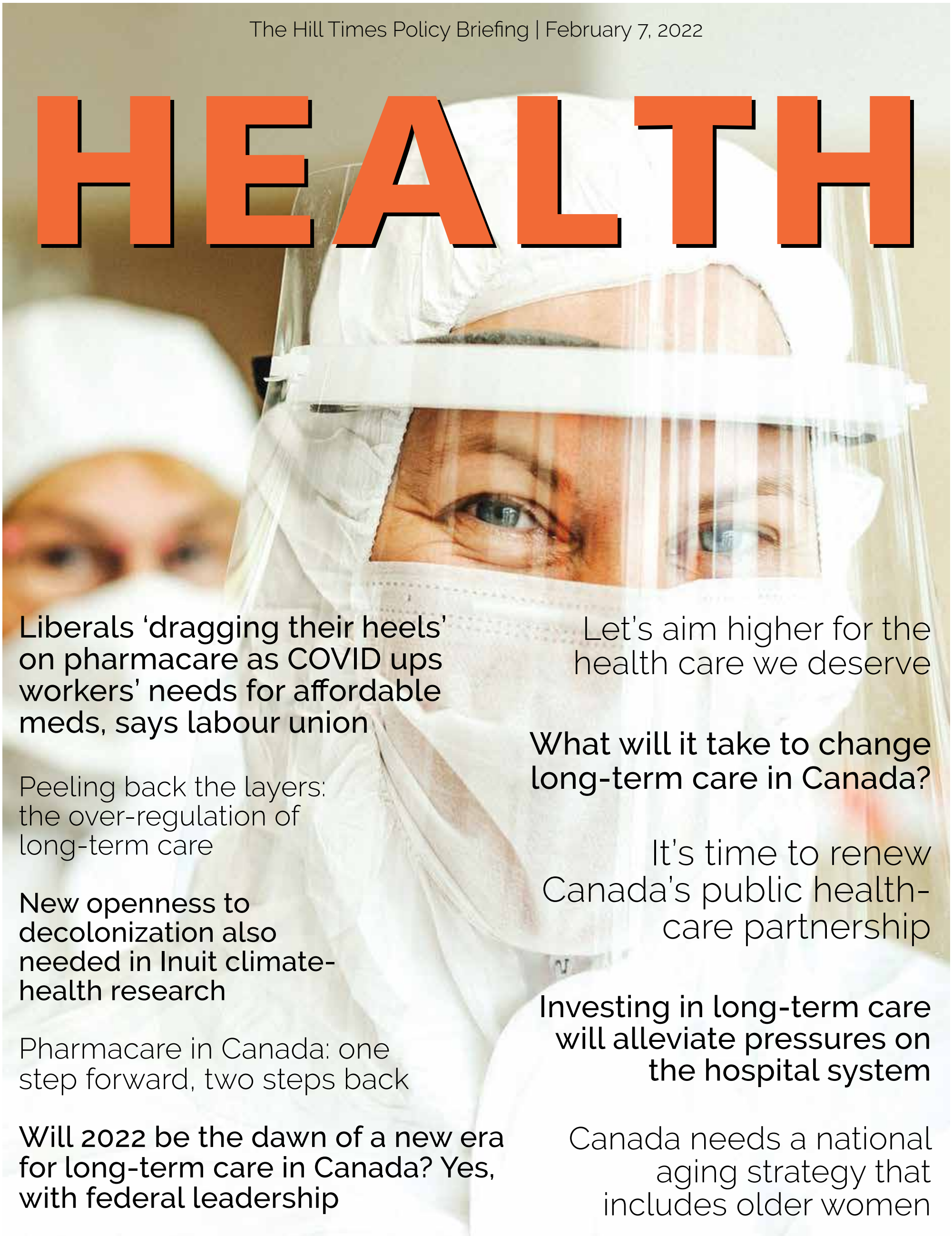
HEALTH



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

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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.

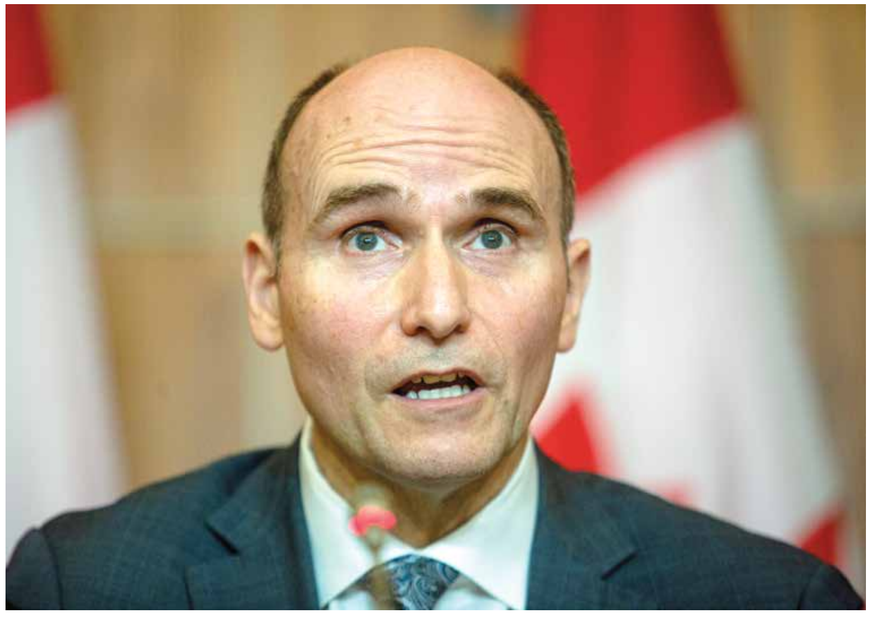
The ARI study was conducted in partnership with the University of British Columbia's School of Population and Public Health; St. Michael's Hospital and University of Toronto; the Carleton University Faculty of Public Affairs and School of Public Policy and Administration; and, the Women's College Hospital 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."

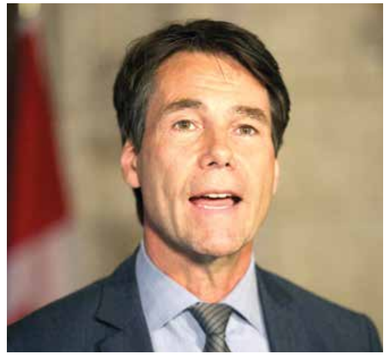
Davies said that he views pharmacare as an expansion of the basket of services provided by the public health system.

"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.

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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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The Hill Times