

Beyond COVID-19:

HEAL's recommendations for a healthier nation

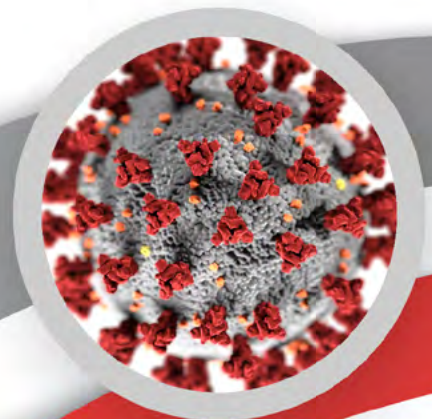


HEAL



Organizations for Health Action

A Consensus Statement 2020



Executive Summary

HEAL, Organizations for Health Action, is a non partisan coalition of 40 national health organizations dedicated to improving the health of Canadians and the quality of care they receive. Created in 1991, HEAL now represents more than 650,000 providers and consumers of health care.

Our member associations include those representing regulated health care providers working within the public sector, those working in communities and in the private sector, as well as organizations that deliver health care services to Canadians. We are an effective and essential conduit to Canada's regulated health care providers.

In 2016, HEAL published its first consensus statement, *The Canadian Way – Accelerating Innovation and Improving Health System Performance*, following more than two years of research, review, and reflection. HEAL's *The Canadian Way 2.0* statement was published in 2018, moving the conversation forward, adding additional recommendations on the two areas of priority identified by our members in 2018.

Work began to review *The Canadian Way* in 2020 as the world entered the COVID-19 pandemic. In March 2020, HEAL created a special COVID-19 Response Task Force to ensure that the health providers it collectively represents are well informed and equipped to effectively respond to the pandemic, and that communications between government and providers flows quickly and accurately as this crisis unfolds.

Beyond COVID-19 : HEAL's recommendations for a healthier nation outlines issues our members have seen on the front lines, including recommendations for pandemic readiness in the future, in addition to our remained focus on HEAL's two key priority areas to the federal government.

Section 1: Pandemic Readiness

Section 2: Seniors' Care in Canada

Section 3: Mental Health Services

Introduction

The Government of Canada has acted promptly to put in place far-reaching measures intended to support the safety and security of all Canadians, including the professionals working to serve those made vulnerable by the COVID-19 crisis. While it has taken significant steps toward mitigating the physical, psychological and economic concerns of the nation, more must be done to support and protect all Canadians through this time of grave uncertainty. We also have a unique opportunity and responsibility to implement longer-term structural changes to our healthcare systems.

Our recommendations focus on the need to mitigate further impacts of future COVID-19 waves, in particular on Canadian seniors. The lasting effects of the pandemic on the mental health and the substance use of Canadians, and the ongoing lack of access to care, must also be at the forefront of Canada's efforts.

Canada has had unacceptable rates of COVID-19-related deaths in Long Term Care (LTC). These tragic deaths, nearly 80% of COVID-19 related deaths in Canada by September 2020, are in part a result of decades of neglect of the LTC sector including the devaluing of home care, caregivers, and the structural flaw that the increased costs of an aging population is carried disproportionately by some provinces and territories.

The COVID-19 crisis has also challenged the mental health and problematic substance use of Canadians as they deal with uncertainty and stress. HEAL feels it is time to recognize mental health to the same extent as physical health by having federal and provincial/territorial governments formally recognize parity between mental health and physical health.

Further to COVID-19, recent events affirm, once again, that Canada has far to go in pursuing justice for racialized people, including fighting for safety from violence and discrimination, access to income, and accessible health care and many other basic human rights.

The September 28th, 2020 death of 37 year old Joyce Echaquan at Centre hospitalier de Lanaudière in Joliette, Quebec has drawn calls to confront systemic racism in health care across the country. She died screaming for help while enduring verbal abuse in the final moments of her life. COVID 19 has also shed a bright light on the gaps that exist in health care in Indigenous communities – which lack basics, such as clean drinking water, inadequate over -crowded housing, lack of access to broad band – all of which make frequent hand washing, social distancing and virtual care impossible.

As a coalition of 40 national health organizations dedicated to improving the health of Canadians and the quality of care they receive, each member organization, as well as the coalition itself, commits to engaging in ongoing and meaningful journeys of reconciliation that will support the recovery from the ongoing colonization of Canada.

HEAL also recognizes the sense of urgency to address climate change. To quote the World Health Organization in its February 2019 online report: "the overall health effects of a changing climate are likely to be overwhelmingly negative. Climate change affects social and environmental determinants of health – clean air, safe drinking water, sufficient food and secure shelter."

As we prepare for future impact of the COVID-19 crisis as well as look forward to recovery, we must support not only the economy, but also the health of our nation.

1. PANDEMIC READINESS

HEAL created a COVID-19 Task Force to coordinate its efforts during the pandemic. Its mandate is to facilitate coherent and timely information exchange and action by healthcare workers, administrators and Federal/Provincial/Territorial authorities to help contain and mitigate the crisis. The Task Force met for the first time on March 30, 2020 and has reconvened on a weekly or biweekly basis since then. It has shared broadly its findings and recommendations with civil servants and elected officials on a regular basis.

In this section we would like to share some of the rich information gathered up to July 31, 2020 by this Task Force, and propose COVID-19 specific recommendations.

Key issues:

In March 2020, HEAL surveyed its 40 members representing more than 650,000 healthcare professionals to identify their top COVID-19 related issues. These were the most cited:

- **Exposure to COVID-19 in the workplace, and the risk it poses to frontline workers and by extension, to their families. (79%)**
- **Mental health of employees, colleagues, and those working on the frontlines of the outbreak. (67%)**
- **Likely loss of income due to clinic shutdowns, including impact on their employees, as well as eligibility of EI concerns. (67%)**
- **Growing scarcity of protective equipment required to carry out their professional duties in the next few weeks or months (i.e., masks, gloves, etc). (64%)**
- **Needs of special or marginalized populations concerning COVID-19 and its mitigation. (48%)**
- **Health care students no longer being able to find placements to complete their programs, having their classes cancelled and sometimes seeing their confirmatory and entry-into-practice exams postponed. (48%)**
- **Potential lack of hospital and clinic space, or other human or healthcare resources, to treat patients with serious conditions other than COVID-19 who need in-person care. (48%)**

While these themes emerged early in the pandemic, many of them remained at the forefront of our discussions, and new ones emerged.

The following issues have been consistently raised:

PPE SUPPLIES: Consistent and clear guidance on protocols (lack of coherence between jurisdictions), costs, education on use. Priority access to public health at the detriment of private care settings. Priority access to hospitals vs long-term care and home care settings. Lack of consistency and specificity of Aerosol Generating Medical Procedures guidelines.

BURDEN ON FRONTLINE HEALTHCARE WORKERS: Lack of protection for workers and their families, stress and anxiety, burnouts, poorly coordinated resource planning.

RAPID ADOPTION OF VIRTUAL CARE: Telehealth experienced a boom during COVID-19. While there had been resistance to its adoption, under COVID-19 it often was the only way to consult with patients and as a result, barriers to adoption dropped significantly. However, broader adoption was hindered by a lack of consistent reimbursement (public and private) across jurisdictions and professions, limited regulatory scope of practice, bandwidth limitations, lack of

educational resources for patient and provider, lack of telehealth platforms, cybersecurity threats, professional liability insurance concerns, licensing issues across Provincial/Territorial borders.

FINANCIAL DURESS: Many professionals, especially those working in private practice, who had to close their clinics to non-urgent patients suffered financially and put the viability of their clinics at risk. The federal relief measures were much appreciated but their roll-out was often confusing and often did not meet expectations.

MENTAL HEALTH: Stress, anxiety, and social isolation peaked due to COVID-19. This has affected everyone: patients, providers and the population at large.

VENTILATORS: Ensuring the right equipment is deployed, and that therapists are properly trained (this issue was resolved by increasing the collaboration between PHAC and the Canadian Society of Respiratory Therapists).

NUTRITIONAL RISK: Lack of resources to ensure quality and sufficient nutrition and hydration in long-term care facilities. Anticipation of increased malnutrition of priority populations in the community due to COVID-19 and exacerbation of preexisting chronic conditions.

FOOD INSECURITY: The financial impact of the pandemic has led to an increase in the number of Canadians living in a situation of food insecurity.

TESTING: Availability of tests, logistics, validation of testing devices, storage of specimens, tracing.

RETURN TO WORK GUIDELINES: Guidelines for re-opening clinics or to work in special environments like long-term care facilities lacked coherence. For example, guidelines were not always aligned with PPE availability and healthcare professionals were left on their own to source the required products.

BACKLOG: Many procedures and treatments were postponed to focus resources on COVID-19 and minimize the spread of the virus. This resulted in a large backlog. This had an impact on the physical and mental health of Canadians. When elective procedures resumed in hospitals it often created an extra burden for medical staff who had not yet recovered from the exhaustion of working on COVID-19 patients.

RESEARCH: Many medical research programs were delayed or cancelled. Funding sources dwindled.

ACCESS TO DRUGS: Supply chains were disrupted worldwide and as a result, many drugs became in short supply or non-available altogether.

MESSAGING CONSISTENCY AND MANAGING EXPECTATIONS: Between PHAC, provinces (masks, return to school, vaccines, second wave, etc).

DISPROPORTIONATE IMPACT OF THE PANDEMIC ON WOMEN: The economic crisis that accompanies the pandemic is having a disproportionate impact on women.

ADVERSE EFFECTS ON MARGINALIZED POPULATIONS: Several studies showed that priority populations were disproportionately affected by the virus. For example, from May to mid-July 2020, racialized people made up 83% of COVID-19 cases in Toronto.¹ This reveals health and social inequities that were present pre-COVID-19 and will persevere unless there is widespread societal action with strong government leadership.

Assumptions and recommendations

The HEAL COVID-19 Task Force identified a list of assumptions about permanent, mostly positive, changes to healthcare resulting from this pandemic:

- Telehealth will become mainstream.
- Long-term care of seniors and priority populations dependent on other supports will be re-designed.
- Acute care will need to be pandemic ready.
- Work from home will become the new normal.
- Supply chain management of medical devices, supplies and pharmaceuticals will rely less on global supply chains and more on in-country suppliers.
- The wait-time situation for health care services will be exacerbated.
- The approach to public health will be more coherent across the country.
- We will learn from the pandemic and improve our ability to cope with new crises in the future.
- Canadians will follow scientific advice (e.g., use of vaccines, social distancing guidelines).

Our Recommendations

HEAL believes that the various issues identified above and the assumptions about what is likely to change in a permanent way post COVID-19 can be addressed in part by our two priority focus areas (seniors and mental health) discussed above and the following six more specific COVID-19 priorities:

- 1. HR Load Management:** Workers have been sustaining high levels of stress and anxiety and the uncertainty and ambiguity of the pandemic are compounding the problem. We are starting to see losses of productivity and an uptake in cases of depression amidst pressure to get back to “normal.” We must allow leaders and health care workers to rest and recover and find a solution to dealing with the backlog being created by the pandemic without further taxing an already overwhelmed workforce. It is not sustainable for front line health care workers to continue working at this pace.
- 2. Supports for Front Line Health Care Workers:** Sufficient supports for front line health care workers (FLHCWs) are also required to recognize their significant contributions, the risks being posed to them and their families, and the financial burden they have taken on. For instance, the Canadian Medical Association is recommending that the government implement a Frontline Gratitude Tax Deduction for FLHCWs during the pandemic, in addition to extending the eligibility of the Memorial Grant to families of FLHCWs.²
- 3. Behavioural change:** Managing the public and workers expectations and behaviours to ensure compliance with public health guidance (e.g., masks, vaccines) is crucial to our ability to contain pandemics. Efforts should be made to apply the science of behavioural change to help individuals feel they have some control over the situation. Authorities have to take into consideration the mental anguish caused by the pandemic risks, the inability of many to go back to work due to confinement, and the scarcity of supplies and human resources.
- 4. Supply Chain Management:** We need to re-think the manufacturing, distribution and storage of strategic drugs, devices and supplies and provide the right incentives to prevent future shortages. Over the years, to reduce costs and increase efficiencies, many products manufactured in Canada were outsourced to lower-cost production facilities around the world. This happened with most large medical device and pharmaceuticals manufacturers in Canada and elsewhere. The COVID-19 crisis highlighted the need for local (Canadian) access to strategic goods, like masks and ventilators. Anything that could disrupt the global

logistics system would instantly deprive us of much needed products. When demand exceeds supply, globally, there ensues a global race to secure supplies. Such as, countries with deeper pockets and larger purchasing power often win the race. How do we address this? We must find incentives to encourage companies to produce “strategic” goods in Canada in sufficient quantities. Market forces might not be enough. Once this crisis is over, it is doubtful hospitals and consumers will be willing to pay more for their products simply because they are made in Canada. We must come up with new incentives: Should governments commit to buy Canadian-sourced products? Could we tax strategic imports? Should healthcare providers have buy-Canadian purchasing policies imposed by provincial/territorial health authorities? In August, the federal government announced a new 5 year investment in a Canadian N95 masks manufacturing center. While this is a welcomed effort, we must ensure there are long-term incentives to guarantee Canadian supply beyond a 5 year horizon.

5. **Virtual care:** We must continue to support the equitable adoption and expansion of virtual care and invest in innovation. Governments at all levels must work together to reduce barriers to its adoption: lack of consistent reimbursement (public and private) across jurisdictions and professions, limited regulatory scope of practice, bandwidth limitations, lack of educational resources for patients and providers, lack of telehealth platforms, cybersecurity, professional liability insurance concerns, licensing issues across Provincial/Territorial borders and others. Addressing these barriers is critical to ensuring that all those in Canada have equitable access to health care throughout the pandemic and beyond.
6. **Planning:** Now is the time to reflect and learn from the past and to plan for possible future scenarios. What are the world’s best practices in dealing with COVID-19? What are the key priorities? What are key sources of information? What are the most appropriate decision-making matrices and processes? Do we have the right response protocols in place? Do we have clear delegation of authority in place? Do we have all the resources we need, the right supply chains in place? It is important that we reflect on lessons learned and develop and implement strategies based on these learnings and we move into the second wave and beyond

2. SENIORS' CARE IN CANADA

The COVID-19 pandemic has tragically exposed the weaknesses and inadequate health supports available to Canada's aging population, particularly for residents of long-term care facilities. Canada's National Institute on Ageing (NIA) reports that almost 80% of all the deaths in Canada since the beginning of the outbreak have been in long-term care settings (NIA, 2020)³. As we move through the pandemic and focus on the future, it is important to note by 2036, more than 25% of Canada's population will be over the age of 65. Because health care costs increase with age, the demands of this demographic shift on the Canadian health care system will be further compounded.⁴

Canada requires a more robust approach to home care and community health services for older adults, and those living with dementia. The original health care system was based on a biomedical model of primary care physicians, acute care hospitals, and long-term care facilities. No specific part of the original universal health care plan incorporated public health, community-based health services such as home care, or access to a broader variety of regulated health care professions and specialists. Although these have developed over time, they are uneven across the country due to provincial/territorial fiscal and political decisions. While the federal government committed to invest \$6 billion over ten years in home care in 2017, more is needed to improve access to home, community and palliative care services needed to support Canadians as they age.

HEAL believes that the federal government can play a key role in ensuring that the health care systems effectively and appropriately meet the challenge of Canada's aging population. Seniors' care is a complex issue involving most components of the health care system. As such, HEAL identifies several concrete measures through which the federal government could affect significant change.

Canada's Premiers have previously called for the federal government to increase the CHT (Canada Health Transfer) to 25% of provincial and territorial health care costs to address the needs of an aging population. Rather than change the current CHT formula, HEAL recommends that an additional demographic top-up be transferred to provinces and territories based on the projected increase in health care spending associated with an aging population. It is noted that prior to the September 23, 2020 Speech from the Throne the Premiers have upped the threshold to 35%, which they indicate would add another \$22 billion per year to the CHT.

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RECOMMENDATION 2.1:

Implement a demographic top-up transfer that would be allocated based on the increased provincial-territorial health care costs due to population aging, with the federal contribution set to the current share of the CHT as a percentage of provincial-territorial health spending.

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Supporting a fully funded and implemented national dementia strategy

HEAL commends the federal government on its June 2019 release of A Dementia Strategy for Canada: Together We Aspire.⁵ Budget 2019 provided start-up funding of \$50 million over five years to the Public Health Agency of Canada, starting in 2019-20, to support implementation of key elements of the strategy. This funding is in addition to the \$20 million over five years announced in Budget 2018 to support community-based projects which address the challenges of dementia.

Canada has taken historic and positive steps towards improving dementia care and support with the launch of its first national dementia strategy and committed funding in Budget 2019. However, for the strategy to be fully implemented, it will require further and sustainable funding to achieve

its vision. The initial federal investment of \$50 million over five years will not be sufficient to meet the future needs of the more than half a million Canadians living with dementia today.

The Alzheimer Society has been calling for an investment of \$150 million over five years in the national dementia strategy.⁶ With the aging of the baby boom generation, the number of Canadians with dementia is expected to double by the end of the decade. The COVID-19 pandemic has underlined the urgency of fully funding and implementing the national dementia strategy. More than two-thirds of the residents in long-term care homes are living with dementia, most of them women.

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RECOMMENDATION 2.2:

Increase initial investment of \$50 million over five years in the national dementia strategy to \$150 million to ensure measurable and timely progress on the strategy's vision and national objectives.

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Implementing national standards for long-term care

Implementing national standards for long-term care There are immediate interventions needed to ensure Canada's long-term care settings are able to safely enact infection controls, are adequately staffed to provide quality care and that the right staff mix of regulated health care professionals is in place to ensure residents' complex health needs are met.

HEAL joins the Royal Society of Canada (RSC) in calling on the federal government to develop and implement evidence-based national standards for long-term care facilities⁷. These standards should have a particular focus on the health human resources/staffing mix, workforce training that includes palliative and end of life care⁸ and other workplace supports required to ensure residents of long-term care have access to safe, quality care in a safe work environment.

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RECOMMENDATION 2.3:

Working with the provinces and territories, immediately establish and implement evidence-based national standards for long-term care facilities.

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Investing in home and community care for aging in place

When you talk to Canadians about where they want to live as they age, nursing homes or institutionalized care are not the answer. Older adults overwhelmingly want to stay in their homes, or as it is known in healthcare policy circles, age in place.^{9,10,11} There is consensus in the policy and research community around the key factors needed to enable aging in place – adequate income, social connections/community supports, transportation, safety, and the ability to maintain physical well-being, independence and quality of life.^{12,13}

Not all Canadians will be able to age in place – some will need to live in long-term care (nursing home) facilities to ensure they have supports to manage their complex health needs. But for many Canadians, increasing investments in health promotion (both physical and mental health) and disease prevention, along with a more robust approach to home and community care holds the promise of a better quality of life and health as they age. A well-organized community support and home care system in tandem with a supportive and safe long-term care system will also ease pressure on the acute-care system and eliminate many gaps in the continuum of care that too

often result in previously independent seniors landing in hospital or long-term care facilities.

Health care services provided to seniors living with a frailty, individuals with chronic conditions, individuals recovering from an illness or injury, and those who are at the end of life, are provided at home, not a hospital or long-term care facility.

During the first wave of the COVID-19 pandemic in Canada, hospitals prepared for a surge of COVID-19 cases, moving many seniors out of the hospital into long-term care facilities. Jurisdictions cancelled “non-urgent visits” early in the pandemic to plan for surge capacity from hospitals. To prevent the spread of the virus, provinces and territories deemed home care services as non-essential. The burden on family and informal caregivers also increased, and people did not receive the supports usually provided by specially trained regulated and unregulated home health care staff.

COVID-19 reinforced the challenge of maintaining infection control procedures in close congregate care settings such as nursing homes, and also reinforced the impact on both workers and the seniors who resided there. Isolation, neglect, dehydration, malnutrition, and potentially preventable deaths were some of the negative impacts of unmanaged COVID-19 outbreaks in long-term care facilities. While there are several factors that influenced the devastating outcomes of the first wave of COVID-19, an overarching consideration must be the high proportion of Canadian seniors living in long-term care facilities versus those receiving services at home.

The pandemic has highlighted that home and community care are essential for the safety of Canadian seniors and that home care will be essential in the fight against future waves of COVID-19. Further funding is needed to provide health care services for priority populations while limiting exposure to COVID-19 by increasing care in the home setting prior to and during future waves of the virus. Funding should also be allocated to train health care professionals working in this setting with core palliative care skills, referred to as the palliative care approach, to provide timelier, more effective and more compassionate palliative and end of life care.

Recognizing that community helps to create a wrap-around effect to better support seniors who are dealing with a serious illness and their families, funding is required to mobilize communities through the Compassionate Communities model. This approach empowers local communities to provide physical, emotional, social, spiritual, and practical support to patients, families, and caregivers¹⁴.

Providing care and support in the home setting enables hospitals to discharge clinically stable patients to a safer care setting and provides alternatives to long-term care facilities for frail seniors and priority populations who are especially at risk from COVID-19.

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RECOMMENDATION 2.4:

Working with provinces and territories, increase investments in community, home and long-term care to meet the needs of our aging population, to ensure that all individuals receive the necessary care, in the appropriate setting, at the right time.

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Supporting healthy active aging

The Public Health Agency of Canada (PHAC) defines healthy aging as “the process of optimizing opportunities for physical, social and mental health to enable seniors to take an active part in society without discrimination and to enjoy independence and quality of life.”¹⁵ Healthy aging would lead to improved well-being and reduced reliance on the health-care system over time, but requires a cultural shift to make it happen. Seniors continue to be major contributors to the Canadian economy and workforce as well as to their communities. They also provide considerable volunteer support to many and provide care to family members and friends.

Health status and quality of life, for instance, can be substantially affected by the detection, prevention, education and treatment of malnutrition in the community. Almost half of older adults admitted to hospital are malnourished, leading to longer hospital stays and adding \$2 billion to health system costs¹⁶. Another example is the reduction of falls, the leading cause of injury-related hospitalizations among Canadian seniors, which can greatly impact health status and quality of life. Nutrition and exercise programs that improve knowledge, balance, mobility¹⁷ and strength are one of the most effective and low-cost ways to improve a person’s stability. Restrictions and quarantine measures placed on the population to manage and reduce the risk of exposure to COVID-19 have resulted in reduced physical activity opportunities, a concerning trend particularly for older adults, for whom maintenance of independence is tied to avoiding sedentary behaviour through an active lifestyle¹⁸. It is also anticipated that the increased isolation of seniors during COVID-19 has further impacted the incidence of community-based malnutrition.

Activities and programs provided by primary care teams can help seniors maintain or improve their health through the management of chronic diseases and chronic conditions. Such initiatives may also improve seniors’ social engagement and prevent cognitive decline. The services of an interprofessional, coordinated primary care team can contribute to decreased hospitalization and greater independence in the community, with cost savings over the long term.

The inability to afford adequate food in Canada is a public health problem. Living in a home that is unable to afford enough food is associated with poorer physical, mental and social health.¹⁹ Government policies that have promoted adequate incomes in Canada have been shown to effectively reduce food insecurity, such as Old Age Security and Guaranteed Income Supplement Programs. These programs have resulted in a decrease in food insecurity in older adults by ensuring seniors have at least the minimum amount of money to afford basic needs²⁰; however, income is still the biggest predictor of food insecurity among older adults²¹.

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RECOMMENDATION 2.5:

Increase programs to support physical activity, nutrition, injury prevention, mental health and sufficient income for older Canadians.

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Supporting age-friendly communities

The PHAC suggests “in an age-friendly community, the policies, services and structures related to the physical and social environment are designed to help seniors age actively”²².

This approach has long been supported by the World Health Organization (WHO) as an important approach to promote the health and well-being of our aging population²³. In addition, making communities accessible to older adults further encourages them to engage in community activities and creates a culture of respect, connectivity and personal empowerment²⁴.

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RECOMMENDATION 2.6:

Support an age-friendly approach by taking the needs of older Canadians into account when designing buildings, walkways, transportation systems, and other aspects of the built environment and to support seniors to be active in all areas of community life.

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Addressing the digital divide

Technology has brought about many changes for everyone in society, including older adults²⁵. Older adults have experienced this impact in many ways from needing to access health information on the Internet to learning to use a smartphone to stay connected socially²³. There will continue to be many new and potential applications of technology to support healthy active aging, from virtual medical visits to sensor data to track falls, or to reminders for tasks to manage chronic conditions²³. Without access to affordable, reliable and sustainable internet connectivity, important services and programs will not be accessible to all older adults.

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RECOMMENDATION 2.7:

Provide support for seniors to maximize their use of digital technologies such as virtual care and wellness programs.

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Creating a pan-Canadian caregiver strategy

The COVID pandemic has brought increased recognition of caregivers' rightful place as essential partners in care.²⁶ A caregiver (also referred to as family caregiver or carer) is a person who takes on an unpaid caring role for someone who needs help because of a physical or cognitive condition, an injury, or a chronic life-limiting illness. HEAL supports measures that recognize and support their essential role, and action on this front must be an immediate priority.

Caregivers providing care for a family member or friend, be it in a home or a long-term care residence, often experience a range of adverse health conditions themselves (physical, mental, social) and other consequences, including financial stress as a result of their caregiver roles and tasks. Many caregivers are seniors themselves who may have their own health and social needs. The caregiver's role during the COVID-19 pandemic has been more challenging than ever due to fewer supports and in the case of long-term care, an inability to properly support their family member due to outbreaks and restrictive visitation policies. Financial support programs often do not support those most in need, such as non-refundable tax credits.

Nearly half (46%) of Canadians aged 15 and older, or 13 million Canadians, have provided care to a family member or friend with a long-term health condition, disability, or aging needs. Age-related needs are the single most common problem requiring help from caregivers (28%). Caregivers contribute more than \$25 billion in unpaid labour to our health care system. More than 2 million Canadians can live safely in their homes because of the support of caregivers who provide over 80% of the personal care needs.

To better support Canadian seniors and their caregivers, we must create a pan-Canadian Caregiver Strategy that is supported by national caregiver legislation that defines and strengthens the rights

and recognition of caregivers in the health and social care system. The expansion of the family caregiving benefit for adults to 35 weeks, and making the benefit refundable, would help address the needs of low-income caregivers.

The adoption of carer-friendly workplace standards through corporate tax incentives and support to create direct caregiver support organizations are additional measures that would enhance support for caregivers under a pan-Canadian Caregiver Strategy.

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RECOMMENDATION 2.8:

Create a pan-Canadian Caregiver Strategy including national legislation that defines and strengthens the rights and recognition of caregivers in the health and social care system, and greater financial assistance through benefits, tax credits, and job protection for caregivers be made available to ensure they are not penalized financially for stepping into a caregiver role, including those in long-term care.

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3. MENTAL HEALTH SERVICES

While we continue to stay at home, practice physical distancing and look to brighter days ahead, we recognize that isolation, job security, job loss and worry for ourselves and loved ones are taking a significant toll on Canadians. A recent survey of Canadian employees by the Conference Board of Canada and the Mental Health Commission of Canada detail these concerns underlying the decline in our collective mental health.²⁷

Prolonged isolation and physical distancing can lead to increased depression, anxiety, suicidal crises, domestic crises and violence. HEAL is concerned about the long-term mental health and substance use impacts of the global pandemic on the general population, as well as on Canadians with preexisting severe physical, mental, intellectual, cognitive or sensory impairments who have been disproportionately affected.

While programs and initiatives such as Wellness Together Canada provide important (online) information and educational tools about how to cope with the mental health impacts of COVID-19, many people were already experiencing long wait times to access mental health and problematic substance use treatments before the pandemic. Consider:

- **94%** of Canadians think that provincial and territorial governments' health plans should cover mental health care (2019).²⁸
- A majority (**89%**) say increasing funding to improve access to mental health care professionals (including psychologists and counsellors)²⁹
- **53%** of Canadians report that they know someone who has had a mental health problem or illness and has experienced delays in accessing services (2019).³⁰
- **55%** of Canadians were dissatisfied with wait times for publicly-funded mental health practitioners, and **20%** said they had to seek and pay for private mental health services due to long wait times or lack of publicly-funded mental health services (2019).³¹
- **5 million Canadians** do not have a family doctor.³²
- **80%** of Canadians rely on their family doctor for their mental health needs, and many of them do not have the necessary supports, resources or time to treat patients with mental illnesses.³³

The United Nations recently acknowledged that decades of neglect and underinvestment in addressing people's mental health needs have been exposed by the COVID-19 pandemic. HEAL believes that there is more that the federal government can do to assist the provinces and territories (in addition to the programs they have primary responsibility for) and ensure that those who need mental health care will have timely access when they need it.

Both now and into the future, more Canadians will require access to mental health care, not less. To ensure that people who need mental health care have timely access, governments need to move from provider-based to patient- and service-based health systems. Governments need to fund evidence-based care that is delivered by the health-care provider, or team, trained and licensed to deliver it. Currently, the bulk of mental health and problematic substance use care is delivered by non-physician providers like psychologists, social workers, psychotherapists, and occupational therapists in addition to other regulated health providers, such as dietitians, who are part of mental health teams and deliver care to people.

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RECOMMENDATION 3.1:

Working in partnership with the provinces and territories, and other key stakeholders, increase funding for sustainable, evidence-based mental health services and supports to meet the growing demand for timely access to mental health care.

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To advance discussions between the federal, provincial and territorial governments, it would be practical to build on the recent ten-year bilateral agreements that were signed in 2017. While the financial terms of the final five years have yet to be negotiated, the onset of the COVID-19 global pandemic accelerates the need for federal, provincial and territorial discussion and collaboration.

As a starting point, HEAL supports the position of the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) that provincial and territorial governments should invest a minimum of 9% of their public health expenditures into mental health programs and services.³⁴ Assuming that the federal share of public health spending should be 25% of provincial-territorial health spending,³⁵ the total federal share for mental health is \$777.7 million annually.³⁶ Knowing that the federal government has already contributed \$500 million per year via the 2017 bilateral agreements with the provinces and territories, there is a minimum additional annual contribution of \$277.5 million.³⁷

Mental Health Parity, National Standards and System Performance

In its December 5, 2019 Speech from the Throne, the federal government committed to “strengthen health care and work with the provinces and territories to make sure all Canadians get the high-quality care they deserve.”

This commitment was clarified in the Prime Minister’s mandate letter to the Minister of Health, which directed the Minister to “set national standards for access to mental health services so Canadians can get fast access to the support they need, when they need it.”

While Health Canada has initiated a consultation process to consider definitional issues related to what would constitute national standards for access to mental health services, there is also the question as to how the federal government would implement such standards.

HEAL is encouraged by the September 23, 2020 Speech from the Throne commitments to improving access to mental health resources. The question remains how the federal government will implement such standards nationally.

If they were adopted in federal legislation, the government could choose to amend the existing Canada Health Act (CHA), or introduce a new piece of legislation such as a *Mental Health Parity Act (MHPA)*.^{38 39}

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RECOMMENDATION 3.2:

HEAL recommends that the federal government formally recognize parity between mental health and physical health in legislation with appropriate and sustainable funding to the provinces and territories.

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Health supports the federal government's commitment to establish a (legislative) framework that ensures Canadians of all ages have timely access to the breadth and depth of evidence-based mental health services they need, and recognizes the long overdue necessity of funding parity between mental health and physical health.

The development of national standards for access to mental health services is inextricably linked to an appropriate and sustainable level of federal funding that would be provided to the provinces and territories, as well as for those specific populations that fall under the federal government's jurisdiction.

While these standards could be enshrined in an amended Canada Health Act, HEAL, along with the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) proposes they be embodied through a new Mental Health Parity Act.^{40 41}

A Mental Health Parity Act would affirm that mental health is valued equally to physical health, as well as ensure that governments, communities, organizations and workplaces treat mental and physical health equitably through their policies, programs and services.^{42 43} This means that governments would publicly-insure a basket of evidence-based mental health services beyond traditional physician and hospital settings that all Canadians would be eligible to receive on a timely basis, when and where they need it (i.e., universality), from the health provider trained and licensed to deliver it, irrespective of patients' ability-to-pay.

An important barrier to parity is that much of mental health problematic substance use care is delivered by non-physician health care providers whose services are not typically funded by public health insurance, such as psychologists, psychotherapists, counsellors, social workers, occupational therapists and dietitians. While Canadians with employer-based health benefits may have coverage for mental health programs and services, often it is too low to ensure a meaningful amount of evidence-based care from the most appropriate health service providers.⁴⁴ We need to build on the precedent of the Canada Health Act and recognize that the health system has evolved since its promulgation in 1984.

Governments need to move our health care systems from ones that fund specific providers to ones that fund evidence-based care, delivered by providers trained and licensed to deliver it via interprofessional teams that include, but are not limited to, physicians.

A key feature of the Mental Health Parity Act would be the development and implementation of a series of national mental health indicators and/or standards that support an accountable, high-performing mental health system. This would include a balance between administrative, system-based, and patient-centred clinical outcome indicators. These measurable goals and outcomes could be reflected in the Act – or would flow from it, and would build on the agreed upon Federal, Provincial and Territorial Common Statement of Principles on Shared Health Priorities, and recent national indicator development for mental health and addictions led by the Canadian Institute for Health Information (CIHI). It is expected that the provinces and territories would report out to their respective populations on an annual basis.

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RECOMMENDATION 3.3:

Working with the provinces and territories, regulated health professionals, and others, develop an accountable mental health system performance framework that includes indicators and/or national standards that are tracked and publicly reported across all jurisdictions on an annual basis.

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Conclusion

HEAL commends the federal government's actions and efforts to improve the healthcare system for all Canadians during these unprecedented times. HEAL, representing a broad range of health care professionals, is in a position to assist the federal government in strengthening necessary research, and designing strategies to implement the outlined recommendations.

To support the federal government's efforts to improve overall health system effectiveness, HEAL is seeking an ongoing dialogue to share the collective views of our membership. HEAL offers its services to facilitate coherent and timely information exchange and action by healthcare workers, administrators and Federal/Provincial/Territorial authorities to help contain and mitigate the crisis, and build on our learnings and experiences to improve the system for all Canadians moving forward.

Endnotes

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