JUNE 20, 2024 | UNIVERSITY OF OTTAWA

Canadian Health Coalition

University of Ottawa's Centre for Health Law, Policy and Ethics

Desmarais Building, Room 4104, University of Ottawa Google Maps

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SCHEDULE

8:00 AM | Registration opens

8:45 – 9:00 AM | Welcome

9:00 – 9:45 AM | THE 2024 CANADA HEALTH ACT ANNUAL REPORT

JENNIFER GOODYER, Executive Director, Canada Health Act Division, Health Canada

LEE WHITMAN, Assistant Director of Compliance and Interpretation, Health Canada

9:45 – 10:00 AM | Break

10:00 – 11:00 AM | CREEPING PRIVATIZATION

ANDREW LONGHURST, Simon Fraser University

Blurring the lines: health care outsourcing and private payment. Context: Federal and provincial legislation that maintain publicly financed provincial health systems, free at the point of delivery, are threatened by the incursion of corporate health care providers and private payment. Methods: This paper reviews health care outsourcing developments and evidence of unlawful private payment in British Columbia, Alberta, and Ontario through Freedom of Information requests and publicly available data over the last ten years. Findings: Public sector outsourcing is a gateway to private payment, and appears to be a preferred corporate strategy that blurs the lines between publicly funded, for-profit delivery (free at the point of delivery) and private payment contrary to provincial and federal legislation. Conclusions: Some governments and for-profit providers rationalize outsourcing as a benign form of private sector involvement in provincial health systems that maintains public health care, free at the point of delivery, and compliance with the Canada Health Act and provincial legislation. This paper draws on empirical evidence that questions this claim by governments and private interests.

PROGRAM

DANYAL RAZA, University of Toronto/Unity Health Toronto, and
SHERYL SPITHOFF, Women's College Hospital/University of Toronto

Paying with more than your credit card: The rise of for-profit virtual care and the commercialization of patient data. Virtual care has rightly become a mainstream healthcare tool. However, its rapid rise has led to an explosion of for-profit, direct-to-consumer and online-only businesses. These companies seek to maximise revenues not only by levying fees for care, but through the commercialising of patient data. In a recent study involving interviews with "industry insiders," the Health, Tech and Society lab has identified the pathways in which such commercialization is occurring, as well as risks to patient privacy. These companies collect data — like names, email addresses, and browsing history — as patients accessed care to display targeted ads or send marketing emails for "in-house" or third-party products and services. One insider reports that "if you are frequently looking up dermatology terms on our app, we might offer additional services around dermatology for you." Often, these services are paid privately with higher markups than publicly-funded services. These were described by another insider as "sell-up conversions," a known feature of for-profit care. Industry insiders have also described how some companies were funded by pharmaceutical companies to analyse patient data, and adjust care pathways with the goal of increasing uptake of a drug or vaccine. Concerningly, such data practices expose patients to potential harm not only from micro-targeting for commercial gain, but privacy loss, and discrimination. According to industry insiders, patients who engage these services often do so because of high levels of trust in the Canadian health system, problematic consent processes and a lack of other options for care.

REBECCA GRAFF-MCRAE, Parkland Institute, University of Alberta

'Innovation' guinea pig or canary in the privatization coalmine? A case study of medical laboratory services in Alberta. Despite their centrality to medical decision-making, medical laboratory services are often considered an afterthought or self-contained entity that can be carved out from the wider healthcare system without consequence. Lab services fit uneasily and incompletely within the framing of the Canada Health Act, making them particularly susceptible to short-sighted, ill-considered, and ideological policy-making intended to test the boundaries of healthcare privatization. The case of Alberta presents a window on the challenges faced across Canada in pushing back against privatization in lab services, and an eye-opening perspective on the impacts of political intervention on laboratory workers and on the wider healthcare system - and the patients who rely on it. In the last three decades, laboratory services in Alberta have been subject to a barrage of political experiments, with spectacular failure currently outweighing success stories: failed contracts, corporate bailouts, skyrocketing wait times and diminished access, inadequate investment in space, equipment, and workforce, and above all a lack of consultation with frontline workers has led to a demoralized workforce who never know what to expect next. This presentation will examine the recent ups and downs in Alberta's lab services rollercoaster, and offer lessons for politicians, policymakers, and advocates of protecting and improving public healthcare in Canada.

11:00 – 12:00 PM | WINNING PHARMACARE

MARC-ANDRÉ GAGNON, Carleton University

L'Assurance-santé à 40 ans; l'assurance-médicaments en gestation [Health insurance at age 40 - Drug insurance in the making]. Although health insurance is 40 years old in Canada, drugs are still not part of it. In Canada, access to medications remains organized on the basis of a privilege offered by employers to employees, as if medications were not an essential health service. The Liberal Party of Canada, allied with the New Democratic Party, tabled Bill C-64 at the end of February 2024 for universal public insurance for health products used for contraception or against diabetes, without co-payment or franchise. The bill proposes to lay the foundations for the longer-term implementation of a universal public drug insurance plan by making it possible to extend the basket of covered drugs and by allowing the development of a national formulary for reimbursed medications. The presentation will update what we know about the bill and assess its scope and challenges. What exactly does the bill contain? What would be the mechanics of its

implementation? Is starting with contraception and diabetes a good first step? Will this first step allow coverage to be extended to other essential products? What are the weaknesses of the bill? Could it go off the rails? What could be done to ensure its sustainability?

NIK BARRY-SHAW, Council of Canadians

How Big Pharma is Poisoning the Public Debate on Pharmacare: Think Tanks, Experts and Conflicts of Interest. Pharmaceutical and insurance companies are some of the least trusted actors in debates over reforming Canada's public health care system, and they know it. For years they have relied on a nexus of think tanks, institutions and experts to in order to push their perspectives out into the public debate. The aim is to create "echo chambers" in the media and in the halls of power that resonate with industry-approved talking points, delivered by seemingly independent voices. This paper will explore how these actors have intervened in the debate over national pharmacare since 2022, and detail the extent of their professional and financial ties to Big Pharma, the insurance industry and their lobby groups, examine how often the glaring conflicts of interest these relationships represent have been noted in the media.

JOEL LEXCHIN, York University

Quality and quantity of data used by Health Canada in approving new drugs. Background: This presentation looks at the approval of new drugs between September 1, 2012 to March 31, 2022: the characteristics of the drugs, the quality and quantity of information that Health Canada discloses about the demographics of patients enrolled in clinical trials, the characteristics of the trials and the type of review used. Methods: A list of all new drugs approved, type of review and drug characteristics was generated from Health Canada annual reports. Summary: Basis of Decision documents were used to identify patient demographics in clinical trials and clinical trial characteristics. Results Health Canada approved 326 new drugs. The percent of orphan drugs increased from 35.6% to 51.3%. The number of pivotal trials per drug decreased. The percent of Phase 3 trials dropped from 76.3% in 2012-2015 to 64.8% in 2019-2022. There was also a statistically significant decrease in the percent of trials that were randomized, controlled and blinded. The percent of trials which had information about the number of patients enrolled, that gave the age of the patients and the sex breakdown all significantly increased. Conclusion: There has been a change in regulatory standards that may be due to them becoming less rigorous. At the same time, there has been some improvement in the transparency of data. Health Canada has recently embarked on a series of reforms in drug regulation and clinical trial management. These changes need to be closely evaluated to be sure that they enhance the efficacy and safety of new drugs.

12:00 – 1:00 PM | Lunch Provided

1:00 – 1:30 PM | TEN UNHELPFUL MYTHS REVISITED ABOUT THE CANADA HEALTH ACT

GREG MARCHILDON, University of Toronto, and
BILL THOLL, McMaster University and Canadian Health Leadership Network

1:30 – 2:30 PM | EXPANDING MEDICARE

DAVID MACDONALD, Canadian Centre for Policy Alternatives

Missing teeth: Who's left out of Canada's dental care plan. A family income of $90,000 annually for families with children isn't unusual in Canada: Earning $45,000 for each parent isn't a tremendous salary in Canada. But making more than that precludes those families from receiving federal dental care coverage. The first phase, underway through to June 2024, is called the Canada Dental Benefit (CDB). It's a cash transfer of $1,300 a child if that child sees a dentist; 65 per cent of children under 12 without other dental insurance—794,000 young children—could get the $1,300 transfer. 382,000 young children have actually received support so far. However, 35 per cent—426,000 young children—without dental insurance cannot access it because their families

make over $90,000. In phase three, the only eligibility restriction is the $90,000 family income cap and the lack of other dental insurance. Phase three of the CDCP will cover 8.5 million people but will leave another 4.4 million out of the plan due to the income restriction. A further 1.4 million people might have their inadequate provincial public dental insurance supplemented by the new federal plan. Upon full implementation, 9.8 million people will either gain dental insurance or have it supplemented by the CDCP. It would cost an estimated $1.45 billion on top of the $3.3 billion presently budgeted for the 2025-26 year to include the people without dental insurance who won't qualify for the CDCP.

SARAH KENNELL, Canadian Mental Health Association

Righting the wrongs of the past: addressing the exclusion of mental health & substance use health services from the Canada Health Act. Under the Canada Health Act, most mental health and substance use health services (MHSU) are covered only if delivered by physicians or in hospitals and are considered "medically necessary/required." Notwithstanding the objective of the Act to provide universal and comprehensive health care to promote the physical and mental well-being of Canadians, the scope of the Act – particularly in its definitions of "insured services" and "comprehensiveness" – predominantly addresses physical health care needs and fails to address MHSU needs. The result is that coverage of mental health and substance use care are relegated to discretionary, non-core status and are left either unaddressed or are inadequately addressed on an optional basis by the provinces and territories. In the absence of a federal obligation to cover MHSU services, some jurisdictions offer services, and others do not. Services not covered can include counselling, psychotherapy, substance use and addictions treatments, eating disorder treatments, and treatment for PTSD, among others. The result is a systemic pattern of unequal access to essential health services for persons with mental health or substance use health needs. During this presentation, CMHA will examine the period leading up to the adoption of the CHA and make the case that the federal government, through the Act, must ensure access to MHSU services delivered outside of hospital settings and by providers beyond physicians. CMHA will further present its ongoing advocacy with the federal government to realize a vision for universal mental health care.

SUZANNE DUPUIS-BLANCHARD, Université de Moncton

Aging in Place: Advancing Public Health Care and the Canada Health Act. Most older adults want to age in place, but many provinces and territories still lack an efficient model of service delivery that is reliable and accessible. In fact, home support services and community care remain absent from the Canada Health Act. With the current health care challenges, along with an aging population, access to services for aging in place is critical. Also, older adults living in Official Language Minority Communities (OLMC) have the additional burden of access to services in their language. It is essential that non-urgent visits to the emergency department be prevented as well as delaying or preventing admissions to long-term care facilities for older adults that could remain at home with appropriate supports. One promising evidence-based practice is the New Brunswick led Nursing Home Without Walls (NHWW) program for aging in place. The objectives of NHWW are to ensure that older adults and their care partners have access to appropriate services and information related to aging in place while providing social health initiatives to counter social isolation and loneliness, increasing knowledge of health-related issues important to aging in place and empowering the local community to respond to the needs of an aging population while becoming an age-friendly community. With a focus on health promotion, the social determinants of health and timely appropriate accompaniment and supports, this program has been proven successful. This presentation will highlight the components of the NHWW along with supporting evidence of increased access to services including in OLMC and rural communities.

2:30 – 3:30 PM | REVISITING THE CANADA HEALTH ACT

YIN YUAN (Y.Y.) CHEN, University of Ottawa

Revisiting the Waiting Period Allowance under the Canada Health Act. The Canada Health Act ("CHA") permits provincial and territorial health insurance plans to impose on applicants a waiting period of up to three months before their coverage begins. To date, all provinces and territories have availed themselves of this waiting period allowance with respect to new residents who move from another Canadian jurisdiction. About half of the provinces and territories have further extended such a waiting period (sometimes exceeding three months) to new residents moving from outside Canada, including Canadians returning from residence abroad and many newcomers to the country. Research shows this latter form of waiting requirement often undermines the health and wellbeing of those affected, who unlike people moving from within Canada, typically do not have any publicly funded health insurance to fall back on during the wait. This presentation argues that it is time to eliminate the CHA's allowance of a waiting period on returning Canadians and newcomers. Insofar as the waiting period is meant to deter so-called "health tourism," there is currently little evidence that health tourism is of serious concern in Canada. Moreover, given that people are already required to show a certain citizenship and immigration status, as well as proof of residency in the relevant province or territory, in order to qualify for Medicare, the need for a waiting period to counter health tourism is questionable. Instead, all that the waiting period does is delaying people's access to medically necessary care, adding pressure to emergency rooms, and fuelling the demand for private health insurance.

MARIE CARPENTIER, Université du Québec à Montréal (UQAM)

Le droit international à la rescousse de la Loi canadienne sur la santé [International law to the rescue of the Canada Health Act]. Although not specifically enshrined in Canadian law, the right to health is guaranteed by several of the international instruments to which Canada is a party. Canada's legal regime does not, however, provide for the immediate application into domestic law of Canada's obligations under its international commitments. In other words, domestic courts refuse to directly apply treaties signed by Canada. However, these commitments should not remain a dead letter, as they have legal consequences. The objective of the presentation is to demonstrate, on the basis of relevant Supreme Court jurisprudence, how international law, and in particular provisions relating to the right to health, should serve as a persuasive source of interpretation of domestic law, including the provisions of the Canada Health Act. The argument for the interpretation of domestic law is reinforced by the fact that Canada itself invokes the law when it reports to international forums on how it implements its obligations under, inter alia, the International Covenant on Economic, Social and Cultural Rights. The interpretation of the right to health will also be discussed. It is therefore a question of reflecting on how the right to health can and should influence our thinking about the Canada Health Act.

MARTHA PAYNTER, University of New Brunswick

Barriers to abortion without barring abortion: Addressing private costs in family planning care. The R v Morgentaler Supreme Court of Canada decision of 1988 resulted in the complete decriminalization of abortion, establishing Canada as the jurisdiction with the most progressive legal regime for abortion in the world. Procedural abortion was publicly funded as a physician-provided service under Medicare. In 2017, when medication abortion was finally implemented in primary care across the country, the pills- usually a domain kept firmly outside of public funding- were understood and authorized to warrant Medicare funding as well. As COVID-19 ravaged the health system, billing codes for telemedicine services for medication abortion were approved, significantly improving patient privacy and convenience. In 2023, the province of British Columbia, which had for years provided post-abortion contraception freely, became the first to offer universal coverage for contraception for all. Finally, in 2024, the federal government announced plans to expand the

universal contraception coverage nation-wide. In this context of ever-improving public funding for obvious family planning services, more critical examination of invisibilized costs and encumbrances is called for, with a lens towards reproductive justice implications. What does it matter if medication abortion pills to induce a miscarriage are freely dispensed, if you do not have a home? Or if telemedicine abortion is funded, but you cannot afford a phone? In the contemporary abortion care landscape, analysis must shift to consider how austerity economics erodes the patient-facing impact of substantial, otherwise successful, recent changes to enhance access. Future efforts to advance reproductive justice must address the privatization of non-clinical essentials to care.

3:30 – 3:45 PM | Break

3:45 – 5:00 PM | PUBLIC HEALTH CARE SOLUTIONS AND ENFORCEMENT

EDWARD XIE, Canadian Doctors for Medicare

Public Solutions to Reduce Wait Times in Canadian Health Care. Background: Wait times for medical and surgical consultants and Emergency Department wait times have markedly increased in Canada and abroad since the onset of the COVID-19 pandemic. Given health human resource challenges and funding limitations, there is a need to deliver care more efficiently. The purpose of this study is to identify evidence-based ways to reduce i) wait times to see consultants and ii) emergency department wait times in Canada's publicly-funded health care system. Methods: Seven volunteer physicians conducted a narrative review of the academic and gray literature to identify effective wait time reduction strategies. Both Canadian and international studies were included. Reviewers met regularly to share findings and reach consensus over the 7 most evidence-based strategies. Findings were summarized in briefing documents describing each intervention. Results: The evidence-based interventions to reduce wait times for consultants included centralized intake for referrals, e-consultation models, and allied health assessment pathways. The evidence-based interventions to reduce Emergency Department wait times included overcapacity protocols, physician at triage models, observation units, and improved access to primary care. Studies were often conducted at the local or regional level with limited scaling. Conclusion: There are several evidence-based strategies for reducing wait times in health care in Canada. These strategies should be communicated to health care leadership and policymakers to help scale local innovations to provincial, territorial, or national initiatives.

NATALIE STAKE–DOUCET, Université de Montréal/Quebec Nurses Association

The Nurse Retention Toolkit and the Canada Health Act. This presentation aims to introduce the Nurse Retention Toolkit, published in March 2024, and how it relates to the Canada Health Act (CHA) This document, developped by nurses, for nurses, supports a novel application of the CHA; how the act can support nurse retention through engagement in defending and defining the public character of health systems in the provinces and territories. The toolkite came out of the meeting of hundreds of nurses from across Canada, from all clinical settings, under the leadership of Leigh Chapman, Chief Nursing Officer (CNO). This level of collaboration between nurses was unprecedented in Canadian history. The discussions revealed how nurse retention is fundamentally intertwined with several aspects of the Canada Health Act; more specifically for the purpose of this presentation, comprehensiveness and public administration. 1- Comprehensiveness: while "essential nursing services" are included in the CHA, very little detail is provided as to what essential nursing services are. The enduring incapacity of healthcare systems accross Canada to retain nurses is related in part to nurses themselves not being sufficiently included at the decision tables where the extent of nursing services are determined. The nurse retention toolkit directly addresses this issue. 2- Public administration: nurses are the biggest professional group in healthcare, the vast majority working within the public healthcare system, yet have little say in the management of the public system. Through the CHA, establishing chief nursing officers in all provinces and territories, for instance, could strengthen nursing voices at decision-making tables.

FRÉDERIQUE CHABOT, Action Canada for Sexual Health & Rights and
CELIA ZHANG, LEAF (Women's Legal Education and Action Fund)

The Abortion Access Tracker. Amidst rising attacks on sexual and reproductive rights at home and globally, Action Canada for Sexual Health and Rights and the Women's Legal Action and Education Fund (LEAF) have launched the Abortion Access Tracker, a tool for advocates, policy makers, and journalists working to protect and strengthen access to abortion in Canada. Abortion is a safe and common procedure that 1 in 3 people who can get pregnant will need to access in their lifetime. While we have seen great progress in improving access with the introduction of the abortion pill and a rise in political will to protect the right to self-determination, the Abortion Access Tracker highlights persisting barriers, as well as discrepancies in laws, policies, and regulations between provinces and territories that make access to this medical procedure better in certain regions over others. In this new resource collated by experts in the field, we take a deeper look at gaps, as well as identify opportunities to protect and improve abortion access through policy and law at various level. While this conversation has been ongoing for decades, the urgency is rising as the United States' Supreme Court overturned Roe v. Wade in 2022, ending 50 years of constitutional protection for abortion. While some may have been tempted to introduce a new law to protect abortion in Canada, we already have one, the Canada Health Act, through which we must explore how to best ensure all people can access a procedure that has been long politicized.

IAN JOHNSON and DR. ROBERT BARKWELL, Nova Scotia Health Coalition

Importance of Enforcement for the *Canada Health Act*. The Nova Scotia Health Coalition witnessed in the early 1980's the rise of "extra-billing", "balance billing", and "billing above tariff" which had risen since 1977-78 to 1983-84. Approximately 50 percent of physicians were extra-billing in Nova Scotia. We also heard the threats of hospital user fees to be imposed by the provincial government. This threat did not happen due to increasing public pressure until the then Premier then committed to "no user fees as long as I am premier." Sections 18 and 19 of the Canada Health Act discussed deductions from federal cash contributions to the relevant provinces/territories for extra-billing and for user charges for any of the previous consecutive fiscal years, which could be re-paid to the relevant provinces/terrorities once the practices are stopped. There have been three policy letters that have clarified the intent of the federal government for the interpretation and implementation of the Canada Health Act. Some progress has been been made against the presence of extra-billing and user charges. Nova Scotia was one province who moved within six months to ban extra-billing. However, since the passage of the Act in 1984. However, other issues have arisen such as private clinics and facility fees. More progress needs to be made. The Chaoulli and the Cambie Surgeries in B.C, legal cases draw further attention to these problems. We need an overall plan and mechanism to make substantial progress towards the primary objective for Canadian health care policy.

5:00 – 5:30 pm | Fireside Chat with Jane Philpott

JANE PHILPOTT, Dean of the Faculty of Health Sciences and Director of the School of Medicine, Queen's University and former Minister of Health, author of *Health for All: A Doctor's Prescription for a Healthier Canada.*

5:30 – 6:30 PM | Book signing with Jane Philpott and reception

For more information, contact Tracy at **tglynn@healthcoalition.ca**.

Organized by the Canadian Health Coalition and the University of Ottawa's Centre for Health Law, Policy and Ethics, with support from St. Thomas University.

BIOGRAPHIES

Convenors

VANESSA GRUBEN is a professor in the Common Law Section of the University of Ottawa's Faculty of Law. She is the co-editor of the 5th edition of Canada's leading health law text, *Canadian Health Law and Policy* (LexisNexis, 2017) and co-author of Families and the Law in Canada: Cases and Commentary (Captus, 2019). She currently serves as a board member of the Canadian Health Coalition and AMS Healthcare.

ANNE LAGACÉ DOWSON is the Media Director of the Canadian Health Coalition. She is an award-winning interviewer and commentator, former CBC radio host, reporter and researcher. Anne worked for 25 years for CBC, Radio-Canada and BellMedia. She has an MA in History from Carleton and is fluently bilingual.

TRACY GLYNN, PhD, is the National Director of Operations and Projects of the Canadian Health Coalition. She also holds a regular teaching appointment at St. Thomas University and is a co-founder of the Madhu Verma Migrant Justice Centre where she engages in migrant health care advocacy.

STEVEN STAPLES is National Director of Policy and Advocacy of the Canadian Health Coalition. He is an accomplished policy advocacy, strategist, communicator and author, with 30 years of experience in non-profit, labour, and research organizations. He holds a Bachelor of Education and a Master of Leadership and Community Engagement.

Presenters

NIK BARRY-SHAW is the trade and privatization campaigner for the Council of Canadians. He has a Master's of History from Queen's University and is co-author (with Dru Oja Jay) of *Paved with Good Intentions: Canada's NGOs from Idealism to Imperialism* (2012).

Email: nbarryshaw@canadians.org

ROBERT BARKWELL, MD, is a recently retired family physician. He has a long-standing commitment to public health care, and has been on the Executive of the Nova Scotia Health Coalition since 2017, and Chair since 2022.

Email: barkwell@prontomail.com

MARIE CARPENTIER is a Doctor of Law. A lecturer for various Quebec law faculties, she was legal counsel at the Commission des droits de la personne et des droits de la jeunesse for more than a dozen years. She is the author of several briefs adopted by the Commission, some of which have been presented to the National Assembly. She currently works as a lawyer in the Legal Affairs Department - expert advice - of the Commission des normes, de l'équité, de la santé et de la sécurité du travail and is an associate researcher at COMRADES.

Email: carpentier.marie@uqam.ca

FREDERIQUE CHABOT (she/her) is the Acting Executive Director of Action Canada for Sexual Health & Rights, a national organization safeguarding and advancing sexual and reproductive health and rights in Canada and around the world. She has been with Action Canada for a decade, leading on health promotion and domestic advocacy activities.

Email: Frederique@actioncanadashr.org

Y.Y. CHEN is an Associate Professor at the University of Ottawa's Faculty of Law, Common Law Section. He holds Doctor of Juridical Science, Master of Social Work, and Juris Doctor degrees from the University of Toronto. Specializing in health law, immigration law, and constitutional law, his current research leverages socio-legal and action research methodologies to identify and examine injustices that surface at the intersection of international migration and health. His published work has touched on such topics as migrants' right to health, social determinants of health, border control of infectious diseases, and medical tourism.

Email: yy.chen@uottawa.ca

SUZANNE DUPUIS-BLANCHARD, PhD, is a registered nurse, full professor at the School of Nursing at Université de Moncton where she hold a research chair in aging and is director of the Centre on Aging. Her program of research focuses on the multiple dimensions of aging in place with a special focus on Official Language Minority Communities. She is currently leading an innovative intervention to support aging in place. She is the immediate past chairperson of the National Seniors Council, the past president of the Canadian Association on Gerontology and past co-chair of the development of the NB Strategy on Aging.

Email: suzanne.dupuis-blanchard@umoncton.ca

MARC-ANDRÉ GAGNON is an associate professor at the School of Administration and Public Policy at Carleton University, Ottawa. He specializes in pharmaceutical policies, social policies, as well as science policies. He holds a doctorate in political science from York University, a Diploma of Advanced Studies in economics from the École Normale Supérieure de Fontenay/St-Cloud and the University of Paris-I Sorbonne. His current work focuses on institutional corruption in medical research, regulatory capture of public institutions by private lobbies, innovation policies in the knowledge economy and the structures of drug insurance plans.

Email: ma.gagnon@carleton.ca

REBECCA GRAFF-MCRAE is the Research Manager for the Parkland Institute at the University of Alberta, where her areas of research include public healthcare, seniors' care, and public services. She holds a PhD in Irish Politics from Queen's University Belfast, and has previously held fellowships with the QUB Institute of Irish Studies, Memorial University Newfoundland, and University College Cork. In addition to many reports for Parkland, Rebecca is the author of Remembering & Forgetting 1916: Commemoration and Conflict in Post-Peace Process Ireland (Irish Academic Press, 2010). Her scholarly work has appeared in Éire-Ireland, Nordic Irish Studies, and Ethnopolitics among other publications.

Email: rgraff@ualberta.ca

IAN JOHNSON is the founding Chair of the Nova Scotia Health Coalition. He helped to prepare the Health Coalition's Public Series on Medicare in 1983. He was a member of the delegation of the Canadian Health Coalition and Nova Scotia Health Coalition before the House of Commons Committee examining the new Act in 1984. He was the Policy Analyst/Communications Coordinator with the Nova Scotia Government and General Employees Union from 1995 to 2015.

Email: johnsonianfeb@gmail.com

SARAH KENNELL (she/her) is the National Director, Public Policy with the Canadian Mental Health Association. In this role, Sarah drives federal systems change in mental health and substance use health. Prior to joining CMHA, Sarah was the Director of GR with Action Canada for Sexual Health and Rights (Planned Parenthood), where Sarah led national advocacy and campaigning on issues including contraceptive care, abortion, and comprehensive sexuality education. Sarah has years of experience – within and outside government. Sarah holds a MA in Globalization and Women's Studies. Sarah sits on the Board of Directors of the South East Ottawa Community Health Centre.

Email: skennell@cmha.ca

JOEL LEXCHIN received his MD from the University of Toronto in 1977. He is a Professor Emeritus in the Faculty of Health at York University and worked as an emergency department physician for 34 years. He recently published two books: Private Profits vs Public Policy: The Pharmaceutical Industry and the Canadian State and Doctors in Denial: Why Big Pharma and the Canadian Medical Profession Are Too Close for Comfort. He is a board member of Canadian Doctors for Medicare, a fellow of the Canadian Academy of Health Sciences and among the top 2% of the world's most highly cited researchers.

Email: jlexchin@yorku.ca

ANDREW LONGHURST, M.A., is a political economist, health policy researcher, and PhD candidate in the Department of Geography at Simon Fraser University. He is also a research associate with the B.C. Office of the Canadian Centre for Policy Alternatives. His past publications include At What Cost? Ontario Hospital Privatization and the Threat to Public Health Care (CCPA-Ontario, 2023), Failing to Deliver: The Alberta Surgical Initiative and Declining Surgical Capacity (Parkland Institute, 2023), and the Concerning Rise of Corporate Medicine (CCPA-BC, 2022).

Email: andrew_longhurst@sfu.ca

DAVID MACDONALD has coordinated the Alternative Federal Budget for the Canadian Centre for Policy Alternatives since 2008. The Alternative Federal Budget takes a fresh look at the federal budget from a progressive perspective. David has also written on a variety of topics, from child care to income inequality to federal fiscal policy. He is a regular media commentator on national policy issues, often speaking to the CBC, Globe and Mail, Toronto Star and Canadian Press.

Email: david@policyalternatives.ca

EDWARD XIE works as an emergency physician, member of the Board of Directors of Canadian Doctors for Medicare, and Assistant Professor at the University of Toronto. He is also a PhD student in Health Systems Research with a focus on financial protection and pharmacare and serves on the Canadian Drug Expert Committee of CADTH (Canada's Drug Agency). Edward works with academic and community groups on issues of climate change and health and is a member of the newly launched Centre for Climate, Health and Sustainable Care at the University of Toronto.

Email: edward.xie@utoronto.ca

MARTHA PAYNTER, PhD, is Director of Nursing Research with the Contraception and Abortion Research Team-UBC and Assistant Professor, University of New Brunswick Faculty of Nursing, where her clinical teaching and research focus on the intersection of reproductive health and the criminal justice system. The Affiliate Scientist for the ROSE Clinic (Reproductive Options and Services), she is also Director of Research of Wellness Within: An Organization for Health and Justice, the only organization in Canada dedicated to advancing reproductive justice for people experiencing criminalization. She is the author of *Abortion to Abolition: Reproductive Health and Justice in Canada*, published by Fernwood.

Email: martha.paynter@unb.ca

DANYAAL RAZA, MD, is a family physician with Unity Health Toronto's St. Michael's Hospital, and Assistant Professor at the University of Toronto. Dr. Raza is a past Chair of Canadian Doctors for Medicare, and founding physician lead of the Sumac Creek Health Centre in Toronto's Regent Park.

Email: danyaal.raza@utoronto.ca

SHERYL SPITHOFF, MD, is a Clinician Scientist at Women's College Hospital and an Assistant Professor at the University of Toronto. She has appointments at Women's College Research Institute and the School of Public Health at the University of Toronto. Her research explores the intersection of new technologies, commercial interests and the healthcare system. Dr.

Email: Sheryl.Spithoff@wchospital.ca

NATALIE STAKE-DOUCET, RN, PhD, is assistant professor of nursing at Université de Montréal and board member of the Quebec Nurses Association.

Email: natalie.stake-doucet@umontreal.ca

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