HEALTH

THE HILL TIMES POLICY BRIEFING
FEBRUARY 5, 2018

PROPOSED PRICE CAP REGULATIONS WILL IMPACT CANADIAN R&D, SAYS BIG PHARMA, BUT ACADEMIC NOT CONVINCED

PALLIATIVE CARE, THE NEXT STEP FOR CANADA

FROM MARIJUANA TO MEDICATIONS: TRUDEAU GOVERNMENT AND THE HEALTH FILE IN 2018

WHY ARE THE LIBERALS SHUTTERING CANADA'S COMMUNITY-BASED HIV ORGANIZATIONS?

A CANADIAN PARTNERSHIP TO ADDRESS DEMENTIA

RACISM IS A HEALTH CRISIS

From marijuana to medications: Trudeau government and health file in 2018

Health Minister Ginette Petitpas Taylor oversees one of the most important portfolios in government, one that also bears significant symbolic importance for the party she represents in the House. *The Hill Times photograph by Andrew Meade*

A
FIGHTING
CHANCE.

R&D of new medicines and vaccines is helping more Canadians improve their odds.

Medicine for health, innovation for the future.

INNOVATIVE MEDICINES CANADA

innovateforlife.ca

#innovateforlife

After more than two years in office, what exactly is the Trudeau government doing to address a growing list of health priorities, including an increasingly urgent crisis with opioids and the impending legalization of marijuana?

BY MARCO VIGLIOTTI

Whether cannabis legalization, the spiralling opioid crisis, or keeping medication prices affordable, there's no shortage of meaty policy files on the desk of Health Minister Ginette Petitpas Taylor.

Serving her first term in the House, Ms. Taylor (Moncton-Riverview-Dieppe, N.B.) has been tasked with handling not only an immensely important portfolio that directly affects the lives of Canadians on a daily basis, but also one that is hugely symbolic for the party she represents in the House.

After all, the Liberals never tire of reminding voters that they are the party that introduced national publicly funded health insurance, via the Canada Health Act. And when campaigning in the run-up to the 2015 vote, Prime Minister Justin Trudeau (Papineau, Que.) promised that if elected, his government would restore Ottawa's rightful role in the national health care conversation, after accusing the former Conservative regime of devolving responsibility.

The Hill Times reached out to the health minister's office to hear what the minister and department was doing to address the country's biggest health-related policy issues, but the minister declined an interview. Health Canada's chief of media relations Eric Morrissette took leadership and responded to *The Hill Times'* questions. This email Q&A has been edited for length and style.

How is Ottawa helping the provinces and other lower orders of governments provide efficient and effective mental health care?

"Budget 2017 confirmed $11-billion over 10 years in new federal investments to improve access to mental health and addiction services. In August 2017, the federal, provincial and territorial governments reached agreement on the Common Statement of Principles on Shared Health Priorities, which outlines key priorities for federal investments in mental health and addiction services, and home and community care. The common statement of principles provides a list of priority actions where provinces and territories have agreed to focus the funding for mental health and addiction services and home and community care.

"With their endorsement of the Common Statement of Principles, provinces and territories received their share of funding for fiscal year 2017-18. The funding for the remaining years of the 10-year commitment will flow to provinces and territories through bilateral funding agreements. The bilateral agreements will include detailed action plans on how provinces and territories plan to invest federal funds and will be posted online as they are signed. Agreements with New Brunswick and Newfoundland and Labrador have already been signed.

"The government of Canada is also working with partners and stakeholders to put in place programs and initiatives

Continued on page 30

Vancouver mayor says major gaps remain in fighting opioid crisis with the help of task force

Vancouver Mayor Gregor Robertson says 'We need to establish a comprehensive timeline and measures and evidence-based targets for the four pillars to the crisis and that doesn't exist.'

BY SHRUTI SHEKAR

Vancouver Mayor Gregor Robertson says there are visible gaps remaining in accomplishing the objectives of a task force, which was launched by Federation of Canadian Municipalities, to help the federal government find a solution to the ongoing opioid crisis.

In a phone interview last week with *The Hill Times*, Mr. Robertson said since the task force was aunched last February and nine recommendations were put forth, a national response of setting clear targets, sharing information, and coordinating responses across all orders of government has not taken place yet.

"Our priority is getting the federal and provincial governments to treat this like the emergency that it is," said Mr. Robertson, who chairs the task force which includes the mayors of 13 cities including Vancouver, Surrey, Edmonton, Calgary, Regina, Saskatoon, Winnipeg, Hamilton, London, Kitchener, Toronto, Ottawa, and Montreal.

In 2017, more than 1,400 people died of an illicit-drug overdose and that number has grown exponentially since the crisis hit hard back in 2015, according to the B.C. coroner's service.

Mr. Robertson said the task force has been collecting data on a monthly basis that includes reports from first responders and coroners. The four pillars of the task force are harm reduction, treatment, prevention, and enforcement.

The following Q&A has been edited for style and length.

What has been achieved since the recommendations were put forward?

"There's been some progress made on data and the provinces are slowly improving their data sharing but there's still a long way from the full data we need for evidence-based decisions.

"The data piece is critical for shaping next steps, but ultimately the recommendations focus on the four pillars of addressing addiction.

"So we have seen some progress on harm reduction, which is led by cities and requires provincial and federal support. … In B.C. we have a long history and we have a full complement of harm reduction and overdose prevention sites in operation in Vancouver and there are a number of sites in other cities across Canada starting up, but it's been a much slower process and some sites have pop up sites [that] have been shut down.

"So it's harm reduction; [there is] some progress, but the big burning need is for treatment. We don't have a solid addictions treatment system in Canada and this overdose crisis has exposed that massive failing and thousands have died last year as a result. So we dramatically need more investment in treatment for addictions across the country and this is where the federal government needs to play that leading role and coordinated response.

"To the point of prevention, we have a big public awareness campaign against stigma being launched in B.C. ... earlier this week.

"Prevention and education is a huge part of this, they need to be ramped up across Canada and fed government can help to address stigma and make sure drug users aren't pressured by that stigma to stay solo and put their lives at risk of overdose and they need to reach out and get the help to stay alive and access treatment ultimately.

"I think there's been some work on the final pillar of enforcement and reducing the flow of drugs into the country and the operation of pill presses in provinces; again, there's some progress but more work is needed there too."

You said there is an importance placed on treatment and there is a gap in this pillar. What is the task force doing in terms of fixing this gap?

"All the task force can do is push harder for the provinces and Ottawa to step up their investment and increase budgets for addictions treatment across the country.

"We can only push back on provinces and the federal government to do more on mental health and addictions and that's the four-pillar approach, but the weakest link is treatment that's clear and it requires significant resources and coordination across the country."

What kind of resources?

"[It is] having a range of treatment options. There is no quick fix and, as we are seeing in B.C., we are now moving towards opioid substitution therapy and making sure that clean opioids are available to people with addictions so they are not at risk of death from the toxic street drugs."

The task force has said there needs to be a concerted effort between all levels of government. Is there a concerted effort? If not, why?

"The national response is not coordinated so it's a patchwork of data and investment to fight the overdose crisis across the country. Provinces are talking via their health ministers, but we are not seeing the federal government aggregate the data and ensure there is a coordinated response across Canada.

"We need an intergovernmental plan that aligns the actions and resources with the work on the ground and the response to the specific needs in cities and Indigenous communities and wherever the impact is significant."

sshekar@hilltimes.com
@shruti_shekar

INVESTMENT, INNOVATION AND OUTCOMES: A COLLABORATIVE MADE-IN-CANADA FRAMEWORK FOR INNOVATIVE MEDICINES

By Pamela C. Fralick, President, Innovative Medicines Canada

In December, Health Canada unveiled proposed regulatory amendments to the Patented Medicines Prices Review Board (PMPRB), a federal body charged with establishing price ceilings for patented drugs, as part of the federal government's promise to introduce "sweeping changes" to Canada's 30-year-old drug pricing regime. These proposals, should they come become regulation, will profoundly impact Canada's life sciences sector, with the potential to impair health system investment and reduce access to new medicines for Canadian patients who need them.

The current proposal appears to be a narrow cost-cutting exercise that fails to recognize how drug prices relate to investment, innovation and patient access.

PDCI Market Access, a leading consulting firm, predicts that the changes will cost $26.1 billion in lost revenue over a 10-year period. When taxes and R&D impacts are factored in, the number rises to $35.1 billion. This compares with the Health Canada's estimate that lost revenue will amount to $8.6 billion the same period. Canada is currently home to world-class researchers and exciting biotech start-ups, and the industry has a significant footprint here – supporting 30,000 jobs and conducting 4,500 clinical trials annually. Our industry also invests 9.97 percent of its gross patented product sales into research and related investments.

There is no question that if Ottawa moves forward with these changes, there will be profound impacts to Canadian healthcare and the life sciences sector for decades to come. There will be less access for patients to the latest breakthrough medicines, less investment in R&D and clinical trials and there will be job losses.

Our industry is ready to do its part to help with drug costs. But it is possible to do so in a way that preserves patient access to life-changing and life-saving drugs and strengthens Canada's vibrant life sciences sector. Here are a few ideas that demonstrate industry is open to discuss with governments to drive sustainable investments, innovation and improve patient outcomes.

AFFORDABILITY

We understand that governments need an affordable solution, one that maximizes spending while ensuring sustainability. Our members have worked with governments to provide significant savings through joint price negotiations via the pan-Canadian Pharmaceutical Alliance. These efforts are generating $1.28 billion in annual savings on brand and generic medicines. Governments and industry need to continue to work together on potential budget, price and market predictability solutions. Possible solutions include: implementing a price freeze on current patented drugs, and utilizing value-based agreements using improved data sources.

ACCESSIBILITY

We agree that there is room for improvement within the current system. The innovative pharmaceutical industry is eager to work with governments on solutions to provide Canadians with timely access to new, affordable innovative treatments. Possible solutions include: addressing the issue of the un- and underinsured population, forming public-private Canadian partnerships, as well as collaboration on a universal coverage/essential medicines list and supporting the infrastructure to educate Canadians on coverage availability, understanding that many Canadians who qualify for prescription drug coverage are not currently enrolled in coverage.

APPROPRIATE PRESCRIBING

To help with appropriate prescribing, we would like to explore and collaborate on ideas where industry can help create capacity for health data infrastructure for provinces and territories.

ADOPTING INNOVATION

Last, but not least, we must not lose sight of the urgent need to promote research and innovation in Canada. The spin-offs from new innovations are tremendous. They are economic engines that, if nurtured, can have a significant and positive impact on our economy and on the lives of Canadians. To enhance research and innovation, we need to explore and collaborate on a new potential investment threshold governed by a modernized industry investment calculation.

I am hopeful and optimistic that, together, we can see progress on pan-Canadian priorities regarding affordability, accessibility, appropriate prescribing and innovation. And I know that we can do so while finding a collaborative and timely made-in-Canada framework for innovative medicines. In the meantime, we encourage the federal government to adopt an ambitious and pragmatic approach to preserve Canada's status as a top-tier country for clinical trials and for launching new medicines.

innovativemedicines.ca

Proposed price cap regulations will impact Canadian R&D, says big pharma, but academic not convinced

Health Canada says the proposed changes to the Patented Medicines Prices Review Board could be between $8-billion and $24-billion over the next decade, but Innovative Medicines Canada's study by PDCI Market Access predicts impacts of $26-billion to $35-billion.

BY EMILY HAWS

Brand name drug companies are warning the government to think through its proposed regulations for the Patented Medicines Prices Review Board, saying it could curb investment in Canadian research and development.

However, one University of British Columbia academic is calling the claims "rhetoric."

The Patented Medicines Prices Review Board (PMPRB), founded in 1987, is a regulatory body that prevents pharmaceutical companies from charging excessive prices. When a new drug is introduced to Canada, it determines the ceiling limit as the median list price of seven comparable countries. In May, Health Canada announced a proposal to drop the United States and Switzerland, who have high drug costs, from the list and add in new comparator countries with lower prices.

The proposed change is part of larger review of the board's regulations, the first major one in 20 years. Another significant change includes a move toward transparency, requiring drug companies to disclose all price reductions to the board.

Those are the main changes, but others include new factors allowing the PMPRB to consider drug costs in relation to the value to patients and impact on the healthcare system; reducing the reporting requirements for veterinary, over-the-counter and generic drugs; and amending price information reporting requirements to include reporting in relation to the new factors.

Generic drug companies are not as concerned about the proposed regulations, but want to ensure the reduced reporting requirements also cover generic medicines with patents. The proposed amendments were published in the *Canada Gazette*, Part I, by Health Canada on Dec. 1. The government has invited stakeholders to submit feedback until Feb. 14.

Steve Morgan, a UBC health economist, said the concerns are "rhetoric people are paid to say because they want to maintain a high pricing profile for medicines." He said the only country where high prices equal high research and development (R&D) investment is the United States.

"Every other country that is a high research and development country … [spends] less than we do on medicines," he said, adding the United Kingdom spends 40 per cent less per capita on pharmaceuticals than Canada and attracts five times the per capita levels of research and development.

PMPRB's 2016 Annual Report states Canadian patented drug prices were fourth-highest among the seven countries Canada compares itself to under its regulations. It fell just behind Switzerland, Germany, and the United States.

Comparing drug prices can be difficult because list prices are often different from what governments or insurance companies confidentially negotiate—sources told *The Hill Times* it is similar to buying a vehicle. However, a 2015 Organisation for Economic Co-operation and Development (OECD) study said Canada was the fourth-highest drugs spender out of 29 countries, per capita. Canadian 2013 spending was US$713 per person, compared to the average of US$515. The U.S. was most expensive at US$1,026, whereas Denmark was at US$240.

Health Minister Ginette Petitpas Taylor speaks to media before Question Period in October. One of the minister's mandate letter commitments is reducing Canadians' high drug costs. *The Hill Times photograph by Andrew Meade*

Innovative Medicines Canada (ICM), which represents patented drug companies, disputes the claim that Canadians pay high drug prices because the data is usually from PMPRB, which looks at list price rather than the true negotiated one.

ICM president Pamela Fralick said members understand the government's concerns, and a deal could be reached if the groups sat down and shared information. However, "Health Canada [has]…not been that interested in that kind of in-depth conversation," she said.

"All input to the first round of consultation was considered in the creation of the Regulatory Impact Analysis Statement that is now open for further consultation," said Sindy Souffront, a Health Canada Spokesperson, in an emailed statement.

Reduced revenues will harm R&D 'ecosystem'

PMPRB uses the median of listed prices in France, Germany, Italy, Sweden, Switzerland, the U.K., and the U.S. to determine the cap. Under the proposed changes it would axe Switzerland and the U.S., adding in Australia, Belgium, Japan, the Netherlands, Norway, South Korea, and Spain. This promotes a more balanced perspective of market prices and provides a more stable median, according to Health Canada.

By reducing the cap, it reduces a company's revenue, therefore reducing the amount it can invest in drug development, argues IMC, and less revenue in Canada means impacts on Canadian R&D.

"[Health Canada is] saying that through the measures they're proposing, that there will be an impact on the industry's revenues of $8.6-billion, that's over ten years," Ms. Fralick said, adding Health Canada has said the impact could be as high as $24-billion. "In addition they are saying that they feel this will have no impact whatsoever on jobs or investment in research."

An analysis by PDCI Market Access suggests the industry could be hit with a minimum 20 per cent reduction in revenues, which Ms. Fralick said could result in the elimination of high-quality jobs, reduce health research investments, and lead to difficulty procuring clinical trials. PDCI's estimates the impact would be at least $26-billion.

"If you include some other factors such as taxes and R&D impact, it could be as high as $35.1-billion," she said, adding ICM commissioned PDCI's study.

Along with economic impacts, a lower cap could restrict market access, said Ms. Fralick, as "the global firms are not going to launch their products in a country where the starting price is very low."

Prof. Morgan said there are more factors than drug costs that determine where R&D is conducted. Other government incentives such as tax credits or other programs have more pull, he said. Health Canada echoed the sentiment.

If a country has a "reasonable" regulatory regime and ways of covering drugs, it will save a lot of money—notably, government money— to go into "the kinds of things industries really need to attract R&D," he said, including direct investment in "scientific infrastructure, personnel and scientific networks."

PMPRB argues drug companies are not investing enough in research and development, saying drug companies are investing 4.4 per cent instead of the target of ten percent of revenues. It's findings are based on a 30-year-old funding model that includes the use of the Scientific Research & Experimental Development (SRED) tax credit, in which Canadian companies get a tax credit on part of the money they spend on R&D. However, ICM said the definition used to determine the percentages is out of date.

The calculation fails to consider Johnson & Johnson's investment in Toronto's JLABS, for example, despite incubator and hub methods being key funding sources. JLABS houses biotechnology startup companies as "residents," providing them with the lab space, equipment, and educational programs, as well as support to obtain venture capital funding.

The companies aren't obligated to be affiliated with Johnson & Johnson, but often become so, said Andrew Casey, president and CEO of BIOTECanada, an association representing commercial and pre-commercial patented biotech companies. Biotechnology companies spend years pre-commercial due to drug approval regimes.

Mr. Casey is particularly concerned about how the changes could impact those startup companies, as the reduced investment in places such as JLABS could result in reduced investment for the startups.

"Without the pharmaceutical companies in the ecosystem investing in those companies, or partnering with them, or investing in the incubator organization that really support them, we're going to be missing a huge component of that, and we're going to lose out," he said. "That's our fear."

Drug companies are okay giving heavily discounted prices to public payers for vulnerable populations, assuming they can make up the difference with the private payers, said Ms. Fralick. Confidential negotiations protect the company's bottom line.

Under the current regulations, drug companies are required to report only the direct price reductions they offer to Canadian customers at the first point of sale, such as wholesalers and pharmacy chains. The proposed changes would require reporting on all reductions, said a press release, so the board can take all reductions into consideration when settling a price ceiling.

"It's going to result in the prices for government going up," Ms. Fralick said. "It's not going to benefit the government."

Prof. Morgan said drug companies are probably also concerned that they will not only have to be competitive against the drug's list price of their competitors, but also the discounted net price.

Clarity on reporting requirements key, says generics association

Canadian Generic Pharmaceutical Association president Jim Keon is submitting feedback to ensure that generic medicines with patents are indeed excluded from the PMPRB's reporting requirements. The reporting requirements are being reduced for veterinary, over the counter, and generic medicines under the proposed regulations.

Some generic medicines have patents because of how they're made, he said. The patents can require them to report under PMPRB regulations, but Mr. Keon said their focus should be on brand name pharmaceuticals as those are the most likely to have excessive price regimes. Under new regulations, generic drug prices would only be investigated by the PMPRB if there is a complaint.

He added that generic prices are already regulated by Pan-Canadian Pharmaceutical Alliance (PCPA), a provincial alliance formed to get better prices. The generic price is a percentage of its brand name counterpart, according to the agreement.

"If Lipitor tabs cost $2, the generic medicine would cost 20 cents," he said, for example.

Generic companies could be impacted by a lowered price cap, but Mr. Keon said those concerns are long term because of patent protection. Reduced revenues could reduce generic spending on R&D in Canada, but overall he is more concerned about clarity around the reduced reporting requirements.

ehaws@hilltimes.com
The Hill Times

ADVERTISEMENT

Our Commitment to Curbing Opioid Misuse

A November 2017 public opinion poll conducted by Angus Reid Institute found that Canada's opioid epidemic continues to affect a significant number of Canadians.

Michael Green
President and CEO
Canada Health Infoway

Despite the very public concerns about opioid misuse, one in eight – almost 3.5 million Canadian adults – report that close friends or family members have become dependent on opioids in the past five years.

Medication management is ripe for innovation in Canada: Medication is the second largest area of health care spending in the country, nearly doubling from 8.8 per cent to 15.8 per cent of health expenditures over the past 40 years, according to a 2015 report by the Canadian Institute of Health Information. An environmental scan conducted by PwC for Canada Health Infoway (Infoway) in 2015 found Canada was among the few developed countries without a comprehensive electronic prescribing (e-prescribing) system. e-Prescribing is a solution which both the Canadian Medical Association and Canadian Pharmacists Association say facilitates better, safer and more appropriate prescription drug use, improves health outcomes and reduces drug costs.

The United States is also grappling with the health and social issues of its own opioid crisis. It has implemented various federal and state-level responses to curb these problems, including e-prescribing, which has been in existence in the U.S.A. since 2001. Certain states have now gone one step further to maximize the health and patient benefits of e-prescribing. New York and Maine have demonstrated heightened health system benefits after enacting mandatory e-prescribing and subjecting prescribers who don't use electronic prescriptions and continue to use paper pads to fines. Minnesota has similar legislation but does not penalize prescribers who do not adhere.

Canada's federal government has taken an important step by supporting Infoway's PrescribeIT™ service as the first multi-jurisdiction electronic prescribing service available in Canada. By enabling prescribers to transmit a prescription electronically between a prescriber's electronic medical record (EMR) to the pharmacy management system of a patient's pharmacy of choice, PrescribeIT can eliminate paper prescriptions, safeguard patient health data from commercial use and maintain an influence-free prescribing and dispensing environment for clinicians. It will also help reduce prescription fraud by eliminating handwritten prescriptions; provide prescribers with better information at the point of care; and provide enhanced support and surveillance for narcotics monitoring programs.

Trials of PrescribeIT have started in Alberta and Ontario. Starting in mid-2018, the service will be available for wider rollout and the following functionality will be available to benefit more patients, prescribers and pharmacists:

- Secure electronic transmission of prescriptions for all medications, including narcotics
- Ability to send prescription renewal requests from a pharmacist to prescriber
- Prescriber integrated access to public drug formulary to help confirm relative costs and coverage
- Secure messaging between prescribers and pharmacists to eliminate fax and phone activity
- Integration with provincial/-territorial drug information systems to contribute to secure patient medication histories
- Access to and implementation of the Canadian Clinical Drug Data Set, terminology co-developed by Health Canada and Infoway, which will provide consistent prescription medication nomenclature in PrescribeIT.

The success of PrescribeIT depends heavily on the trust and collaboration of multiple stakeholders, each of whom stands to benefit substantially from Canada's new service.

For patients, it means pharmacies can receive the prescription ahead of time, allowing them to resolve clinical or insurance issues. It also means improved patient safety through fewer data entry-related errors. Studies have also shown e-prescribing can lead to increased first fill compliance for patients.

And, of course, the benefits don't stop at the patient. For the federal government, it means improvements in clinical practices, patient safety and reporting on the use of prescription narcotics.

"PrescribeIT will help reduce prescription fraud by eliminating handwritten prescriptions."

For provinces and territories, e-prescribing provides enhanced data in jurisdictional drug information systems, which can be used to evolve policy and improve clinical practices. For prescribers, e-prescribing replaces phone and fax communications with more convenient secure electronic messaging. And this can be done with minimal disruption to their current flow, since PrescribeIT is being integrated into EMRs.

For community pharmacies, e-prescribing means more time to spend on patient care as a result of improved workflow efficiencies. Finally, for professional organizations and regulators, e-prescribing can support clinical practice guidelines and legislative requirements.

Opioids are not the only class of pharmaceuticals that pose health risks when prescribed inappropriately. Inappropriate and excessive use of drugs, including antibiotics, leads to poor patient health outcomes, medication resistance and unnecessary increased health system costs. Inappropriate medication use in older adults increases the risk of hospital admissions and death. Prescription drug misuse is a leading public health and safety concern for all jurisdictions.

Canada Health Infoway is committed to scaling and implementing PrescribeIT across the country, and will continue to monitor the impact of related policy decisions in the context of Canada's goal to encourage full adoption and use of PrescribeIT services.

For more information about e-prescribing and PrescribeIT, please visit www.PrescribeIT.ca.

Health Policy Briefing

Veterans complain government's new 'centre of excellence' for PTSD prioritizes research over in-patient treatment

Veterans' advocates say they were shocked that the 'centre of excellence' is focused on healthcare providers given high demand for an in-patient, longterm centre for PTSD treatment.

BY JOLSON LIM

Veterans advocates are criticizing the Trudeau government's new Centre of Excellence on Post Traumatic Stress Disorder and Related Mental Health Conditions for wrongly prioritizing researchers and doctors instead of improving in-patient treatment for Canadians dealing with the psychological pains of war.

"This is a bag of money for them to do research, and that is all it is," said Aaron Bedard, one of Canada's most-prominent veterans' advocates who served in Afghanistan as a military engineer.

The centre of excellence was first announced in the 2017 budget and was touted by government MPs of the fulfillment of a Liberal election promise to improve mental health supports for Canadian veterans. The Liberals promised during the 2015 campaign to budget $20 million to create two new centres of excellence in veterans' care, and one with a "specialization in mental health, PTSD, and related issues for both veterans and first responders."

Veterans Affairs Canada said it plans to spend $17.5-million over four years and $9.2-million annually going forward on the centre of excellence, which will "optimize mental health treatment outcomes" for veterans and serving members, focusing on providing health care providers with information and best practices on working with and treating veterans, according to the initial press release.

The centre of excellence won't be a "brick-and-mortar" facility, but rather a "virtual" network with a core group of researchers and specialized staff linking a network of organizations including universities and other leading mental health organizations, according to the department. The centre is working with the Canadian Institute for Military and Veteran Health Research, a hub of over 1,000 researchers at 40 universities.

Funding will go towards research, but also support developing treatment guidelines, programs, tools, and education efforts for healthcare providers, according to department spokesperson Marc Lescoutre. He said more details will be announced in the summer.

However, advocates are saying that improving research shouldn't be the major priority of the new centre, considering the number of veterans returning adjusting back to civilian life after serving in Afghanistan.

In fact, a mental health advisory group struck by the department also recommended in 2016 that a centre of excellence should be focused on in-patient treatment and therapies dedicated to veterans.

Mr. Bedard told *The Hill Times* he helped the Liberals craft its election platform in 2015 focused on veterans, consulting with now-Defence Minister Harjit Sajjan (Vancouver South, B.C.) and retired lieutenant general Andrew Leslie (Orléans, Ont.), who is now a Liberal MP and parliamentary secretary for Canada-U.S. relations. All three served the country in Afghanistan.

Mr. Bedard said the $20-million figure that appeared in campaign literature came from a costing analysis done for a physical in-patient care facility and not for a research network. He said he feels "cheated" by what he considers the Liberals picking doctors and bureaucrats who have their own priorities and vision of mental health policy.

In Prime Minister Justin Trudeau's (Papineau, Que.) mandate letter to Veterans Affairs Minister Seamus O'Regan (St. John's South-Mount Pearl, N.L.) last summer, he called for the one centre of excellence in mental health to enhance research "to enhance research and best practices," and another, yet to come, "based on the area of greatest need."

When reached by *The Hill Times*, Mr. O'Regan said in an emailed that would be "utterly irresponsible" if the federal government didn't invest in veterans' mental health research.

"That research will then be translated into real on-the-ground approaches, tools and best practices that healthcare providers will be able to use with Veterans and their families right across the country and in communities of all sizes," he wrote.

The minister also said the mission of the centre would be providing doctors, nurses, and other direct healthcare providers with "information and best practices on working with and treating veterans."

But Mr. Bedard said a physical veterans-focused facility or centre is needed immediately. He cited stories of veterans and former police officers suffering from PTSD who enter addiction centres and are lumped in with criminals, "rich kids," and non-military members. He said doctors serving such facilities don't understand the unique experiences of veterans.

He added that PTSD treatment for veterans right now is often reliant on drug prescriptions and "one-hour visits" by doctors.

"Imagine your car breaks down and you want to get it fixed, the mechanic calls you back and says he can fix it but says I'm only going to work on it one hour a week," he said.

Mr. Bedard is also the lead plaintiff in the so-called Equitas lawsuit filed in protest of the former Conservative government's decision to replace lifelong disability pensions for veterans with a onetime lump-sum payment, as well as career training and income-replacement programs.

Currently, there is a network of operational stress injury in-patient and out-patient clinics across the country, which are funded by Veterans Affairs. The department funds one inpatient residential clinic located in Montreal operated by the Quebec government and several smaller private government-approved inpatient facilities across the country.

Scott Casey, a veteran who operates a popular website called Military Minds that provides peer support, advice, and connects veterans with treatment services, said "the centre of excellence has already happened, in layman's terms."

The veteran community has developed a grassroots system of best practices and knowledge that doctors can consult, said Mr. Casey, who served as a peacekeeper during the Balkans conflict.

"The government's apathy over the last 10 years have basically downloaded the costs of this veterans' centre of excellence to veteran organizations," he told *The Hill Times*.

Mr. Casey called the centre of excellence "a bunch of hogwash," and the government need to put "the money where it counts," in better in-patient, long-term PTSD and mental health treatment.

Meanwhile, a mental health advisory group was struck at the beginning of the Liberal government's four-year term, adding a mix of veterans' advocates and health care professional executives, alongside veterans and defence bureaucrats.

In August 2016, a sub-group of the advisory panel was formed to provide the Veterans Affairs Minister advice on the centre of excellence on mental health. Based on two prior teleconferences involving involving four doctors from an operational stress injury clinic in Vancouver, the sub-group recommended a "physical establishment whose primary function is in-patient treatment and therapies only for veterans."

Mr. Bedard also said the "deck was stacked" against veterans such as himself on the advisory panel, because of the number voices from professional medical backgrounds whose interest doesn't perfectly align with the veteran community. He's also wondering whether an patient-focused centre will ever be delivered.

"There's no planned meetings for the advisory groups from this point forward and the last eight months to fulfill that other part of the mandate, which is a physical place to treat us," he said.

Dr. Patrick Smith, national chief executive officer of the Canadian Mental Health Association, declined an interview with *The Hill Times* prior to publication due to his desire to seek the advisory committee's blessing before speaking to the media.

The CMHA is registered to lobby the federal government on the "development of a Centre of Excellence for Veterans and Their Families," according to the lobbyist registry. The Sunnybrook Health Sciences Centre in Toronto is also registered to lobby on the centre of excellence and hopes it can establish and run a PTSD program.

Conservative MP Phil McColeman (Brantford-Brant, Ont.), the party's critic on veterans' issues, told *The Hill Times* that many veterans "are having their PTSD compounded by overly bureaucratic processes."

"The devil really has been in the details with this government. And on this file there aren't even any details," he said.

jlim@hilltimes.com
The Hill Times

These tiny seeds treat cancer patients all around the world

Processing I-125 for shipping

McMaster is the world's largest supplier of I-125

In a Brighter World, we're helping society at an atomic level

Nuclear research is about more than energy. It has the power to positively impact the world around us. At McMaster University, our research reactor allows us to discover new ways to improve lives. In fact, we are the world's largest producer of Iodine-125, which helps treat 400 cancer patients every single day. That's just one way we're creating a Brighter World.

Learn more at BrighterWorld.ca

BRIGHTER WORLD

Palliative care, the next step for Canada

If implemented, these priorities would go a long way towards helping Canadians to choose to live as well as they can, for as long as they can.

Conservative MP Marilyn Gladu

Opinion

With Bill C-277, "An Act Providing for the Development of a Framework on Palliative Care in Canada," receiving royal assent in December 2017, there is a real opportunity to accelerate plans to fill the gap that exists in palliative care across Canada. Consider that upwards of 70 per cent of Canadians have no access to palliative care—this is truly a national issue. For those that can access services, there are many limitations and costs are only partially covered. So, what should the federal governments' next steps be?

Bill C-277 seeks to create a framework that will define the services that will be covered, ranging from hospice and home care, pain and crisis control, and counselling supports for both patient and caregiver. It defines training for the various levels of care providers. Today, we have a shortage of at least 400 palliative care physicians nationwide, and many nurses are graduating with no palliative care training whatsoever.

Training for doctors is variable, and there is an opportunity to train personal support workers, paramedics and family caregivers to meet the ever increasing need for palliative care that we have with our aging population. Benchmark data to track palliative care and research to find and leverage best practices will be important. And most critically, the government will need a plan to get consistent access to palliative care for all Canadians—a big challenge when we consider the rural and remote parts of our nation.

The government pledged in $3-billion for home and palliative care in the 2016 budget. In the 2017 budget, they pledged an additional $6-billion over five years for home and palliative care. However, when asked in December at health committee how much had been spent to date, only $200-million has been dispersed. Although this discrepancy is alarming, I am pleased to report to Canadians that we know how to proceed.

I would suggest five priorities for the committed spending:

• Hospices—Currently there are fewer than 100 hospices in Canada, compared to 1,300 that exist in the U.S. Targeting 50 in the remaining four years of the promised funding would likely take care of approximately $1-billion of the promised $9-billion.

• Rural Internet—For remote areas, enhanced internet access must be in place to facilitate access to the 24/7 Virtual Palliative Care centers that exist. It would be wise policy to suggest another $1-billion from the budgeted federal health funds for these services be allocated accordingly. There are many other economic incentives to enhancing internet access in these regions as well.

• Training for Palliative Care—the government should fund a program with the palliative care training centres in Canada to provide palliative care training for doctors, nurses and home care workers with a priority for Indigenous and remote communities. The suggested amount to start with would be approximately $600-million to train 200,000 nurses and homecare workers, 4,000 doctors and all paramedics in Canada. This addresses an additional barrier to palliative care which is getting transportation to treatment. With paramedics, they can come to the patient on their non-emergency response time.

• Research and Data Benchmarking—I suggest $400-million for standard data collection across the provinces to benchmark palliative care, and leverage best technology

• Transfers to the provinces to cover the cost of palliative care delivery—I recommend that the remaining $6-billion over four years be given to the provinces to fund additional home care, to cover costs of hospice operations, and to fill in gaps that exist in providing palliative care.

On each of these suggestions, we have heard from expert national stakeholders verifying their effectiveness at the House Committee on Health during review of my private member's legislation on palliative care. In order to drive this program with focus, it would be wise to have someone in charge of the Palliative Care Framework Program reporting directly to the minister of health.

These are the priorities I have suggested to the health minister. If implemented, these would go a long way towards helping Canadians to choose to live as well as they can, for as long as they can.

Conservative MP Marilyn Gladu, who represents Sarnia Lambton, Ont., is her party's health critic.

The Hill Times

Why are the Liberals shuttering Canada's community-based HIV organizations?

Health Minister Ginette Petitpas Taylor, pictured recently on Parliament Hill. *The Hill Times photograph by Andrew Meade*

Canada's New Democrats will continue to press the Trudeau government to re-instate stable and predictable funding for these grassroots groups and finally honour its pledge to expand the Federal Initiative to Address HIV/AIDS in Canada.

NDP MP Don Davies

Opinion

In 2016, Canada brought together leaders from around the world in Montreal for the Fifth Replenishment Conference of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. This conference represented an historic opportunity for Canada and the world to end three of the world's most devastating diseases by 2030.

The Global Fund supports programs in more than 140 countries which have resulted in an estimated 17 million lives saved to date. Canada has committed more than $2.1-billion to the Global Fund since its inception in 2002 and Prime Minister Justin Trudeau deserves credit for pledging $804-million to the Global Fund for 2017 to 2019.

Unfortunately, however, the Trudeau government has not matched this impressive international commitment here at home.

In fact, in late 2016 it emerged that the Public Health Agency of Canada (PHAC) has cut funding to 33 per cent of Canada's community-based HIV organizations.

This meant that a significant number of organizations previously resourced by PHAC—in some cases for decades—were left scrambling to keep their doors open.

In order to preserve these critical services, then minister of health, Jane Philpott pledged to make these organizations whole through 2017-18 with full transitional funding.

While this was welcome news, this funding should have been made permanent through a long-overdue expansion of the Federal Initiative to Address HIV/AIDS in Canada; after all, in 2003, both the Liberal and New Democrat MPs on the House Health Committee agreed that the federal initiative should be increased to $100 million annually. It is currently frozen at $72-million.

But by spring 2017, many community-based HIV organizations reported that they had not received their transitional funding, had seen their transitional funding scaled backed, or were still waiting for signed funding agreements to be put in place.

When this issue was raised in Parliament, the Liberal government attempted to dodge the question by claiming to have secured "new investments in the budget to expand the federal initiative on HIV in the order of $30-million of new funding."

However, with the release of PHAC's departmental spending documents it became clear that this is patently untrue. In fact, there isn't a single dime in extra funding for the federal initiative and there isn't an extra nickel for the Community Action Fund (the very program that funds these community-based services) through 2019-20.

These cuts now mean that more than 40 community-based HIV organizations across Canada will lose their funding completely on April 1, 2018. Others will have their funding dramatically decreased.

This uncertainty has already led to the closure of B.C.'s only support group for HIV-positive women. And after three decades of tireless advocacy, these cuts will likely force the Canadian AIDS Society to close its doors permanently this year.

Other organizations across Canada will end services that they currently offer clients or operate at a diminished capacity moving forward.

This is completely unacceptable.

Canada's HIV movement is a proud and resilient sector that deserves to be treated with honesty and respect. We must support the vital role that community-based organizations play in reducing HIV infection rates and providing care for those living with HIV/AIDS. Although we have made impressive progress in fighting HIV/AIDS, there have been flare-ups in certain communities and vulnerable populations that must be addressed.

Looking forward, Canada's New Democrats will continue to press the Trudeau government to re-instate stable and predictable funding for these grassroots groups and finally honour its pledge to expand the Federal Initiative to Address HIV/AIDS in Canada.

It's well past time to make this right, and match our international commitments with action here at home.

NDP MP Don Davies, his party's health critic, represents Vancouver Kingsway, B.C.

The Hill Times

Racism is a health crisis

If our government, and all Canadians, are serious about tackling racism at home, it is time we start treating this oppression like the health crisis it is.

Senator Wanda Thomas Bernard

Opinion

Health Minister Ginette Petitpas Taylor, pictured on the Hill. Black Canadians are marginalized through lack of access to health care and the stress experienced from systemic racism which creates long-term health issues, writes Sen. Wanda Thomas Bernard. *The Hill Times photograph by Andrew Meade*

Lionel Desmond was a black veteran of the war in Afghanistan struggling with post-traumatic stress disorder. In January of last year, after being unable to access the care he desperately needed, he killed his wife, daughter and mother before turning the gun on himself.

We do not know to what extent the added stress of daily and institutional experiences of racism in Canada contributed to Desmond's PTSD. And we will not, as long as society downplays the many ways in which racism affects both mental and physical health. The reluctance of the Nova Scotia justice system to open a full inquiry demonstrates how the two-tiered system devalues black suffering and black lives. Black Canadians are marginalized through lack of access to health care and the stress experienced from systemic racism which creates long-term health issues.

Racism is not just cruel words and ignorance. It is a health crisis.

Indeed, a recent opinion piece by LaRon E. Nelson in The Globe and Mail took this a step further: that racialized and other marginalized groups can have negative experiences within the health-care system, leading to patients not being able to access the care they need.

The ways in which racism, sexism, and other forms of oppression affect health and well-being are vast, dramatically understudied and go well beyond the health-care system alone.

In Race and Well-Being, a book I co-authored, we examine the different manifestations of racism in Canadian society and survey the impacts these have on personal well-being. Some of the manifestations include discrimination within employment practices, criminal justice, health care and education. Considering racism as a social determinant of health is helpful to conceptualize how an individual's health is impacted by everyday experiences of racism and microaggressions that can be dehumanizing and alienating.

The bigger picture also reveals how structural racism impacts health.

Hopelessness among black youth is most pronounced in neighbourhoods with high levels of poverty. These social conditions are not the consequence of individual choices, but of a racist, colonial inheritance.

This environment has a damaging effect on the quality of education, the opportunities for advancement, the number and type of interactions had with police, and access to good quality housing. All of these contribute to poor health, of which the most dramatic illustration is premature death due to violence—for instance, almost half of homicide victims in Toronto are Black despite representing less than 10 percent of the population.

Media tend to focus on symptoms, like gun violence, instead of on these deeper root causes. Notions of colour-blindness, equal opportunity and individual responsibility are also to blame. These neutral terms are simply language used to justify exclusion, creating a politically correct society in which racism is invisible but no less real.

This crisis doesn't end with race either.

Take the case of Lianne Tessier from Halifax: the former firefighter's mental health was negatively impacted when her complaint of gender discrimination in the workplace was not taken seriously by the Nova Scotia Human Rights Commission. Multiple oppressions in North American society overlap and interact with each other—according to Kimberle Crenshaw this is what is called intersectionality. Discrimination due to one's race, class, ability, age, gender and/or sexuality has the same damaging impact on well-being.

How can this cycle be interrupted?

A three-step plan is needed: awareness, analysis and action.

Without a collective acknowledgement of the impact oppression has on physical and mental health, only so much can be done. Without analysing what we know about the experience of black Canadians, we cannot identify specific remedies.

Action comes in many forms. The Black Lives Matter movement is one way. Other social groups have their part to play too, building solidarity across marginalized groups. In April of 2016 there were a series of shootings that shook the black community in the Halifax region. Members of the community and organizations came together to provide safe spaces to talk about the issues. Some provided counselling and workshops on how to cope with grief in the aftermath of these tragedies. This violence revealed a need for deeper healing in my community. Healing is at the core of moving forward.

If our government, and all Canadians, are serious about tackling racism at home, it is time we start treating this oppression like the health crisis it is.

Wanda Thomas Bernard is a Senator representing Nova Scotia (East Preston). She is chair of the Senate Committee on Human Rights, vice-chair of the Canada-Africa Parliamentary Association and a member of the Canadian Caucus of Black Parliamentarians.

The Hill Times

A Canadian partnership to address dementia

With the number of dementia cases in Canada expected to almost double in the next 15 years, we have no time to reinvent the wheel. We know what best practices are, in Canada and in the 29 other countries which already have a national dementia strategy.

Art Eggleton

Opinion

PARLIAMENT HILL —Today, roughly 564,000 Canadians will struggle with dementia. This will not only present a frustrating and frightening challenge to them, but to their loved ones as well. In less than 15 years, that number is expected to increase to nearly one million. It is estimated that by this time, the total direct and indirect costs associated with dementia will be $16.6-billion a year

Urgent action is needed if we are to confront this condition in any meaningful way. Parliament took an important first step last year with the adoption of private members Bill C-233, an Act Respecting a National Strategy for Alzheimer's Disease and Other Dementias. A bi-partisan effort led by Conservative MP Rob Nicholson and Liberal MP Rob Oliphant, the new law mandates that the government must create a national dementia strategy. The passage of Bill C-233 is an indication that dementia is something that not only our government, but all political parties are ready to take seriously.

Yet for all its importance, legislation was the easy part. The government must now put together an effective and sustained strategy that will improve the lives of those with dementia and their families. Fortunately, the framework for such a strategy already exists.

In 2016, the Senate adopted a report entitled "Dementia in Canada: A National Strategy for Dementia-Friendly Communities." This report included 29 recommendations, the most important of which advocated for the creation of a Canadian Partnership to Address Dementia, which could develop and implement a national strategy. Such an entity should include representation from federal, provincial and territorial governments. It should also have representation from dementia and other health-related organizations, people living with dementia and their caregivers, health-care professionals, housing organizations, researchers and the Indigenous community. This organization should also receive adequate, annual funding from the government.

We need only look at the success of the Canadian Partnership Against Cancer to see how successful a pan-Canadian health organization can be. The federal government created the cancer partnership in 2007, with an initial five-year mandate to implement a national cancer control strategy, as well as to assess whether this model was effective in improving cancer control. It proved so effective that it concluded its second mandate just last year.

Encouragingly, Minister of Health Ginette Petitpas Taylor has committed to working with a wide range of organizations, healthcare professionals and people with lived experience in developing a dementia strategy. But this must go beyond simple consultation. The government must incorporate all stakeholders into an organization like a Canadian Partnership to Address Dementia as we move forward. Such an organization will prove better able to adapt to our changing understanding of dementia and will provide more points of entry for individuals and their families' to access much needed support and education.

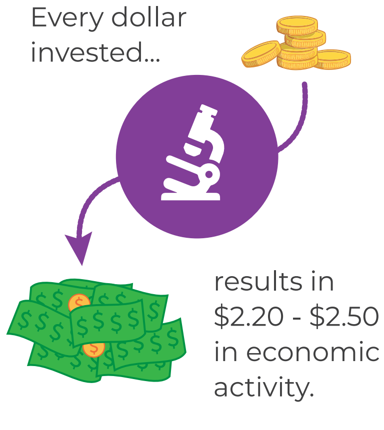
With the number of dementia cases in Canada expected to almost double in the next 15 years, we have no time to reinvent the wheel. We know what best practices are, in Canada and in the 29 other countries which already have a national dementia strategy. Any strategy must include all stakeholders in a Canadian Partnership to Address Dementia. Only then can we make a real difference in the lives of those who live with this condition.

Liberal Senator Art Eggleton (Toronto) is chair of the Senate's Social Affairs, Science and Technology Committee.

The Hill Times

Health Research
GIVING CANADA ITS MONEY'S WORTH

STIMULATES ECONOMIC ACTIVITY



GENERATES A POWERFUL RETURN

Healthcare expenditures result in a 60% direct return to the Canadian economy.

EMPLOYS CANADIANS

Healthcare & life sciences employs 13% of Canadians

SUPPORT HEALTH RESEARCH
#SupportTheReport

Health Policy Briefing

Continued from page 22

that promote positive mental health and contribute to the prevention of mental illness and suicide across various stages of life. Our efforts and investments help to build resilient communities and support the mental well-being of all Canadians by: strengthening factors that lead to positive mental health, such as family attachment, social inclusion and taking pride in one's culture; reducing and addressing the risk factors that can lead to mental illness, such as substance abuse, intimate partner violence, child maltreatment and other traumatic events; and providing culturally appropriate interventions, services and support for Indigenous peoples, in partnership with them.

"In addition, in the 2017 budget, the government committed $118.2-million over five years to continue to strengthen First Nations and Inuit mental health crisis supports, mental wellness teams and youth-specific initiatives that have been established since 2016. These new investments are supplementary to the more than $350-million provided annually to First Nations and Inuit communities for community-based mental health programs."

What is Health Canada doing to ensure medication prices remain affordable for most Canadians?

"Prescription drugs are an important part of Canada's health care system. That is why federal, provincial and territorial ministers of Health have made the affordability, accessibility and appropriate use of prescription drugs a shared priority.

"To better protect consumers, governments and private insurers from excessive drug prices, the government of Canada is proposing to modernize the way drug prices are regulated.

"The Patented Medicine Prices Review Board (PMPRB) is a federal quasi-judicial tribunal with a mandate to protect Canadian consumers from excessive patented drug prices. Through the PMPRB, the government of Canada regulates maximum allowable prices of patented drugs. For the first time in more than 20 years, the government intends to update the Patented Medicines R*egulations* which, together with the Patent Act, provide the PMPRB with the tools it needs to protect consumers from excessive patented drug prices.

"On Dec. 2, 2017, these proposed amendments to the Patented Medicines Regulations were published in the Canada Gazette, Part I for consultation. This process, which is open for 75 days, until Feb. 14, 2018, provides an opportunity for interested individuals and organizations to review the regulatory proposal and provide written comments to Health Canada for consideration as the regulations are finalized.

"The government of Canada is also working with the provinces and territories as an active member of the pan-Canadian Pharmaceutical Alliance (pCPA). The pCPA combines governments' collective buying power to negotiate lower prices on brand name drugs for all public plans. The pCPA also sets the price point for many generic drugs. As of March 31, 2017, it is estimated that pCPA's collaborative efforts have achieved approximately $1.28-billion in annual cost savings for government drug plans."

What sort of public health education campaigns can we see on cannabis use targeting pregnant women, young people, and those with psychological issues?

"Public education and awareness on cannabis use is a priority for the government of Canada. This is why the government of Canada has announced investments of $46-million over the next five years to help support these activities.

"These activities will include: educating Canadians, particularly youth, about the risks involved with consuming cannabis, allowing for informed decisions on cannabis use; informing the Canadian public about what will and will not be allowed under the proposed cannabis legislation, including penalties for driving under the influence and for providing youth with cannabis; engaging with Indigenous communities and organizations to develop culturally appropriate public education and awareness activities; and providing evidence-based information and messaging for priority populations, including pregnant women and individuals with a history of personal or family mental illness."

Can you provide us with more information on the FCM opioid-fighting task force that was set up last year to help the government? What's going on with that? Where does it stand?

"The Mayors' Task Force on the Opioid Crisis was launched in February 2017 by the Big-City Mayors' Caucus of the Federation of Canadian Municipalities (FCM). The Task Force convenes mayors of 13 Canadian cities: Vancouver, Surrey, Edmonton, Calgary, Regina, Saskatoon, Winnipeg, Hamilton, London, Kitchener, Toronto, Ottawa and Montreal.

"On May 25, 2017, the FCM released a report entitled 'Recommendations of the Mayors' Task Force on the Opioid Crisis,' which calls on the federal government to lead a national response to the opioid crisis and sets out specific recommendations for this response."

What is the government doing or plans to do to help address the spiralling opioids crisis?

"The opioid crisis is the most significant public health crisis in Canada in recent history.

"There have been more than 2,800 apparent opioid-related deaths in Canada in 2016. It is expected that the total number of deaths in 2017 is likely to exceed 4,000 if current trends continue. This is nothing short of tragic. The Government of Canada is deeply concerned about the growing number of overdoses and deaths caused by opioids and is committed to addressing this complex issue.

"The Government of Canada's approach to address the crisis is based on the four pillars (prevention, treatment, harm reduction, and enforcement) of the Canadian Drugs and Substances Strategy and supported by a strong evidence base. The Government of Canada has already taken a number of concrete actions to address the ongoing opioid crisis, including: significant new federal investments; enacting new legislation; and fast-tracking regulatory action.

"Budget 2017 included an investment of $100 million over five years, and $22.7 million ongoing, to support the Canadian Drugs and Substances Strategy and to respond to the opioid crisis.

"Our government has also provided urgent support to provinces: $10-million to British Columbia; $6 million to the Province of Alberta; and $5-million to Manitoba for targeted health issues—including responding to the opioid crisis.

"In November 2017, the minister of health announced the government of Canada's next steps to address the opioid crisis.

"As part of this work, the government is supporting new activities that demonstrate its continued commitment to: increasing access to treatment, supporting innovative approaches to address the opioid crisis, and addressing stigma related to opioid use.

"The government of Canada is committed to working with partners across Canada to combat the greatest public health crisis we face in Canada. The government will continue to work with partners—including people with lived and living experience, the provinces and territories, experts, professionals and other stakeholders—to address this crisis and the underlying causes of problematic substance use."

mvigliotti@hilltimes.com
The Hill Times