CANADA *beyond* COVID

Inside:

Pandemic preparedness | Pharmacare | Child care | Climate action | Inclusive health care spaces | Healthier workplaces | And more...

CFNU

CANADIAN FEDERATION OF NURSES UNIONS

CANADA *beyond* COVID

The CFNU Magazine

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Letter from Linda Silas

The COVID-19 pandemic is an unparalleled global crisis that laid bare the shaky foundations of our economic system, already eroded by years of funding cuts to essential sectors, including health care. COVID-19 touched all of our lives and deepened the existing fault lines in our economy and society.

The pandemic brought into sharp focus the low wages and precarious work faced by so many in Canada, prompting a long overdue discussion about how we can better support workers now and into the future. Along with workplace benefits, paid leave, liveable wages and worker safety, child care has emerged as an essential program to help retain workers and support their productivity during and beyond the pandemic.

Our fight against COVID-19 has also led to a greater appreciation of the central role health care plays in our broader society. A functioning health care system, with sufficient staffing, resources and supports, underpins a healthy economy. Pre-pandemic, we knew the health workforce was overstretched, and there were growing concerns about safe staffing. During the pandemic, staffing shortages – a direct result of inadequate planning – have contributed to poorer outcomes throughout the health care system. The effects of the pandemic on Canada's health care system will be felt for years to come as the physical and mental health toll on our health care workers reveals itself. Beyond COVID-19, Canada will need to invest in rebuilding its health workforce and enhancing health human resources planning to meet population needs.

Our failure to include long-term care and universal pharmacare in the *Canada Health Act* stood out starkly during the pandemic. Canada's current approach to long-term care and prescription drug coverage is fragmented and inequitable, leading to tragic consequences during the pandemic. Many lost their prescription drug coverage along with their jobs. Decades of short-staffing and neglect meant that seniors living in long-term care represented the vast majority of Canadian COVID-19 deaths. Canada's record on long-term care is shameful – we owe it to all those who have died to immediately enact fundamental reforms in this sector. Coordinated government action on both long-term care and pharmacare are long overdue.

Seniors, racialized communities, Indigenous peoples, migrant workers, and other vulnerable groups such as trans, Two-Spirit and non-binary people, have borne the brunt of the pandemic, highlighting the urgent need to address the social determinants of health. This approach is also essential if we hope to foster relationships between our health care systems and vulnerable communities, founded on respect and partnership.

As we consider critical investments in workplace health and safety, the health workforce, child care, pharmacare, long-term care and public health, we must also look ahead and address the crises that threaten our recovery efforts.

We must take on the challenge of addressing climate change. Scientists caution us that the current pandemic is directly linked to our failure to honour our environment, and that we must recognize climate change as a serious global challenge requiring immediate action. Canada will need a just transition strategy to tackle climate change and a shifting global economic landscape, and to assist workers and their communities in moving toward newer, more sustainable industries within a green economy. As one of the most trusted professions in Canada and around the world, nurses must be part of the conversation, educating the public on how climate change is linked to our health.

Experts predict that COVID-19 is likely the first of many future pandemics. Canada and much of the world were woefully unprepared for the current crisis. As a nation, we must prepare to safeguard health care workers and the broader community from new global infectious disease outbreaks. Canada must learn the lessons of the pandemic about the importance of investing in crisis-proof systems to help us weather the uncertainties of a rapidly changing world.

As we move toward recovery, we must never forget that Canada owes an enormous debt of gratitude to all our essential workers. As president of the Canadian Federation of Nurses Unions, I am very grateful to the Canadian public for their recognition that we are all in this together and that everyone has an essential role to play in keeping the virus at bay.

To all the nurses across Canada, who stepped up to the plate and met the challenge of this pandemic at great personal cost – Canada's #CovidWarriors – I know that thanks are not enough. Please know that your nurses' unions will always be there to support you. Across Canada, our provincial nursing leaders continue the fight for nurses' workplace safety so that no nurse is alone in this crisis. And we will work tirelessly to ensure that you have safe and healthy workplaces well beyond COVID-19.

Today, we are challenged to make different choices, to transform Canada, and to ensure a healthy economy and an equitable recovery.

In *Canada Beyond COVID*, twelve experts share their insights with the Canadian Federation of Nurses Unions, offering lessons learned from the COVID-19 pandemic and necessary actions for a better tomorrow.

Yours sincerely,

Linda Silas

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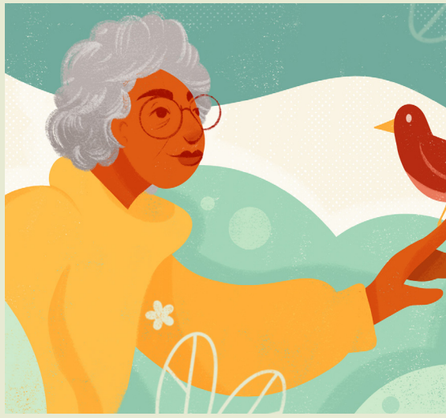


WE NEED A NEW DEAL FOR CANADA POST-COVID, SAYS PROMINENT ECONOMIST

No one said: 'We can't fight the Nazis because we'll have a budget deficit.'"

Canada entered World War II still ravaged by the economic shock of the Great Depression. Thanks in part to measures designed to stimulate the economy, the decades that followed were marked by tremendous growth and prosperity. Jim Stanford, an economist and director of the Centre for Future Work, believes that we can draw important lessons from post-war reconstruction as we conceptualize a post-COVID economic recovery.

"It was another time when we faced an existential external threat," explained Stanford. "As a country, we threw everything we could into that battle."

In addition to investing heavily into the war efforts, Canada also introduced ambitious recovery programs. That period ushered in many of the social welfare provisions and safety nets that we take for granted today: unemployment benefits, health insurance, old-age benefits and family allowances. Along with making sure that families could afford to put food on the table, income supports were intended to help avert a post-war economic slump.

"All that was part of rebuilding the economy after the war – and we entered a period of sustained and unprecedented prosperity for three decades," said Stanford. "Frankly, the economy has never done better."

"There's a similar potential now, but it is going to require a deliberate strategy and public-sector leadership, and lots and lots of money."

But deficit hawks aren't wasting time in pushing their austerity agenda and fearmongering over the government's willingness to spend during the pandemic, noted Stanford. Following the 2020 Speech from the Throne just as the second wave of COVID-19 was starting to take hold, the Conservative leadership was already calling for dramatic reductions in spending and warning that Liberals were going to "bankrupt" the nation.

"The people who wring their hands over debts and deficits were pretty quiet during the first months of [the] pandemic," remarked Stanford. "It was pretty hard to come out – while Canadians were fearful and grateful to government for trying to protect them – and say: 'Government is too big.'"

"They shut up for a few months, but they didn't stay shut up."

Stanford said those who are bemoaning an impending debt crisis are simply wrong. The country isn't going to fall apart. The way we discuss deficits – especially in a time of crisis – is what needs to shift.

"Yes, government deficits have been really big; that's because government did its job."

The Parliamentary Budget Officer has said that the current approach is "sustainable over the long term". This is especially true if we keep interest rates low, which Stanford reminded us are set here in Canada.

"In a crisis, government has to marshal resources," explained Stanford. "It's the only part of our economy that has the authority, the financial capacity and the ability to act on a national scale to actually rescue the country."

"So, thank goodness we have those deficits because it's proof that the government did what it was supposed to do."

Stanford noted that this speedy government response was made possible thanks to public-sector workers. Health care workers put their own safety at risk to care for the sick and beat back the pandemic. Teachers, likewise, quickly retooled to provide online learning. And civil servants rolled out assistance programs in record time. These new supports, including the Canada Emergency

"If we don't help them, we're going to see such a widening of the chasm of inequality that we already experience in Canada. The long-term economic, social, health and political consequences of that will be terrible."

Jim Stanford, PhD

Jim Stanford, PhD, is an economist and Director of the Centre for Future Work. One of Canada's best-known economists, Stanford served for over 20 years as Economist and Director of Policy with the union Unifor. Stanford received a PhD in economics from New York's New School for Social Research and has a graduate degree in economics from Cambridge University. He is a professor in economics at McMaster University and an honorary professor at the University of Sydney. Stanford has written, edited or co-edited many books, articles and reports, and provided research and advice to governments on economic and social policy, jobs and innovation. He has an ability to communicate economic concepts in an accessible and humorous manner.

Response Benefit, were critical in helping Canadian households stay afloat and in softening the pandemic's blow to our economy.

That blow hit some harder than others, including low-income and precariously employed workers. This meant that racialized Canadians, who "often have lower incomes and more precarious employment than the White population," according to Statistics Canada, felt the economic toll most acutely.

"Every recession is unfair," Stanford said. "Every recession has an unfair concentration of the costs and consequences on a certain group of people. But this recession is brutally and unforgivably unfair."

The truth is that Canadians are going to need income supports and government job-creation measures for years to come. The vaccine isn't a panacea that can magically restore our economy to its former state. As we work towards a healthy economic recovery, efforts to rebuild must be focused on the people who need it most.

"If we don't help them, we're going to see such a widening of the chasm of inequality that we already experience in Canada," Stanford said. "The long-term economic, social, health and political consequences of that will be terrible."

In addition to planning for the next pandemic, Canada has the opportunity to create a post-COVID New Deal: an ambitious program aimed at supporting the working class, improving health care and promoting greater equity. These could include a number of bold policy initiatives, such as a national child care program, universal pharmacare, fundamental reforms to long-term care, addressing nurse shortages, improving access to mental health services and tackling health disparities and social inequities.

COVID-19 has both amplified and revealed many cracks in our society, which threaten our recovery.

At the time of writing, it's still unknown whether or not a federal election will be triggered this year. If and when we head to the voting booth, Stanford said, Canadians will have to determine for themselves what matters more: abstract ideas or real supports when they are needed.

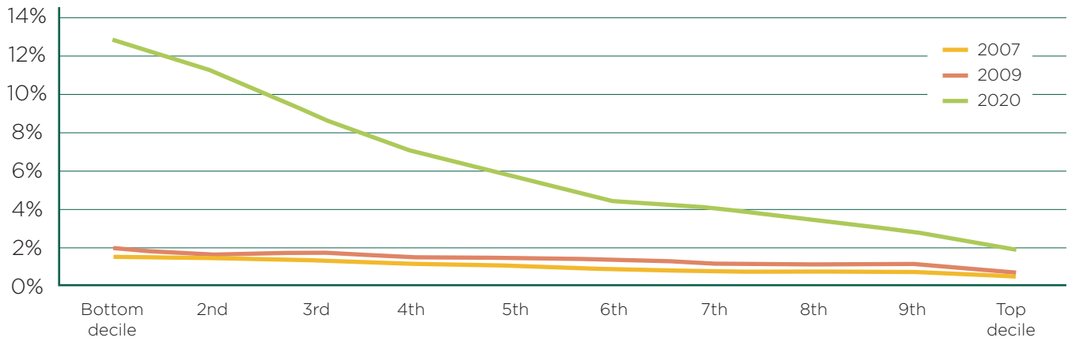
"We should ask quite concretely, 'What matters more to you: having income support when you lose your job because of a pandemic? – having access to first-class quality public health services so you can get the vaccine? – or some abstract idea that we have to keep the debt-to-GDP ratio below 60 per cent?"

If we put it in those terms, Stanford said, we can move the conversation away from ambiguous arguments about the national debt, which are little more than veiled attempts at shrinking the size of the state rather than thoughtful and sound economic reasoning. Now more than ever, we need to focus the conversation on the invaluable role of government in protecting Canadians and helping them get through the pandemic largely unscathed.

"So, thank goodness we have those deficits because it's proof that the government did what it was supposed to do."

LOW-WAGE WORKERS HAVE BEEN AFFECTED BY COVID-19 SHUTDOWNS TO A FAR GREATER EXTENT THAN DURING THE 2008/2009 RECESSION

*Average monthly layoff rates of employees, by wage decile, 2007, 2009 and 2020**

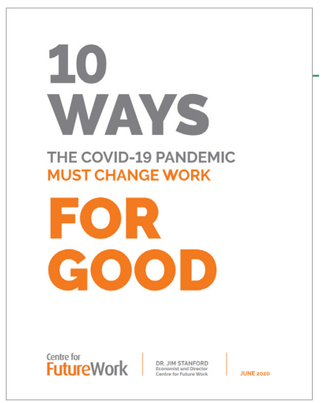


*February–March, March–April and April–May 2020; all pairs of months for 2007 and 2009.

SOURCE: Statistics Canada, Labour Force Survey.

To read more on this topic:

10 Ways the COVID-19 Pandemic Must Change Work For Good (centreforfuturework.ca) argues that reforming work is not just a moral imperative, it is also an economic necessity. Long-standing fault lines in Canada's labour market were brutally exposed by the COVID-19 pandemic and the unprecedented economic contraction it caused. This paper identifies and considers ten ways in which work after the pandemic must change for good.



ESSENTIAL, EXPLOITABLE AND EXPENDABLE: MIGRANT WORKERS NEED STRONGER PROTECTIONS

All those jobs that were deemed 'low-skill' are now being called 'essential work'. Personal care workers, agricultural workers, people who are working in restaurants are now being upheld – during the pandemic – as essential workers."

"But temporary workers arrived in Canada after being categorized as 'low-skill'; they're seen as expendable."

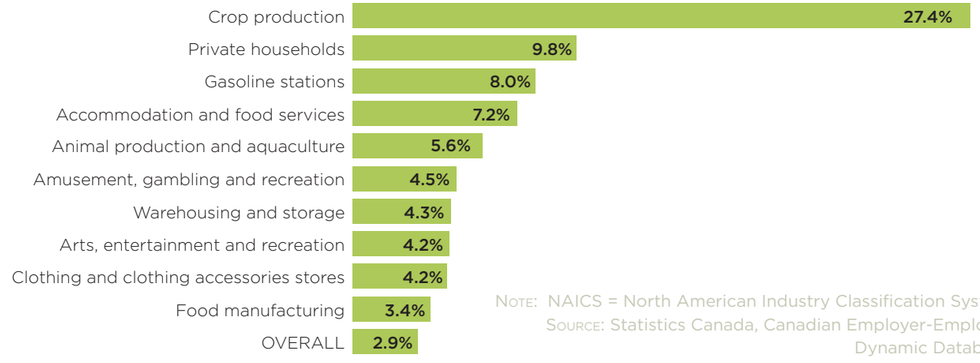
Sharmeen Khan has been working with migrants and undocumented people for over ten years as an organizer with No One Is Illegal – Toronto. As the value of essential work has come into sharper focus, she hopes Canadians will also come to recognize that the people working these jobs deserve safety, dignity, rights and care – regardless of their immigration status.

According to Statistics Canada, close to 470,000 temporary foreign worker permits were issued in 2019. Temporary worker categories include seasonal agricultural workers (primarily men from Mexico and the Caribbean who grow our food – often year after year on eight-month visas), low-wage workers making below the average provincial hourly wage (often racialized people working in a wide variety of sectors, including as personal support workers), and family caregivers (mostly women from the Philippines, Indonesia and Latin America who care for children, the elderly and persons with disabilities).

Sharmeen Khan

Sharmeen Khan began organizing with social movements in Regina, Saskatchewan, in 1994. She currently lives in Toronto, Ontario, where she has been organizing with No One Is Illegal – Toronto for the last ten years. She is also active in other social movements engaged in training and writing. As well, Sharmeen is an editor with *Upping the Anti: A Journal of Theory and Action*. You can follow her on Twitter: @colonizedmutant.

PROPORTION OF TEMPORARY FOREIGN WORKERS, SELECTED INDUSTRIES, 2017



NOTE: NAICS = North American Industry Classification System.
SOURCE: Statistics Canada, Canadian Employer-Employee Dynamic Database.

Temporary foreign workers make up almost 3 per cent of total employment and 27 per cent of the agricultural sector. While they are a significant labour force, they lack political power. Many of these workers come to Canada on employer-specific work permits; their ability to stay in Canada, often their housing and their access to health care depend on maintaining a good relationship with their employer. With so much power concentrated in the hands of employers, migrant workers are often susceptible to exploitation.

"When you're a worker tied with status, you're not going to speak up."

"You're not going to speak up if you make way less than minimum wage. You're not going to speak up if you're working overtime and not getting paid. A lot of workers don't even speak up when they're not getting paid."

As Khan pointed out, migrant workers don't come to Canada and just work; they build roots here. They make connections – they build a community. But because of employer-specific work permits, migrant workers can't simply walk away when their employer crosses the line into abuse or unfair labour practices.

"They can't get another job; they're just expected to leave," explained Khan. "This is how many people become undocumented."

While migrant workers pay taxes and contribute to our social safety nets, they often can't access benefits. During COVID-19, many had no access to income supports. In essential sectors such as agriculture, migrant workers continued to live and work in close quarters with little access to PPE. And without access to paid sick days, these workers had no option but to carry on working.

"No one is going to miss work if it's going to be cut from their paycheque," said Khan. She added that many migrant workers have food and lodging deducted from their pay, so when they take unpaid time off for illness, they can end up owing money to their employer.

Outbreaks peppered the agricultural sector throughout the pandemic. One outbreak at the Ontario Plants Propagation, just outside London, Ontario, is an infuriating example of the flagrant exploitation of migrant workers. According to the Migrant Workers Alliance for Change, the

employer had been warned about an incoming shipment from another farm where an outbreak had just sparked over 100 infections.

"All citizens and permanent resident workers at the farm were given the day off when the shipment arrived, but migrant workers were asked to unload and unpack the shipment. Workers simply received an extra $2.00 per hour, $8.00 in total for working with this shipment."

That incident resulted in at least 20 infections.

These workers had an impossible choice to make: risk contracting COVID-19 or risk getting fired and deported. It's their precarious immigration status that makes this kind of egregious exploitation possible.

"The solution is permanent resident status on arrival," said Khan.

If these workers had permanent resident status, they could more effectively exercise their labour rights. But currently, permanent resident status is often out of reach for the migrant class that come to Canada as temporary workers.

> ***"When you're a worker tied with status, you're not going to speak up."***

"The Canadian value system on immigration is very much based on wealth, income or class," said Khan. "If you can prove you have this amount of money or can invest this amount of money in a certain Canadian industry, you'll have an easier time getting permanent resident status. Or if you get a job as a 'higher-skilled worker', like engineering, you'll get PR on arrival."

People from poorer countries – countries that aren't white-dominated – face an uphill battle in trying to obtain permanent resident status, said Khan. For some, it's practically impossible: seasonal agricultural workers, some of whom have been coming to Canada for decades, have no pathway to permanent resident status.

Thanks to the work of activists, caregivers are one of the only groups with a direct pathway to permanent resident status. But barriers still exist: they need to be in Canada for at least two years, the application fee is over $1,000, and they need to meet education and language requirements.

At the core of Canada's immigration policy is a points system that scores potential economic immigrants on a number of factors, such as language skills and education, as well as 'adaptability criteria'. According to the federal government, the latter is meant to assess 'an immigrant's economic and social integration'.

"Implicit in that is social class," said Khan. "It's so inaccessible that the majority of Canadian citizens [if they were to apply for permanent citizenship] would find out they're not eligible to immigrate to Canada."

"Definitely, if my parents immigrated now, they wouldn't be eligible."

According to Khan, over the last few decades, the number of immigrants who are granted permanent resident status has remained fairly static, while migrants entering the country on a temporary work permit have increased.

"You can see this shift, where Canada wants more precarious workers in, versus people who get permanent status."

Precarious status can often be the result of our bureaucratic system; many migrants lose their status and become undocumented due to simple mistakes. Others become undocumented when they are forced to leave their job because of an abusive employer. It's estimated that there are currently between 200,000 and 500,000 undocumented people living in Canada.

"You miss one deadline, and you're undocumented," said Khan. "It's a very scary position to put people in."

Undocumented people in Canada are forced to the margins of society, Khan explained. The fear of being ripped away from their lives – from their families and communities – constantly hangs over their heads. And as governments began increasingly relying on law enforcement to limit our movements to contain the pandemic, undocumented workers' fears were magnified.

"It should be easy for our government to put in place a way for those people to get status – and not criminalize them and not punish them. It would be a very doable and easy policy change, but there's no political will right now for that."

Meanwhile, our health care system doesn't always know what to do when an undocumented person shows up looking for care, putting them at further risk. When a patient presents themselves without provincial health insurance, hospitals and walk-in clinics may ask for payment up-front and turn patients away if they're unable to pay. Few clinics offer free primary care to those without health insurance.

"Our struggle over health care, which came from strong socialist movements, is still a strong basis of Canadian identity and pride," remarked Khan. "And yet, most people I talk to are shocked [to find out] the amount of people who don't have access to health care because of status."

Throughout the pandemic, Canada's universal health care system was heralded as one of the key reasons we fared so much better than our nearest neighbour. Canadian citizens and permanent residents could readily get tested, receive direct medical care or even spend weeks in an ICU without having to worry about incurring medical bills.

Khan believes it is incumbent upon us to expand our universal health care system so that it truly is universal – to make sure no one falls through the cracks.

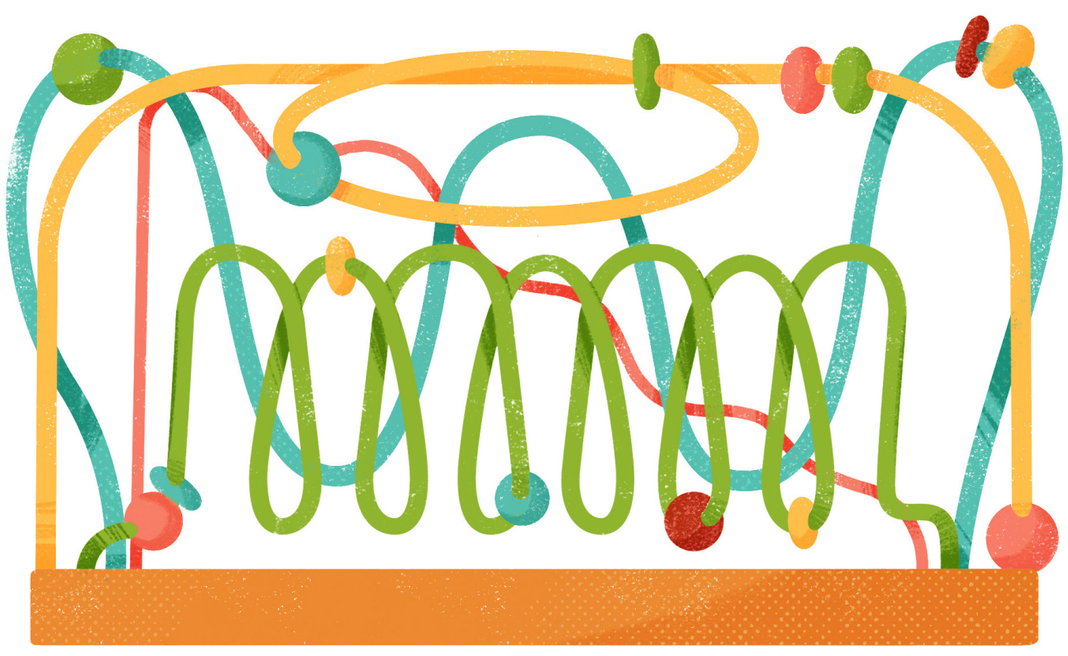
"When people without status or who are undocumented get sick, it impacts a lot more people than just them: it impacts massive communities around them. We need to uphold the safety of communities – the well-being of communities – over the dollar tag attached to that."

"There has to be certain things that we find are a human right and are just provided for. And we don't attach a status of recognition onto those services."

To read more on this topic:

The report *Unheeded Warnings – COVID-19 & Migrant Workers in Canada* provides a snapshot of the abuses faced by migrant farmworkers, including stolen wages during quarantine, being forced to work while awaiting COVID-19 test results, racist threats, decrepit housing and inhumane treatment. The report situates these abuses in a long history of prior warnings made by migrant workers about Canada's temporary immigration and labour laws.

UNIVERSAL CHILD CARE **'BRIDGE' BACK INTO THE WORKFORCE** FOR WOMEN POST-COVID



At the center of the 2021 federal budget was a $30 billion promise to create a Canada-wide child care system. The timing wasn't coincidental – a universal program is desperately needed to get parents, particularly women, back into the paid labour force and ensure that decades' worth of progress on gender equity isn't undone by the pandemic.

"The pandemic [...] has caused the federal government to realize that this is an area of economic and social policy that needs urgent attention," said Morna Ballantyne, executive director of Child Care Now. Key to our economic recovery, she said, is eliminating barriers that push women out of the paid labour force.

According to a recent RBC study, almost half a million women who lost their jobs at the start of the pandemic still had not returned to work as of January 2021. Racialized women and newcomers were among the hardest hit. The data also revealed that mothers faced higher job losses than women without children.

Ballantyne explained that many child care centres had to shut down when COVID-19 first hit. Without sufficient public funding to reopen in a safe way, many were forced to slash enrollment. Since most of their funding comes from parent fees, and fewer children means less operating revenue, early learning and child care centres quickly ran into financial trouble.

A loss of licensed spaces in Canada would be devastating. Even pre-pandemic, an untold number of parents had difficulty in finding quality child care.

"The pandemic revealed just how fragile the system was, but also how essential child care was," remarked Ballantyne. "So essential that governments in almost all jurisdictions took measures to reopen child care for essential workers, including frontline health care workers [and] nurses."

"It was clear that without child care, parents, particularly mothers, were not going to be able to work."

The Atlantic Provinces stepped up and provided direct public funding to support child care centres during the pandemic. Quebec too, long-held as the model for a Canada-wide child care program, fared much better since it was already providing direct funding.

However, Ballantyne pointed out that Quebec actually has two systems: one that directly funds licensed child care centers and home daycares, where parents can access care at a subsidized

Morna Ballantyne

Morna Ballantyne is the Executive Director of Child Care Now, Canada's national child care advocacy organization. A tireless advocate for high-quality and affordable licensed child care for over 30 years, she continues to work with all levels of government to build a publicly managed and publicly funded child care system for the benefit of children, parents and those who work in child care – a system that will contribute to Canada's economic security and growth. Morna serves on the federal government's Expert Panel on Early Learning and Child Care Data and Research, and was recently appointed to serve on the Government of Canada's Task Force on Women in the Economy.

A UNIVERSAL CANADA-WIDE EARLY LEARNING AND CHILD CARE (ELCC) PROGRAM WOULD:

- Create **200,000** direct jobs in child care centres;
- Create **100,000** more jobs in industries which support and supply the ELCC sector;
- Facilitate the employment of up to **725,000** Canadian women
- Provide additional government revenues of **$17 to $29 billion** per year

SOURCE: *The Role of Early Learning and Child Care in Rebuilding Canada's Economy after COVID-19*, 2020

rate of $8.50 a day; and another that provides tax credits to parents who place their children in the care of private, nonsubsidized centers and home daycares, with fees in line with the rest of Canada.

The latter, Ballantyne said, is an incredibly inefficient way of funding child care.

"It doesn't help, of course, with making sure fees are low. [The] quality of care in that sector [isn't] as high as the child care sector that receives direct funding."

"So, the big lesson from Quebec, and a big lesson for the federal government, is that governments have to step up and directly fund [child care] services as they do hospital services and public education."

According to a study by Pierre Fortin, an economics professor at the University of Quebec at Montreal, the percentage of women with preschool-aged children, who participated in the paid labour force, rose by 16 per cent in the decade that followed Quebec's introduction of the low-fee program.

Fortin's research also found that Quebec's program pays for itself, in part because having more workers participating in the paid labour force means the province can collect more in tax revenues. Looking at data from 2008, he estimated that the program generated an additional $919 million in tax revenue.

"Child care serves as a bridge – particularly for women, particularly for women with young children – to the paid labour force," said Ballantyne. "If they don't have that bridge, they're not able to contribute to economic growth, as it's historically calculated."

That bridge is also crucial to women's financial independence, as the high cost of child care can leave many women economically dependent on others, such as parents, a spouse or even other government programs.

These days, most people understand the economic benefits of child care, Ballantyne said. But as we move towards building a Canada-wide child care program, we need to ensure that the economic argument isn't the sole driving force.

"You need good child care, first and foremost, because of the kids – because kids need places that are safe and equipped for the healthy development of children."

"It was clear that without child care, parents, particularly mothers, were not going to be able to work."

Ballantyne also emphasized that a particular focus must be placed on equitable access. The current system can be incredibly difficult to navigate. Parents trying to determine what subsidies they might qualify for face an onerous task. This effort requires a great deal of time, something many working parents don't have in abundance. Low-income workers, often racialized people, new immigrants and Indigenous people can be shut out of the system not only by the exorbitant cost but by the complexity of the current patchwork of child care services.

A universal child care system would go a long way towards tackling those inequities, Ballantyne said.

"Vulnerable populations – populations that have been economically and socially disadvantaged for a whole range of reasons – benefit more from universal programs and universal systems than they do from services that have been targeted or designed just for them."

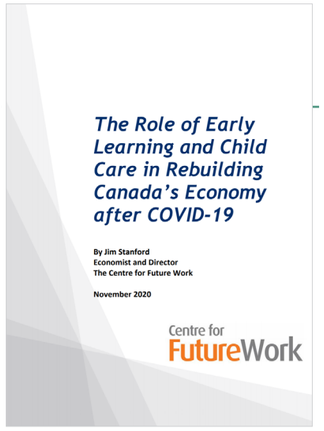
"We have a saying: programs for the poor make poor programs. That's why we've been insistent that [child care] be universal – that we not see child care as a welfare program [that would] lead to segregation based on race and economic status."

According to Ballantyne, Canada's current child care capacity only covers 30 per cent of children aged five and under. It's going to take a long time and significant investments to build the system Canadians need. She hopes to see the necessary funding for a high-quality universal program – one that is truly inclusive, with appropriate facilities and staff who are both well trained and well paid.

"It's not enough to build a system. The system has to be designed in such a way that equity remains a key objective."

To read more on this topic:

According to detailed research from the Centre for Future Work, *The Role of Early Learning and Child Care in Rebuilding Canada's Economy after COVID-19*, implementing a new Canada-wide child care system would generate several important benefits for Canada's economy as it recovers from the COVID-19 pandemic and recession. The report projects large increases in Canadian GDP as a result of direct ELCC provision and increased female labour force participation.



PANDEMIC EXPOSED CRITICAL GAPS IN CANADA'S HEALTH WORKFORCE PLANNING

60%

intended to leave their jobs

A MAJORITY OF NURSES SAID THEY WOULD LEAVE THEIR JOBS WITHIN THE NEXT YEAR, MORE THAN ONE QUARTER OF NURSES SAID THEY WILL LEAVE THE PROFESSION ALTOGETHER.

SOURCE: *Outlook on Nursing*, 2020

Ivy Bourgeault, PhD

Ivy Bourgeault, PhD, is a professor in the School of Sociological and Anthropological Studies at the University of Ottawa, and the University Research Chair in Gender, Diversity and the Professions. She leads the Canadian Health Workforce Network and the Empowering Women Leaders in Health initiative. Bourgeault has garnered an international reputation for her research on the health workforce, particularly from a gender lens. Recent projects focus on care relationships in home care and long-term care, and on the psychological health and safety of professional workers. Bourgeault was inducted into the Canadian Academy of Health Sciences in September 2016 and received the 2016/2017 University of Ottawa Award for Excellence in Research.

Why are nurses stretched to the limit? It's workload."

Ivy Bourgeault is a professor at the School of Sociological and Anthropological Studies at the University of Ottawa. As part of her research, she regularly interviews nurses about their work.

Stressors come from multiple sources, Bourgeault explained. Like all of us, nurses also have to contend with stress from their life outside work. But despite this, Bourgeault's research has consistently revealed workload to be nurses' number one issue.

The short-staffing of nurses is a longstanding problem. With nurse shortages endemic across the country, patients suffer longer wait times, deferred services and reduced care.

This has only been exacerbated by COVID-19.

"In the pandemic, we have people stressed, working really, really hard – working beyond their capacity," explained Bourgeault. "They were doing that before; now, it's in a crisis. And so they feel responsible because we've socialized health workers to [feel] responsible for this. And it's all on their backs."

"And those backs are breaking; they're breaking mentally, they're breaking physically."

Without the proper support – and with the increased pressures brought on by the pandemic – nurses are quitting their jobs in droves, and some are leaving the profession altogether. According to Statistics Canada, there were over 100,000 vacancies (end of 2020) in health care and social services. In Quebec, the number of nurses calling it quits, was up 43 per cent in 2020 compared to the previous year.

The pandemic has wrought an agonizing toll on the lives of nurses, but perhaps most acutely on their mental health. Mental health supports are crucial; they're needed right now and into the future. But we got here largely because of inadequate staffing, and that's a problem that needs to be tackled upstream.

Bourgeault admits that nurses might not be excited to hear that what's needed is data, but the truth is that Canada has very little staffing data when it comes to nurses.

"We have lots of data for physicians," she explained. "The data on nurses is separate. It's not as robust."

One of the reasons why the data is so much better for physicians, Bourgeault explained, is that they're thought of as a cost driver in a publicly funded health care system. And because of fee-for-service, it's much easier to keep track of what physicians are doing.

"We don't have that for nurses; we aren't able to say what nurses are doing because they're not pay-for-service; they're on salary in hospitals."

While no one is arguing nurses should be

"Why are nurses stretched to the limit? It's workload."

fee-for-service, this does mean that the data we have on nurses is often insufficient to make key decisions in a public health care system. Proper health workforce planning depends on our ability to bridge the gap between the population health needs and our capacity to meet those needs.

"Are there sectors where we aren't using nurses to their full potential, taking into consideration what nurses are trained to do and the needs of the population?" Bourgeault asked. It's just one example of how Canada could develop a more adaptive health care system, if only it had the data to drive that kind of thoughtful decision-making.

But as things stand, governments in Canada are largely working in the dark.

Instead of a systemic approach, Bourgeault said, governments are frequently making "one-shot policy interventions", such as offering premiums to draw health care workers to a certain sector, without a model to predict the potential effects on other sectors.

This failure to plan is costly: the health workforce accounts for more than 10 per cent of all employed Canadians, and represents two thirds of all health care spending.

Proper health workforce planning exists in other countries. Bourgeault pointed to Australia and New Zealand, which have better workforce planning models and also fared better during the pandemic. Even the United States, she said, has better data on nurses, including race-based data.

"We don't have any of that. From an equity lens, that's unacceptable."

The issue of equity is something Bourgeault is especially passionate about. She's known for saying "gender always matters". In the case of health workforce planning, gender matters too. Women make up 70 per cent of the global health care workforce; in Canada, it's over 80 per cent, with women making up 90 per cent of the nurse workforce.

The kind of robust workforce data and planning Bourgeault would like to see applied to health care already exists in Canada: in the construction sector. BuildForce Canada collects data on construction workers to study and forecast long-term trends in that workforce. It's an industry-led organization that receives government funding to provide labour market information.

The organization has a number of modellers, Bourgeault explained. Their data feeds into a scenario-based forecasting system, which they use to assess future labour market conditions.

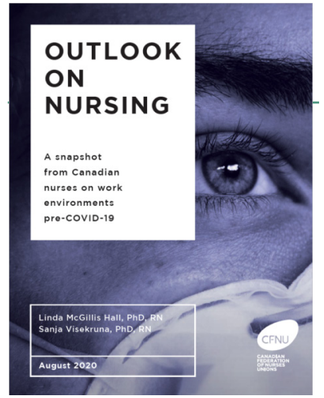
"There's a robust infrastructure there," said Bourgeault. "What's the difference between the health workforce and the construction sector?"

"It's not rocket science. Why it's not happening for the health workforce sector in Canada is beyond me."

"It's not rocket science. Why it's not happening for the health workforce sector in Canada is beyond me."

To read more on this topic:

Outlook on Nursing: A snapshot from Canadian nurses on work environments pre-COVID-19 assessed Canadian nurses' perceptions of their work environments. The study highlighted how nurses' work environments impact their health and work outcomes. Addressing the issues identified in this report is critical to ensuring a sustainable nursing workforce in the future.



NURSES ARE TOUGH AS NAILS, BUT EVERYONE'S RESILIENCE IS FINITE

Throughout 2019, Nicholas Carleton, PhD, a psychologist and professor at the University of Regina, and Andrea Stelnicki, PhD, a post-doctoral student, were busy analyzing data they had collected from a survey of over 7,000 nurses across Canada.

The results were shocking: nurses were grappling with an alarming number of symptoms indicative of major depressive disorder, generalized anxiety disorder, burnout, panic disorder and posttraumatic stress disorder. Nurses were experiencing mental health disorder symptoms at rates consistent with police, paramedics and firefighters, all of whom experience mental health challenges at a higher rate than the general population.

Nicholas Carleton, PhD

R. Nicholas Carleton, PhD, is a professor of clinical psychology at the University of Regina. He is a registered clinical psychologist in Saskatchewan, and Scientific Director for the Canadian Institute for Public Safety Research and Treatment. Carleton has published over 170 peer-reviewed articles exploring the fundamental bases of anxiety and related disorders. He has delivered more than 360 presentations at national and international conferences. Carleton has received several prestigious awards, is an inducted Member of the Royal Society of Canada's College, a fellow of the Canadian Academy of Health Sciences, and received the 2020 Royal Mach Gaensslen Prize for Mental Health Research.

At the time, nearly all nurses were reporting some difficulty with burnout, with nearly one third screening positive for clinical burnout.

Nurses were stressed, overworked, short-staffed and unsupported.

And then COVID-19 hit.

"If nurses had trouble with burnout before because of workload and stress, and then we add COVID, there's every reason to believe that it's more than a third that are having difficulty right now with clinically significant symptoms of burnout," warned Carleton.

"I'm very worried about the pending fallout from COVID-19."

The pandemic, Carleton emphasized, is a stressor like no other: it's a global stressor. The stress brought on by COVID-19 wasn't something nurses could simply leave at the hospital door; the pandemic has permeated every facet of our waking lives.

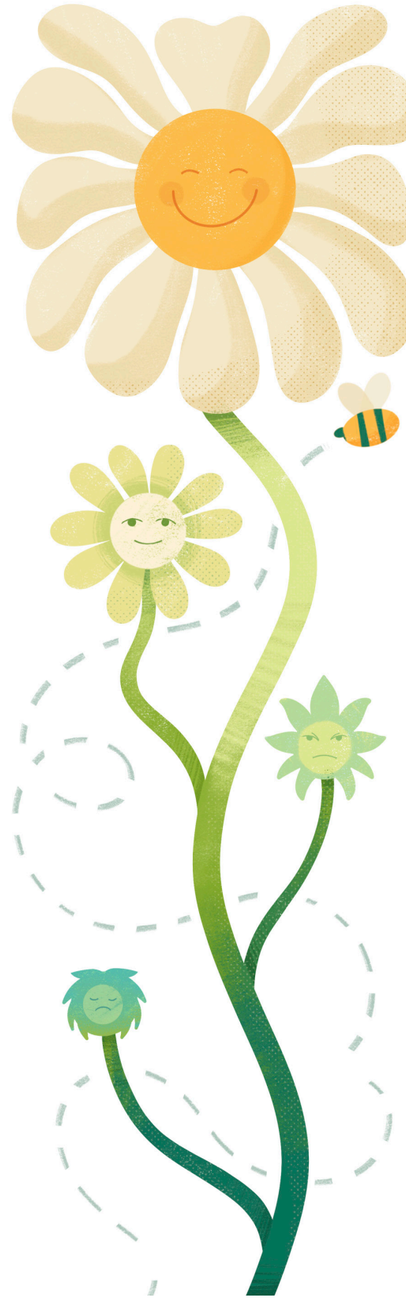
Nurses are tough as nails, but everyone's resilience is finite. In the end, Carleton explained, if your workplace is too stressful, if your workload is too heavy, if there's not enough support from your employer, anyone can get worn down.

"It's really just a matter of time. Because they're humans."

Pre-pandemic, Carleton and Stelnicki's research found that insufficient staff was the number one source of extreme stress: over 80 per cent of nurses said there weren't enough staff to do their job, and almost three quarters said their institution was regularly over capacity. Excessive and mandatory overtime have become standard operating procedure, with nurses working themselves ragged, often at the expense of their mental health.

During the pandemic, the situation worsened. According to Statistics Canada, nurses' average weekly overtime hours increased by 78 per cent in May 2020 when compared with the previous year.

COVID-19 won't disappear overnight. With a vaccination



COMPARISON OF MENTAL DISORDER SYMPTOMS REPORTS FROM NURSES AND PUBLIC SAFETY PERSONNEL

(ABOVE)

- PTSD rates consistent between nurses and PSP overall;
- Nurses screened positively more often than PSP overall for MDD, GAD and PD;
- Nurses reported slightly higher rates of lifetime suicidal ideation, planning and attempts than PSP (differences were not statistically analyzed).

SOURCE: *Mental Disorder Symptoms Among Nurses in Canada*, 2020

campaign well under way, we are hopefully on the verge of seeing the virus recede, easing its heavy burden on our health care system. But as we eye a "return to normal", we can't accept a return to a broken system – one that barely had the capacity to handle a global pandemic.

"Right now, we need to start having more realistic conversations about expectation management," explained Carleton. "We need to start doing staggered planning to make sure people have access to breaks – to make sure they have opportunities to access mental health care."

Crucial in this will be to make sure that nurses know where to go to access evidence-based mental care, like cognitive behavioural therapy. But encouraging nurses to seek the care they need is no easy task; even nurses struggle to deal with the stigma surrounding mental health.

"There's a tremendous amount of stigma," explained Carleton. "Some of it is self-stigma – so, I'm being too hard on myself – and some of it is stigma from our colleagues, and some of it is [societal] stigma that we still have with respect to mental health."

Key to preventing mental health disorders and injuries is knowing the early warning signs and where to get help. In his research, Carleton found that nurses are reluctant to reach out to mental health professionals for help, preferring instead to talk to friends and family. For this reason, family members and loved ones can play an important role in safeguarding nurses' mental health; they will often be the first people to notice changes in mood and behaviour.

Nurses also need good preventive care. It's important to take a mental health break: go outside, exercise, meditate, adopt a healthy sleep routine, keep a journal, open up to someone you trust – whatever works for you. These small daily habits can help safeguard our mental health.

In an ideal world, Carleton envisions people caring for their mental health much in the same way we care for our teeth.

"If I'm brushing my teeth every day, and flossing every day, that's good," said Carleton. "It doesn't mean I'll never have a cavity, but I do those daily little things that help protect my dental health. And at least once a year, I go for a dental check-up. It's a systematic thing. We do it with intention."

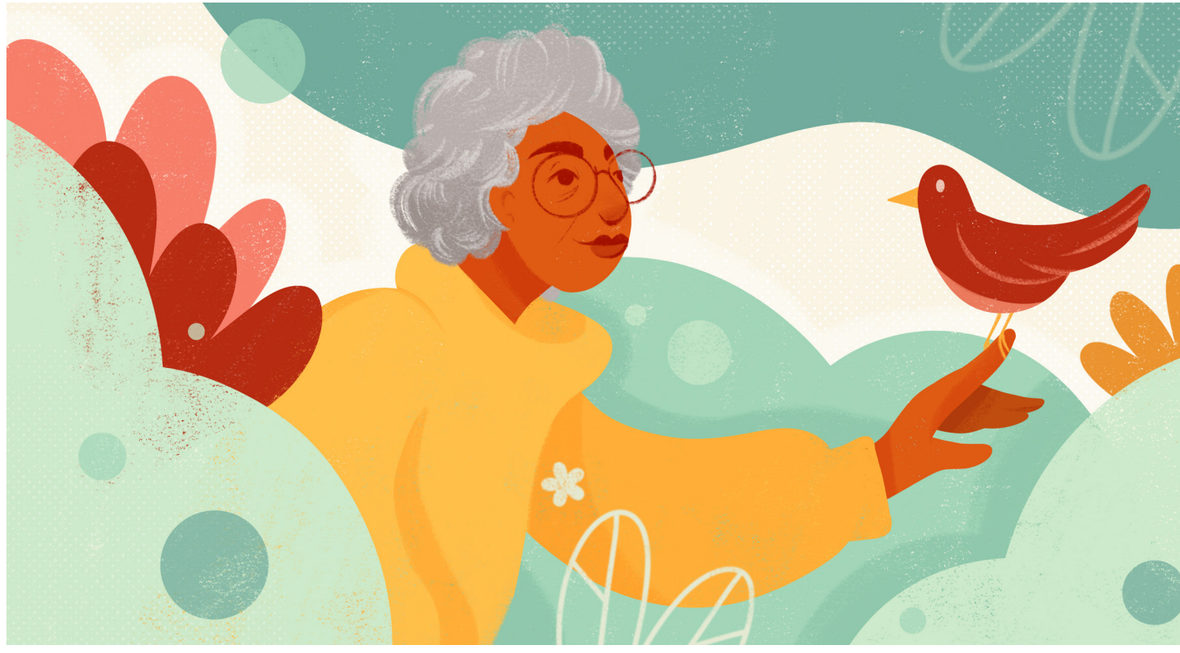
"So, how do we start shifting the population's discussion so that we focus on mental health with as much care as we focus on dental health? I think that's part of our next steps."

"I'm very worried about the pending fallout from COVID-19."

To read more on this topic:

In 2019, *Mental Disorder Symptoms Among Nurses in Canada* surveyed over 7,000 nurses about their mental health in the first nation-wide assessment of post-traumatic stress injuries (PTSI), such as PTSD, generalized anxiety disorder, or major depressive disorder. To put the data into perspective, the report compared nurse data with the results for public safety personnel and the general population.

LONG-TERM CARE: **"WE KNOW WHAT NEEDED TO BE DONE, WE JUST HAVEN'T DONE IT."**



Pat Armstrong, PhD

Pat Armstrong, PhD, is a distinguished research professor in sociology at York University and a Fellow of the Royal Society of Canada. She was Principal Investigator of the 10-year study "Re imagining Long-term Residential Care: An International Study of Promising Practices". Armstrong has published several books focused on social policy, women, work, and the health and social services sector, including books on long-term care. Much of her work centres on the relationship between women's paid and unpaid work. Armstrong often partners with unions and community organizations in her work. She has also served as an expert witness in more than a dozen cases before tribunals and commissions.

In the early days of the pandemic, the Canadian Armed Forces were called upon to stabilize a number of outbreaks that had taken hold in long-term care homes in Ontario and Quebec. The military later published explosive reports detailing deplorable living conditions. The sad truth, however, was that these conditions had existed for some time; they were a product of decades of willful neglect.

Pat Armstrong, a distinguished research professor of sociology at York University, noted that researchers, seniors' advocates, long-term care workers, health care unions and residents have been ringing the alarm for decades. Armstrong has been one of the most prominent critics of long-term care practices in Canada. As the principal investigator for the international project Re-imagining Long-Term Care, she sought to identify how to reform long-term care to allow residents to not only live with dignity and respect, but to flourish.

"We know what needed to be done, we just haven't done it," said Armstrong.

Canada's failure to act on the recommendations of experts has led to tragic consequences: nearly 70 per cent of all Canadian deaths from COVID-19 have been in long-term care.

The main problem plaguing the sector, Armstrong said, is that there isn't enough staff. All the while, residents' clinical, intellectual and social needs are steadily increasing. The average age of a long-term care resident is 85; about 70 per cent of residents have some form of dementia, and almost all residents have a combination of complex care needs.

To prevent a decline in residents' health, the recommended minimum standard of care was four hours – that's four hours of direct care per resident per day. But more recent research, Armstrong said, would suggest that figure should be closer to six hours. But in Canada, it's a struggle just to get provinces to codify a minimum of four hours into law.

"I certainly think we need minimum hours of care," said Armstrong. These actually have to be worked, hands-on care hours, she added; they shouldn't include time taken for vacation, parental leave or management work.

There's an important body of research indicating a very strong causal relationship between staffing and the quality of care, she explained. That research is based on directly measurable incidents: hospital transfers, bed ulcers and falls, for example.

"And there's a whole lot of things that we can't measure that are really important," Armstrong added. "Do the people who live in the home feel

any joy? Do they take pleasure in life – pleasure we know comes from human exchange, activities with other people, from having relationships?"

"Those things aren't measured in any of these studies. But, clearly, you can't have these kinds of social relationships if you don't have the time. And if you don't have the staff, you don't have the time ."

> ***"If you don't have the staff, you don't have the time."***

During the pandemic, the spotlight was also shone on the working conditions of staff in long-term care. This is profoundly skilled work, that is not appropriately recognized or paid, but in Ontario, for example, less than half of workers are full-time. Throughout Canada, many long-term care staff work in casual, precarious positions.

"We have been arguing for 20 years that the conditions of work are the conditions of care," said Armstrong. "You can't focus on the resident if you don't have the conditions to do that."

Unions have made some progress in obtaining paid sick leave for workers – many of whom are racialized women. The fight continues for decent pay, better benefits and access to full-time work.

"We increasingly are running these places as places where profit can be earned, instead of saying every penny should go for care," Armstrong remarked. "We are increasingly organizing them as businesses in the larger sense – and not just in the for-profit homes."

During the pandemic, for-profit homes not only suffered more outbreaks, they also saw more deaths. For example, data from BC collected since March 2020 showed that private for-profit facilities had the most outbreaks. The Toronto Star analysis of long-term care data concluded that "for-profit status has been undeniably associated with worse outcomes throughout Ontario's COVID-19 pandemic".

THE PROPORTION OF COVID-19 DEATHS IN LTC AND RETIREMENT HOME RESIDENTS IN CANADA (69%) HAS REMAINED SIGNIFICANTLY HIGHER THAN THE INTERNATIONAL AVERAGE (41%).

Source: CIHI, April 2021

In a model that constantly is looking for efficiencies and cost savings, it's no surprise that the level of care deteriorates. As a result, the determinants of health – the broad range of personal, social, economic and environmental factors that determine individual and population health – are easily ignored.

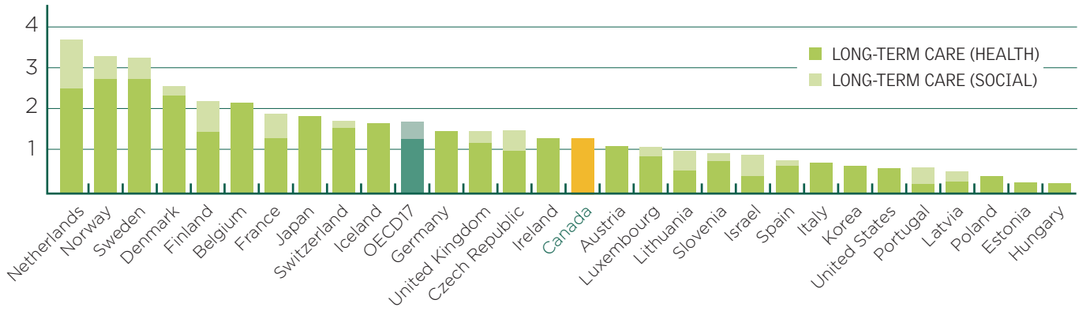
"We know how critical food is to care – how critical clothes and laundry are to our sense of dignity of self and care – how important housekeeping is to keeping people healthy in these homes. "We've known that we should be changing all of these – or at least focusing on making these much better than they are – and we've done very little. The research keeps getting ignored."

Armstrong pointed out that very few of us want to entertain the idea of getting older, much less the idea that we might ever need to go into long-term care. The Canadian population, meanwhile, is getting older; according to Statistics Canada, a quarter of us could be over 65 by 2030.

"My friends say: 'I'm never going to go to one of those places!' Well, virtually nobody plans to go into long-term care – although we should."

"And if we did think that 'I may well be in long-term care', maybe we would invest more in long-term care – and I don't just mean financially, I mean in terms of good ideas – in terms of constructing these places as real places of care."

LONG-TERM CARE EXPENDITURE (HEALTH AND SOCIAL COMPONENTS) BY GOVERNMENT AND COMPULSORY INSURANCE SCHEMES, AS A SHARE OF GDP, 2017 (OR NEAREST YEAR)



Note: The OECD average only includes 17 countries that report health and social LTC.
Source: OECD Health Statistics 2019.

To read more on this topic:
Before It's Too Late: A National Plan for Safe Seniors Care lays out a strategy for safe seniors care that is equitable and inclusive across Canada. Post-pandemic, the need for long-term, dedicated funding, effective enforcement mechanisms and a minimum staffing standard will be more important than ever. This report applies an integrated and holistic approach to seniors' care with the objective of improving the overall quality of seniors' lives.

UNIVERSAL PHARMACARE IS ACHIEVABLE – WE JUST NEED "TO KEEP THE PRESSURE ON"

Before COVID-19 crippled the nation, pharmacare seemed within reach. In June 2019, an advisory council recommended the adoption of a universal single-payer public pharmacare system. It was the fifth time a national commission would conclude that prescription drugs ought to be part of our universal health care system.

Just a few months later, an Angus Reid poll found that nine out of ten Canadians also supported the idea, including 76 per cent of Conservative Party supporters. We've seen this time and time again: Canadians of all political stripes are united in their support for a national universal public pharmacare program.

But has the current pandemic derailed the decades-long fight for national pharmacare?

"COVID, no question, has changed the dynamic," explained Steve Morgan, a professor of health policy at the University of British Columbia and a leading advocate for national pharmacare. "Some of the progress that would have otherwise been made has been stalled."

Against the backdrop of a global pandemic, there's no question that the path to pharmacare is a bit more challenging. The expansion of our public system is often pitted against a health care sector already in a funding crisis.

But Morgan contends that the case for pharmacare has never been clearer.

"COVID has created very significant economic impacts on Canadians – it has caused millions of Canadians to lose their jobs. We estimate that about one million Canadian families lost health insurance in the past year because of work-related benefits disappearing with career changes that COVID has forced upon many people."

"That does increase the need for a safety net that ensures that everyone is covered for the medicine that they need."

Morgan continues to be optimistic. As he pointed out, the current Liberal government has promised pharmacare again and again: in their platform, in two throne speeches and in mandate

Steve Morgan, PhD

Steve Morgan, PhD, is a professor of health policy at the University of British Columbia. An economist by training, Morgan's research focuses on policies to provide universal access to appropriately prescribed, affordably priced and equitably financed prescription drugs. He has published over 150 peer-reviewed research papers, received more than $4 million in peer-reviewed research grants, and provided policy advice to governments in Canada and around the world. Morgan has won many awards for his work, including a 2019 Emmett Hall Laureate for his career-long contributions to health system equity, fairness, justice and efficiency.

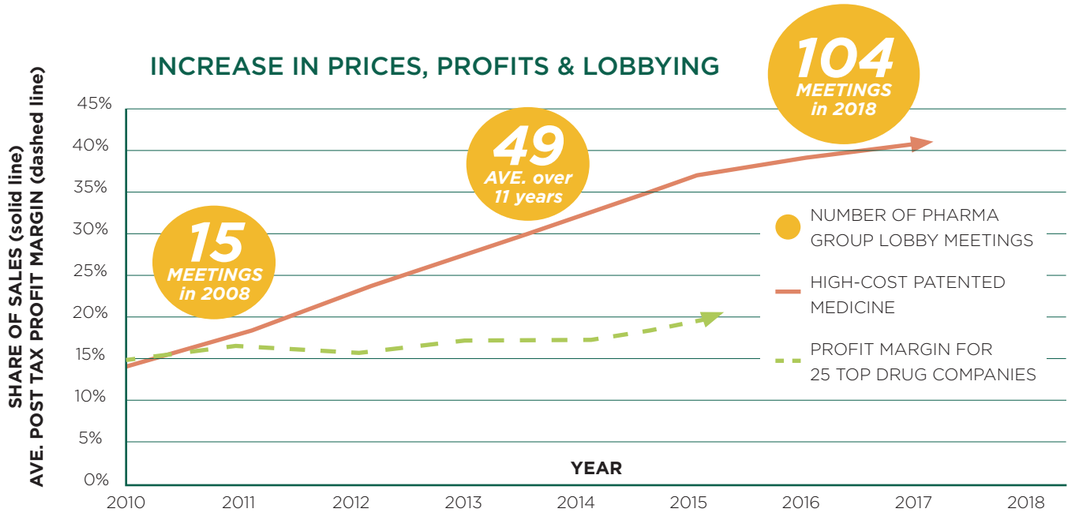
letters to the ministers of finance and health. Despite these commitments, those who care about pharmacare mustn't get complacent.

It still remains unclear what shape a pharmacare program would take under this government, how it would be implemented and under what timelines.

"It's really important to keep the pressure on," cautioned Morgan. "Governments can decide that: 'Well, we promised to do something, but we now think no one cares – or we now think Canadians have other priorities.'"

It goes without saying that pharmacare would greatly benefit the health of Canadians. Nearly 25 per cent of Canadian households include someone who isn't taking their medications as prescribed because of cost; out-of-pocket expenses remain significant for many Canadians. Under pharmacare, the government would have the power to drive down Canada's notoriously high drug prices. That's because a single-payer system would give the government greater negotiating power with the pharmaceutical companies by concentrating the purchasing power in a single hand.

But lower drug prices are just part of the equation. A conservative estimate by the Parliamentary Budget Office suggests that Canadians could save $4.2 billion annually; other studies estimate that those savings could reach up to $11 billion annually.



U.S. General Accounting Office analysis of Bloomberg data, Nov. 2018, PMPRB Annual Report. 2017 – July 24, 2018, Records of the Office of the Commissioner of Lobbying of Canada.
Source: *The Big Money Club*, 2019

So why isn't there greater political will to get this done? Why isn't there cross-party support for a program that is not only cost-effective but would also improve the health of Canadians?

"This is a no-brainer," declared Morgan. "Anyone who would wish to do rational policy in the health care space would have done this years ago."

"When the Department of Finance says that we could save $4 billion or $5 billion per year, someone is hearing that they're going to lose $4 billion or $5 billion in income per year, and in this case it's the multi-national pharmaceutical companies who are extraordinarily powerful on the world stage, in Ottawa and in the provinces."

In the wake of the 2018 federal budget, which established the Advisory Council on the Implementation of National Pharmacare, pharmaceutical and insurance companies embarked on a lobbying frenzy in Ottawa. These industries (and a handful of billionaires) are the only players who stand to lose from pharmacare.

> ***"Nurses are incredible voices in the health care system – and [pharmacare] is first and foremost a health care issue."***

The implementation of national pharmacare is further complicated by the delicate dance between Ottawa and the provinces. Morgan contends that if and when the federal government makes its move, the focus should immediately turn to the provinces' bloc of conservative premiers.

"The pressure on the provinces is going to be very critical," he emphasized. "It's really important for health professionals, for the labour movement, for academic experts, for ordinary citizens just to get out there and remind their MP and provincial politicians that this remains a policy priority."

Morgan noted that nurses' voices are especially powerful, since they can speak to the direct impacts on their patients. Nurses know firsthand what happens when patients with chronic conditions can't afford their medications.

"Nurses are incredible voices in the health care system – and this is first and foremost a health care issue."

Morgan is counting on those voices to drive the project across the finish line. After more than two decades working on pharmacare, he believes that real change is within reach.

"We can't give up. We've got to consider this last phase of getting this program actually implemented as the most important and redouble our efforts."

To read more on this topic:
CFNU's *The Big Money Club* tells the story of the outsized influence of ultra-rich actors in the pharmacare debate in Canada. These actors - big pharma, big insurance and big money - see dollar signs in the preservation of the current system and are funding a lobbying campaign to protect their profits. The book asks governments: whose interests will you defend?

"IT'S NOT BECAUSE YOU'RE BLACK THAT COVID LIKES YOU BETTER."

It was a real aha moment."

It was during a lecture about the impacts of racialization on health that Nicole Welch, a director and chief nursing officer at Toronto Public Health, had her eyes opened to the pernicious and pervasive effects of systemic racism on health.

"[The lecture] talked about the impact and the weathering effect – that slow eating away at our health and our well-being," explained Welch. "Because of the experience of racism, we're always in this fight-or-flight response – a heightened response."

This is the lived experience of people in oppressed communities. It's commonly referred to as 'minority stress': people who belong to equity-seeking communities experience greater levels of stress as they navigate a society where they are regularly subjected to discrimination and prejudice. This higher baseline of stress not only impacts mental health, it also contributes to poorer health outcomes and chronic diseases, such as high blood pressure and diabetes.

"It was shocking to me," recalled Welch. She reflected on her own heightened stress level – how each day she was sending her two Black boys to school and wondering if "today is the day."

"Is today the day I'm going to get that call that they're not being treated equally?"

Welch said that while she carries that additional stress every day, she hadn't consciously recognized its toll because it sadly is part of the everyday Black experience.

During the pandemic, our collective level of stress rose. And for some racialized people, navigating public spaces became even more unnerving, as the number of hate crimes and overt acts of racism increased. According to the Chinese Canadian National Council's Toronto chapter, which has been collecting reports of anti-Asian racism across Canada, there were 1,150 such instances in the pandemic's first year. While three quarters were verbal attacks, numerous physical assaults were documented.

Nicole Welch, RN

Nicole Welch, RN, graduated from McGill University in 2000 with a Masters of Sciences in Nursing. She worked at Brampton Memorial Hospital and Mount Sinai Hospital in Toronto. In 2001, Welch joined Toronto Public Health where she is currently the Chief Nursing Officer and COVID-19 Liaison Director. Welch is passionate about issues related to health equity and social justice, and supporting the development and maintenance of healthy communities. Welch's passion for lifelong learning has led her to the final stages of a PhD in Applied Psychology and Human Development at the University of Toronto's Ontario Institute for Studies in Education.

Minority stress is just one of the factors that contribute to health disparities among racialized communities. These disparities existed pre-pandemic, but the pandemic brought them into sharper focus. In Toronto, Black neighbourhoods were especially hard-hit by COVID-19.

"It's not because you're Black that COVID likes you better," said Welch. Systemic racism, she explained, segregates and relegates racialized people to particular spaces.

"Certain spaces – certain jobs – are for you. They're living in communities that are more densely populated. Because of lack of opportunity – because of racism – you can't get the jobs you want."

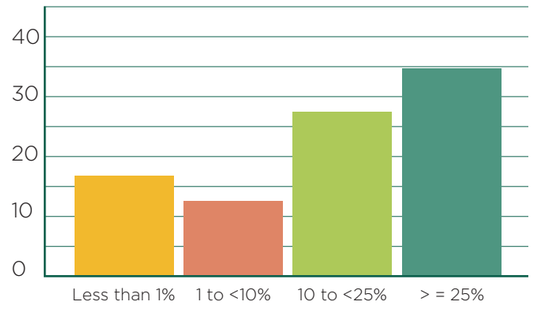
Welch pointed to research by Philip Oreopoulos, a professor of economics and public policy at the University of Toronto. In 2009 and again in 2012, Oreopoulos sent thousands of randomly manipulated resumes to job recruiters in Canada's largest cities. Both experiments revealed that "substantial differences in callback rates arise [...] from simply changing an applicant's name. Oreopoulos' research found that candidates with English-sounding names were 35 per cent more likely to receive a callback than candidates with Indian or Chinese names. A similar study in the US found that applicants with white-sounding names were 50 per cent more likely to get callbacks than applicants with African American-sounding names.

It's just one example of how implicit or unconscious bias works to disadvantage Black, Indigenous and people of colour. And while conversations about racism can often focus on overt acts, such as hate crimes and racial slurs, studies like these point to a more subtle form of racism that is just as harmful – that impedes upward social mobility and contributes to health disparities.

"We know that in any pandemic, whoever is at the lower end of the socioeconomic ladder is going to be impacted," emphasized Welch. "In our society in which we deal with racism, it is going to be Black, Indigenous and people of colour."

A society with greater racial equality, Welch explained, would still see the effects of the pandemic on poor and working-class people, but those impacts wouldn't disproportionately affect

AGE-STANDARDIZED COVID-19 MORALITY RATES, BY PROPORTION OF THE NEIGHBOURHOOD POPULATION BELONGING TO POPULATION GROUPS DESIGNATED AS VISIBLE MINORITIES IN CANADA



SOURCE: Data derived from provisional Canadian Vital Mortality – Death Database (2020) and the Census of Population 2016.

> ***"We know that in any pandemic, whoever is at the lower end of the socioeconomic ladder is going to be impacted."***

specific racialized groups.

When Statistics Canada analyzed a year of COVID-19 data, it found that in areas where 25 per cent or more of the population was made up of "groups designated as visible minorities", the mortality rate averaged 35 deaths per 100,000. In areas where racialized people made up less than one per cent of the population, the average death rate dropped to 16 deaths per 100,000. In Toronto, the data is even starker. In November 2020, racialized people made up 79 per cent of all COVID-19 cases in the city.

Addressing COVID-19's impacts on racialized communities requires immediate action. In the long term, Welch said, addressing the root cause of these impacts means decolonizing our institutions and tackling the systemic racism that permeates them. We simply can't fix inequities without tackling the systems and structures that reinforce those inequities.

Since these populations have been especially hard-hit, getting vaccines into arms is critical. Public health officials have a tough job to do: they have to share evidence-based information with racialized communities in the hope of reducing vaccine hesitancy – and they have to do this knowing full well that they are working within a health care system that has all too often made these communities feel unwelcome, unheard and victimized.

Welch pointed to the tragic case of Joyce Echaquan, a 37-year-old Atikamekw woman who endured racist taunts by health care staff as she lay dying in a Quebec hospital. And last year, British Columbia investigated allegations that ER staff played a game in which they tried to guess Indigenous patients' blood alcohol level. While the investigation failed to confirm the existence of this game, it did find widespread systemic racism. Indigenous patients reported being subjected to negative assumptions based on prejudice and racist attitudes.

Black patients' health and well-being are also undermined by implicit bias in health care. As an example, Welch referred to studies in the US that looked at how Black patients' pain is assessed and treated. According to a 2019 study that examined the treatment of acute pain in US emergency departments, Black patients were 40 per cent less likely to receive pain medications, compared to white patients, and 34 per cent less likely to be prescribed opioids. A 2016 study on racial bias in pain assessment and treatment found that half of first- and second-year medical students held false beliefs about biological differences between white and Black people, including the notion that Black people's skin is thicker than white skin. Students who held these false beliefs rated Black patients' pain lower and made less accurate treatment recommendations.

It also wasn't long ago that Black and Indigenous bodies were used to carry out medical experiments. Between 1942 and 1952, First Nations children in six residential schools became the unwitting subjects of a nutrition study. Malnourished, these children were denied adequate food. The experiment continued, even as some children died.

From 1932 to 1972, the United States Public Health Service enrolled hundreds of Black men in a study that intentionally left their syphilis untreated to study the effects of the disease. Participants in the study were lied to: they were told they were receiving proper medical treatment. Today, the Tuskegee Study of Untreated Syphilis in the African American Male is often raised in the medical community as an example of racism so deeply ingrained that even the Hippocratic Oath was unable overcome it.

These historical harms have contributed to distrust of the medical community among Black, Indigenous and people of colour. Restoring trust will take time and concerted effort. As we work to dismantle systemic racism in health care, we must also create more welcoming spaces where people from all equity-seeking groups can feel seen, heard, validated and included.

Too often, it falls on the very people who are oppressed to call attention to issues of inequity and discrimination. The people who belong to equity seeking groups need allies – people in positions of privilege (yes, that means white people) – to step up to the plate. That means calling out racist and discriminatory practices, and examining our own assumptions, and how these ideas feed into implicit bias and uphold systemic racism.

"I'm a Black person. I have my Master's in nursing. Any time I go into a hospital to care for a family member – it's sad – but I feel I have to say: 'This is who I am. I'm a nurse. I'm well-educated. I know what's going on here.'"

"I'm already assuming that the potential for my family member to not be treated fairly is there," explained Welch.

"I shouldn't have that added stress."

To read more on this topic:
CFNU's *Equity and Inclusion Toolkit* provides resources to support our nurses' union membership advocacy for a more just and equitable society. The toolkit contains a range of materials, including: FAQs, an introduction to using an equity lens, an inclusive language glossary, organizational and event accessibility checklists, sample workshops and sample policies.

TRANS-AFFIRMING CARE **IS LIFE-SAVING CARE**

It's like having your life on pause."

For many of us, the pandemic has been a strange interlude. We're in stasis – waiting for the pandemic to ebb so we can resume living our best lives. But for many in the transgender, Two-Spirit and non-binary community, that wait is twofold; for them, the pandemic also represents a barrier to a number of vital health care services they need to live as their authentic selves.

"It's a waiting game for something that's so important to you in order to be yourself and live your life like everybody else," said Alex Vincent, a registered nurse and the trans health program lead at the Centretown Community Health Centre in Ottawa.

When COVID-19 hit, Vincent's clinic quickly shifted to virtual services to provide their patients with the same access to care. But operating rooms and other services became harder to access. Gender-affirming surgeries and treatments were cancelled or postponed. Wait lists for hormone replacement therapy grew; in Ottawa, the wait list is currently nine months. Access to electrolysis treatments for the removal of facial hair has also been severely limited, given the current restrictions and masking requirements.

Because Canada's health care system pre-pandemic was already stretched thin, hospitals moved to postpone elective surgeries to increase capacity. But labelling gender affirming surgeries as "elective" minimizes their importance. For the trans, Two-Spirit and non-binary people who need these procedures as part of their transition, they're life-saving surgeries.

"Having to live with these body parts that are very much incongruent with how your mind sees your body is very, very difficult," said Vincent. Living with gender dysphoria, he explained, means living with discomfort, psychological distress and unhappiness.

The value of gender transition, which can include hormone therapy and surgery, is backed up by scholarly research. In 2017, The Center for the Study of Inequality at Cornell University undertook a review of 55 studies from across the world that assessed the effect of gender transition on transgender people. Of those, 93 per cent found that "gender transition improves the overall well-being of transgender people". The positive outcomes of gender transition, the research found, included "improved quality of life, greater relationship satisfaction, higher self-esteem and confidence, and reductions in anxiety, depression, suicidality, and substance use."

This underscores just how vital it is for trans, Two-Spirit and non-binary people to be able to access quality care in settings that allow them to feel heard, supported and validated. But quality care like this is hard to come by in a health care system where staff often lack knowledge about the community and where a binary notion of gender seems to permeate every facet of care.

"Everything is structured to be male or female and that's it – everything!"

For Vincent, it was this experience with the health care system during his transition that led him to become a registered nurse.

"I had a lot of trouble going through my transition," recalled Vincent. At the time, services were limited and few surgeries were covered by his province's health care plan. During his transition, he didn't encounter a single trans person working in health care.

"[That experience] really informed my nursing practice."

Vincent's advocacy for trans, Two-Spirit and non-binary patients started the moment he entered nursing school. He conducted research in this area during his undergrad and raised trans issues in class.

"[In nursing school] there was no education about this – or very little," Vincent recalled. "I made a point to [...] bring these topics to the table so that my classmates were aware that trans folks exist and non-binary folks exist."

But it's not just about better education. Vincent said health care is often structured around a binary notion of gender which isn't conducive to providing culture-humble, trans-affirming health care. Something as simple as a charting system can erase a trans or non-binary person's identity.

"Everything is structured to be male or female and that's it – everything!"

"Bloodwork: there's only two boxes. Wards in a hospital – beds: there's only two options. There [isn't] another option. The health care system is just not created in a way to be easily accessible for trans and non-binary folks."

Having navigated the health care system both as a trans person and as a health care worker, Vincent said he understands how the system itself is partly responsible for trans and gender diverse patients' negative experiences.

"I remember I had a situation where I was getting a test at a hospital – it was a test for a body part that someone who has an "M" [on their health card] doesn't normally have in their body. They didn't know how to code it to go to the lab because it wasn't an option."

"It's just one of those odd things – why does it even matter? It's a test for this body part. Why is it such a big deal?"

It's just one example of the pervasiveness of gender markers throughout health care.

Alex Vincent, RN

Alex Vincent, RN, graduated from Trent University in 2020 with a Bachelors of Sciences in Nursing. He works at Centretown Community Health Centre in Ottawa as a nurse in the Trans Health Clinic. He is also the Trans Health Program Lead at the centre. Vincent is passionate about trans health care and draws upon his personal and professional experiences to guide him in his work.

LANGUAGE IS IMPORTANT

To become a stronger ally, familiarize yourself and keep up-to-date with the following terms and concepts.

Transgender/trans (never "transgendered"): A trans person's gender does not align with the one they were assigned at birth. Trans people may identify within the gender binary, either as male or female, or as non-binary.

Two-Spirit: This Indigenous term refers to a culturally distinct gender that includes LGBTQ identities. Historically, Two-Spirit people were often seen as healers and visionaries within their communities because they carry a male and a female spirit.

Non-binary people: Non-binary people's gender lies outside the male/female binary notion of gender. Non-binary people may prefer gender-neutral words and pronouns to be used when referring to them, such as they/them.

Cisgender/cis: Cisgender people's gender aligns with the gender they were assigned at birth.

Updated name: This is the name a trans or non-binary person uses in everyday life and the one they feel best reflects their gender identity. It may not always match their legal name.

Preferred pronoun: Trans, Two-Spirit and non-binary people may prefer a binary pronoun that best reflects their gender identity (he/him, she/her) or one that reflects their non-binary identity (they/them). Simply ask "What is your preferred pronoun?" to find out which one to use.

Gender-affirming surgeries and treatments: These are meant to better align a trans, Two-Spirit or non-binary person's body with their gender. Gender-affirming surgeries are not always part of everyone's transition; there is no "right way" or "wrong way" to transition.

Deadnaming: While deadnaming was not explicitly mentioned in this article, it refers to when a person, whether unintentionally or not, calls a person by the name they used before their transition. Deadnaming can lead to feelings of hurt, invalidation and lack of support.

As Vincent pointed out, a gender marker doesn't tell the full story and can often lead to the wrong assumptions about people's anatomy.

Charting systems are also problematic. For example, most don't have a space to include a trans person's updated name (which may not match the legal name on their health card) or their preferred pronoun.

When they do find supportive and affirming care, trans people have yet another hurdle to overcome: gaps in provincial and territorial insurance coverage that can leave patients paying out of pocket for crucial medical procedures.

While most provinces cover the cost of some gender-affirming surgeries, certain surgeries are not covered because they are considered cosmetic. And due to a lack of access, trans, Two-Spirit and non-binary folks often have to travel to another province to get surgery, adding to the overall cost.

Recently, the Yukon government made headlines when it significantly expanded its coverage. Experts contend that the territory now has the most comprehensive gender-affirming policy in Canada. Notably, facial feminization surgery and body contouring are among the surgeries covered by the territorial government.

Perhaps most importantly, Yukon's policy clearly recognizes that "gender-affirming procedures are not cosmetic and are life-saving for transgender people." The territorial government also underscored that "delaying or denying access to transition-related health care can cause significant harm."

While such sweeping policy wins take time, Vincent said there is something nurses can start doing right now to make a positive impact: paying attention to the language they use with their patients.

"Often, the problem is that people who aren't cisgender and heterosexual are erased in the question before the patient even has the chance to answer," explained Vincent.

A gendered question commonly found on intake forms is: "If you are female, is there a chance you may be pregnant?" The question leaves out trans men and non-binary folks. A non-gendered way of asking the same question could be: "If you have a uterus, is there a chance you may be pregnant?"

"Ask questions in an open way," Vincent advised. "'Do you have a partner? What is their name? What is their gender?'"

"It's just reformulating a couple of words in your question, and it opens it up."

Inclusive language isn't just about being polite; it's about ensuring the safety and comfort of all patients when they seek care. When health care providers create these safe spaces, it allows patients to be more open and obtain better care.

As allies, nurses should also advocate for their trans patients beyond the exam room, Vincent said. For example, he said nurses should insist that a patient's updated name and preferred pronouns are used even when they're out of sight.

"You need to have the same respect in front of the client as you do when they're not present."

There's also knowing what questions are appropriate to ask. If a patient is seeking treatment for something unrelated to their genitals, you probably don't need to ask, Vincent emphasized.

"If the person is there because they have a broken arm and they happen to be trans, their transition has nothing to do with it."

Nurses should have some basic knowledge about trans issues, Vincent said. Individually, nurses should seek out information and learn about how they can be stronger allies to this community. They should also press nursing colleges to add these issues to the curricula and licensing exams.

"[We're talking about] little changes that can make such a large difference to so many people."

To read more on this topic:

The Canadian Labour Congress has developed a guide for union activists who want to be stronger allies and advocates for their trans, Two-Spirit and non-binary members. The guide provides a deeper look at the issues facing trans workers, how best to defend their rights and how to support them through their transition.

"YOU'VE GOT TO TALK TO THE PEOPLE WHO ARE AFFECTED," SAYS METIS SENATOR

She looked at me and said: 'They did it to me.'"

Senator Yvonne Boyer said she was just checking in at a hotel when the woman behind the front desk recognized her as the "senator of sterilization". The woman, Boyer said, was sterilized without consent when she was just 21, after delivering her fourth child.

Boyer first became engaged with the issue of forced sterilization of Indigenous women in 2014, when she received a call from a reporter in Saskatchewan, inquiring about two Indigenous women who were sterilized against their will.

Her mind raced.

"I said: 'Well that's not right. You can't do that. You can't just go sterilize people. That's a criminal act. That's battery. That's assault. Is that medical negligence? What about Aboriginal rights? What about international law? What about the United Nations Declaration on the Rights of Indigenous Peoples?'"

"So, all these legal remedies and issues came to mind."

The two women were Tracy Bannab and Brenda Pelletier. Boyer said she makes a point of saying their names because she has so much respect for them as the first women to bring this issue to light. After Bannab and Pelletier's stories were published, more women came forward.

Soon, two became eleven.

"They were all sterilized in suspiciously the same type of circumstances that the first two had been: it was post-cesarean section, they were Indigenous and they didn't give consent – or they were coerced into consent or had revoked consent."

"Their stories all had the same feel [...] and the same anguish."

The Saskatoon Health Region eventually reached out to Boyer and asked her to conduct an external review on the issue of tubal ligation of Indigenous women immediately post-delivery. Indigenous women's lives, the review found, "were intricately bound within an overriding negative historical context of colonialism." The Canadian medical establishment's interest in eugenics, which peaked in the 1930s, was also responsible for the forced sterilization of thousands of people, many of them Indigenous women.

Most of the women interviewed for the review said they did not understand that tubal ligation was permanent and thought it could be reversed in the future.

Boyer's external review forms the basis of a class action lawsuit currently underway, which now includes about 100 women: ten from Alberta, five from British Columbia, twelve from Manitoba, one from Nunavut, four from Ontario, two from Quebec and 64 from Saskatchewan.

"It's still happening," Boyer remarked. "The last ones that were reported were in 2018. I can guarantee, it's happening at this very moment."

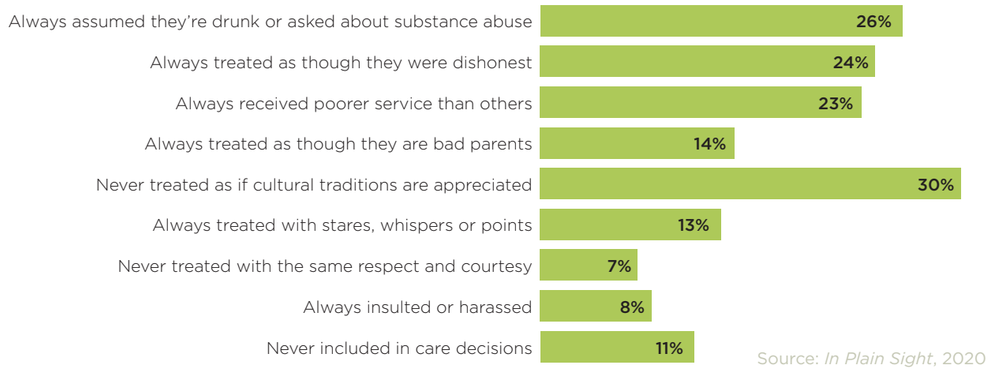
The senator said there's a historic power imbalance that allows for this to happen. It's the same power imbalance that has allowed for anti-Indigenous racism to pervade health care. She's seen it firsthand; before becoming a lawyer and later a senator, Boyer was a nurse.

"Lots of people were very racist within the health care system," she recalled. "Probably because of the way I looked, they thought I was

Senator Yvonne Boyer

Senator Yvonne Boyer is a member of the Métis Nation of Ontario, with ancestral roots in the Métis Nation-Saskatchewan and the Red River. A former nurse, she has more than 20 years of experience practicing law and publishing extensively on the topics of Indigenous health, and how Aboriginal rights and treaty law intersects on the health of First Nations, Metis and Inuit people. Prior to her appointment to the Senate of Canada, Senator Boyer was the Associate Director for the Centre for Health Law, Policy and Ethics, and a part-time professor in the Faculty of Law at the University of Ottawa, where she also completed her doctorate in laws.

WIDESPREAD AND ONGOING STEREOTYPING AND RACISM LEADS TO DISCRIMINATION AT POINT OF CARE



Source: *In Plain Sight*, 2020

very much like them. People would say things to me like: 'The Indian problem won't be solved until we sterilize all those women.'"

"You're talking about my aunties – my sisters," Boyer thought.

Boyer grew angrier and angrier about the racism she witnessed as a nurse. It's what led her to pick away at law classes and eventually become a lawyer.

"I thought: 'I'm either going to do something about it, or I'm going to have to shut up and become complacent.'"

> ***"It's still happening, [...] I can guarantee, it's happening at this very moment."***

"I generally have never been able to shut up."

Now a senator, Boyer said her office regularly fields calls from people who have experienced discrimination. Many also reach out to her with issues involving consent.

Recently, the issue of anti-Indigenous racism in health care captured headlines, when Joyce Echaquan, a 37-year-old Atikamekw woman, endured verbal abuse by Quebec hospital staff as she lay dying. In Echaquan's recording of her last moments in hospital, a nurse can be heard openly denigrating and dehumanizing Echaquan: "She's only good for sex."

This isn't an isolated incident. In a recent report from British Columbia, *In Plain Sight*, Indigenous people reported widespread and ongoing stereotyping and racism when they accessed health care. About a quarter reported health care workers always assumed they were drunk or engaged in substance abuse, a quarter said they were always treated as though they were dishonest, and about 30 per cent said they did not feel it was safe to speak up when they were treated inappropriately.

Not surprisingly, Indigenous people surveyed also had more trouble accessing health care during the pandemic, compared to the general population; as a result, they were more likely to end up in emergency rooms and in hospital beds. Because Indigenous people face important barriers in obtaining care when they need it, they suffer poorer health outcomes and reduced life expectancy.

These racist attitudes towards Indigenous people are endemic in health care, Boyer said. While decision-makers have called for action, in the wake of Echaquan's death, Boyer wonders whether this most recent tragedy will lead to meaningful change.

"There's a lot of handwringing and tears every time something happens," Boyer remarked.

Sadly, the few concrete actions that follow often aren't enough to spur meaningful change, she said. And as is all too typical with issues involving Indigenous people, there isn't enough consultation with the community itself.

"If you're going to do anything, you've got to talk to the people who are affected," said Boyer. It's the same advice she gave during a 2021 federal ministers' meeting on countering anti-Indigenous racism in health care.

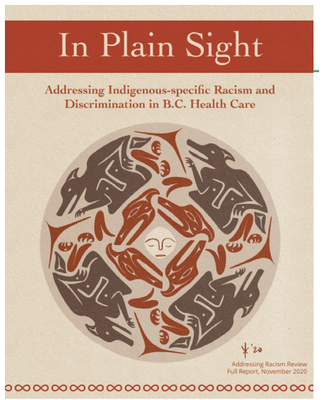
There's been a lot of movement since Echaquan's death – the most movement Boyer has seen on the issue in a long time, she noted. But the senator worries about the health care sector's ability to invite and open itself up to transformative change, especially as paternalistic attitudes dominate the conversation and limit Indigenous peoples' ability to make themselves heard.

"It's the same old top-down approach: 'I know what you need. I'm going to fix you. I'm not even going to ask you what's wrong, but I'm going to fix you.'"

"It's the same thing that's happened with sterilization: 'I know you've got four kids, and I know you mustn't want a fifth, so I'm going to fix you.'"

To read more on this topic:

An independent review of Indigenous-specific discrimination within B.C.'s health care system, commissioned by the government, which drew on the experiences of more than 9,000 Indigenous patients and health care workers, *In Plain Sight* concluded Indigenous people in B.C. are often exposed to widespread racism that, more often than not, results in negative experiences at the point of care, biased medical treatment, physical harm, and even death.



TIME TO SHIFT THE CONVERSATION AROUND CLIMATE CHANGE – HERE'S HOW

Dr. Courtney Howard, an emergency physician and a globally recognized expert on the impacts of climate change on health, wants to shift the conversation around climate change. She says one of the key lessons climate change activists drew from the COVID-19 pandemic is that they need a different approach; we need to drop the doom-and-gloom message and adopt a more empowering one.

The messaging around COVID-19 was particularly successful, Howard said, because it brought together subject matter experts and politicians – and it told Canadians that they could be part of the solution. The message was clear: if you do these things – wear a mask, stay home, wash your hands – we can turn this around. We're all in this together.

"We only have so much mental health energy to deal with bad news in a given day," explained Howard. For that reason, climate scientists need to move away from the disaster message and focus instead on a new message: the "let's do this cool thing" message, as Howard puts it.

The COVID-19 pandemic was dire enough to quickly galvanize and mobilize a global community. It's the kind of action climate advocates wish they could see take place on the global stage when it comes to tackling man-made climate change.

Despite repeated warnings from the scientific community, addressing climate change has all too often gotten the kick-the-can-down-the-road treatment. It was an existential threat, but a distant one. And until recently, as Howard pointed out, our population had never lived through a global crisis.

"Now, everybody knows what a crisis feels like and is a lot more highly motivated to avoid the future crises that they're now much more able to envision."

From her home in Yellowknife, Howard has seen first-hand the climate crisis unfold. In 2014, when her youngest child was just one year old, the region was engulfed by wildfire smoke due to unusually warm and dry weather. After braving an especially cold winter, residents of Yellowknife were asked to spend almost two and a half months of the summer indoors because the outdoor air quality was so poor.

"I was just thinking: 'Wow, what is this doing to all these kids' lungs?'"

That question prompted Howard and her colleagues to look at how the 2014 wildfires had affected her local community. They found that emergency department visits for asthma had doubled over those summer months.

"When I do media interviews around wildfires, almost every single time, I get the question: 'Dr. Howard, is this the new normal?' And every single time I have to say: 'No, it's going to get worse.'"

The World Health Organization considers air pollution a "major environmental risk to health". According to the 2020 World Health Statistics report, the WHO states that air pollution "caused about 7 million deaths in 2016, largely as a result of stroke, heart disease, chronic obstructive pulmonary disease, lung cancer and acute respiratory infections." For its part, the Government of Canada estimates that air pollution contributes to 15,300 premature deaths per year.

> ***"What our movement has, however, is people."***

And, of course, air pollution is but one health concern when it comes to climate change. With rising temperatures and increased flooding, climate change can lead to the proliferation of infectious agents such as such as dengue, malaria, hantavirus, salmonellosis, cholera and giardiasis. It also increases the likelihood of future pandemics.

"Most new infectious diseases have originated at the human-animal interface as a result of zoonotic spillover events," explained Howard. "For that to happen, you need humans, animals and vectors in close proximity – and novel proximity."

"That's what climate change does: the habitat is changing, the temperature and precipitation patterns are changing, and we may be destroying habitat as well. That's when these things happen."

"Climate change puts us at risk of future pandemics exactly like this one."

It's an important connection to make – and one that the medical community is well-positioned to speak to. Nurses, Howard noted, are among the most trusted people in our

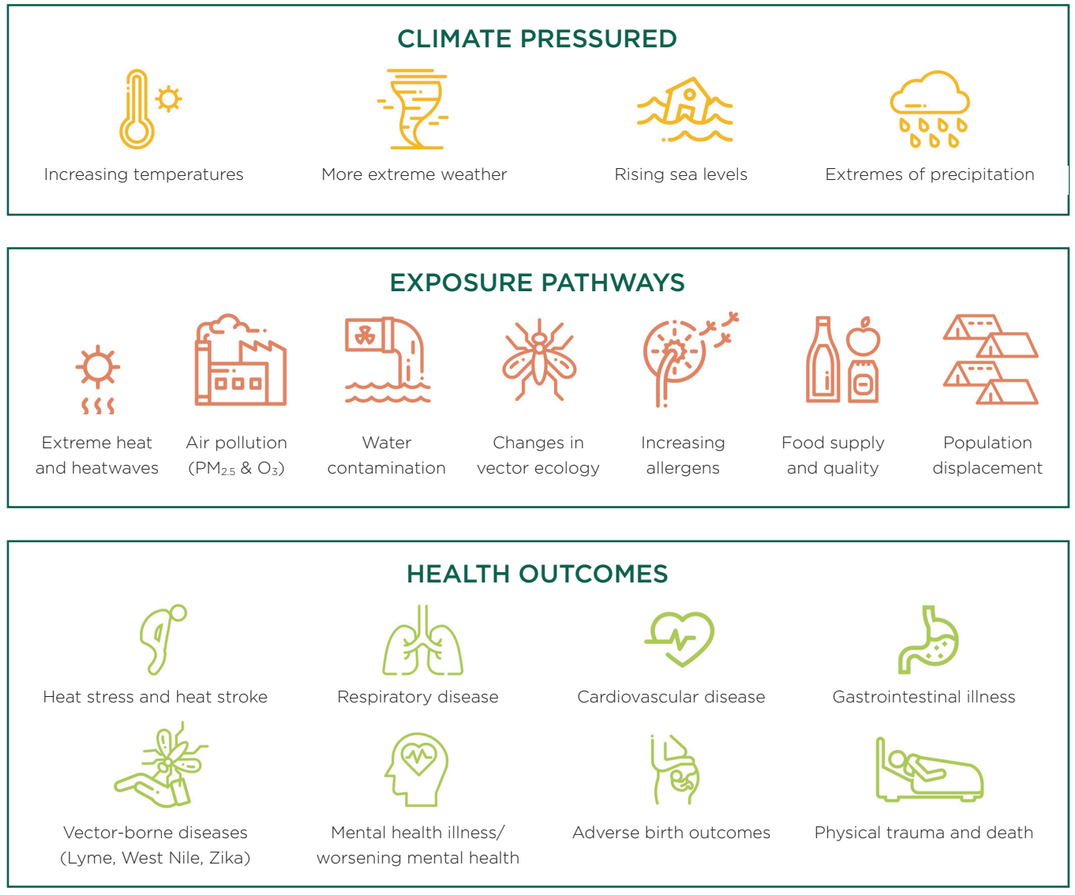
Dr. Courtney Howard

Dr. Courtney Howard is an Emergency Physician, a professor at the University of Calgary, and former president of the Canadian Association of Physicians for the Environment (CAPE). For years, Dr. Howard has led climate change-related policy and advocacy work, including the 2017-2019 *Lancet* Countdown on Health and Climate Change Briefings for Canadian Policymakers, and acting as International Policy Director for the Lancet Countdown in 2018. Working with the World Health Organization Civil Society Working Group on Climate Change and Health, Dr. Howard's advocacy, backed by a majority of the world's health professionals, helped launch a Healthy Recovery initiative calling on G20 leaders to focus on low-carbon investments.

society, regularly ranking in the top-3 most trusted professions. That's why nurses' voices are so desperately needed to make the connection between climate and health. Nurses have the power to move the conversation forward and galvanize support.

Howard said she used to spend a lot of time talking about the problem of climate change, but these days, she likes to tell the story of the coal power phase-out in Canada, which was accomplished largely as a result of advocacy by health care practitioners.

In Ontario, it started as a grassroots effort. In its report on Ontario's coal phase-out, the International Institute for Sustainable Development highlighted how the Ontario Clean Air Alliance started with just six people and came to encompass "90 groups comprising over 6 million Ontarians in health care, unions, environmental groups, faith groups and municipalities."



SOURCE: *Climate Change and Health*, 2019

That movement inspired health care practitioners across Canada and helped secure a national and international commitment. The Canadian and British environment ministers founded the Powering Past Coal Alliance, which is now catalyzing work in this area across the globe.

"You can see how iterative progress inspires other people," said Howard. "And we've done it. We know we can do it. And it was health messengers who led that."

From a mental health perspective, there's a rewarding feeling that comes from taking action, Howard explained. It not only helps us feel inspired, but it can help lessen our anxiety around climate change. And grassroots action is infectious: small wins build hope, and hope builds momentum.

When it comes to climate change, that people power is especially vital.

When the Canadian Centre for Policy Alternatives analyzed the lobbying efforts of the fossil fuel industry, it found 11,452 lobbying contacts with government over a seven-year period. According to the CCPA, the fossil fuel industry lobbied the federal government "at rates five times higher than environmental non-governmental organizations".

"We're getting completely outgunned from a communications and lobbying perspective," remarked Howard. "And that, I believe, is the biggest obstacle. What our movement has, however, is people ."

Howard envisions the impact nurses could make to counter fossil fuel lobbyists. She'd like to see nurses, armed with PowerPoint presentations and briefing notes, making appointments with their MP to expose the linkages between health and climate change – to hammer home why we desperately need bold action to protect the health of Canadians by combating man-made climate change.

"I don't think there would be a better way, in all of Canada, to move the ball on this issue," she concluded.

"I've worked with nurses a long time; I do what nurses say."

To read more on this topic:

Climate Change and Health sets out concrete steps and actions that nurses can take to act on climate change. Nurses know that patient health is closely tied to the patient's environment. The paper lays out the major challenges ahead for health care and humanity as average temperatures continue to rise. It urges nurses to recognize the impacts of climate change on health and how we all must do more to reduce our impact on the planet, and prepare for the challenges ahead.

NURSES "ON THE RIGHT SIDE OF SCIENCE AND HISTORY" IN RESPONSE TO PANDEMIC

Mario Possamai

Mario Possamai served as Senior Advisor to Justice Archie Campbell, who headed Ontario's SARS Commission into the 2003 Ontario outbreak. Possamai led the Commission's investigations into health care worker safety issues and pandemic planning. For decades, Possamai has also led investigations into complex money laundering, corruption and fraud in North America, Europe, Africa, Asia and Australia. His work has assisted in the civil recovery of millions of dollars in stolen assets. More recently, Possamai testified as an expert witness before the House of Commons Standing Committee on Health about the health implications of COVID-19, and has served as an occupational health and safety advisor.

On January 26, 2020, before many of us could even contemplate what COVID-19 had in store for us, Mario Possamai says he received a call from a friend at the U.S. Centers for Disease Control and Prevention.

"This is it; we're in for it," the caller said.

As the former senior advisor to the SARS Commission, Possamai immediately jumped into action. He implored the government to follow the precautionary principle – a key lesson from Canada's experience with SARS. The precautionary principle holds that in the absence of scientific certainty about how an illness is spread, we must err on the side of caution.

"I know that Linda Silas and the CFNU provincial leadership made the same request repeatedly," said Possamai. "But, we weren't listened to, and it is tragic."

Failure to follow the precautionary principle meant that, for many months, the government's advice revolved primarily around the droplet theory: the notion that COVID-19 typically spreads through large droplets (expelled when a person coughs or sneezes) that rapidly fall to the ground.

It would be many months before a scientific consensus emerged and recognized that the virus could be transmitted through aerosols: smaller respiratory droplets that are produced when a person breathes or talks. These aerosols can linger in the air for minutes – even hours. This meant that those working indoors and at close range with infected persons were particularly at risk of inhaling virus-laden particles. Finally, in November 2020, after tens of thousands of health care workers had already contracted COVID-19, the Canadian government quietly acknowledged the potential for aerosol spread.

"It happened during SARS and it happened during COVID-19: the expertise and perspective of nurses were sidelined"

"One of the tragedies for Canada is that the public health leadership has been on the wrong side of history and on the wrong side of science," said Possamai. They based their guidelines and their approach on outdated science – on the [large] droplet theory, which is based on 1930s research. And they've been closed-minded about airborne transmission and the precautionary principle."

Most pernicious of all, said Possamai, was that those who called for the precautionary principle were not only dismissed but attacked.

In May 2020, Possamai was quoted alongside Ontario Nurses' Association President Vicki McKenna in a *Toronto Star* article in which they advocated for a precautionary approach and a wider use of N95 respirators. Days later, the Toronto Star published a scathing response from a group of infectious disease specialists.

"They accused us of throwing gasoline to the fire," recalled an exasperated Possamai. "It was so personal. And so lacking in empathy and openness."

The authors not only maintained that COVID-19 was "almost exclusively spread via droplets", they suggested that Possamai and McKenna had been promoting "unfounded conspiracy theories". They called the original article "irresponsible and a serious risk to public health".

This behaviour, Possamai explained, was emblematic of what he calls the "medical orthodoxy": the experts simply couldn't fathom the idea that they might be wrong. This attitude also severely impeded the adoption of a

CANADA VS SARS PEERS
HEALTH CARE WORKER INFECTIONS
FOLLOWING THE FIRST WAVE OF COVID-19 (JULY 2020)

CANADA	ASIA
19.4% of all COVID-19 cases (21,842 health care workers infected)	**China:** 4.4% of all COVID-19 cases
2 times the global rate (WHO)	**Hong Kong:** 5 health care workers infected
	Taiwan: 3 health care workers infected

SOURCE: *A Time of Fear*, 2020

precautionary approach.

Meanwhile, our counterparts in nations that also had experienced SARS in 2003 were quick to ramp up protection. For example, when China saw a rapid rise in health care workers' infections, they recognized that droplet precautions weren't effective against this new pathogen and quickly moved to airborne precautions.

Possamai points to warnings from Chinese experts, published in *The Lancet* as early as February 2020, which warned the global medical community to use "aggressive measures (such as N95 masks, goggles and protective gowns)" to protect health care workers "especially in the initial stages where limited information about the transmission and infective potency of the virus is available."

These early warnings went unheeded – as did similar warnings about asymptomatic transmission.

"The subtext was that our Western experts know better than the Chinese experts," explained Possamai. "There's was an element of bigotry and Western exceptionalism – and it really hurt us."

"At a time when we're really beginning to look at systemic racism in our society, we also need to look at the systemic racist attitudes that pervade some elements of medicine and public health, where we disregard the expertise of Asians, for example. It's an ugly part of Western medicine, but we really need to confront it."

Humility, Possamai contends, is a quality often missing in medicine – and one that the medical community urgently needs to adopt to be better prepared for the next pandemic.

In recent decades, the world has had to grapple with a decades-long HIV epidemic and outbreaks of SARS, MERS, H1N1 and Ebola. Even as we battle COVID-19, experts agree that the next pandemic isn't too far behind. To be better prepared, Possamai stressed that Canada needs its own federal agency tasked with occupational health and safety – an agency modelled after the National Institute for Occupational Safety and Health in the United States.

"We really need to have our own NIOSH in Canada – we need to have a place where not just infectious disease [experts] and epidemiologists control the agenda, but we bring occupational engineers, occupational hygienists, aerosol experts, health care workers and nurses around the table to deal with issues like how to protect health care workers – how to protect all of us."

When it comes to protecting workers, Possamai feels that nurses are especially attuned to the precautionary principle. He points to Florence Nightingale, who advocated for a precautionary approach by implementing hand washing and other hygiene practices well before the germ theory of disease was firmly established.

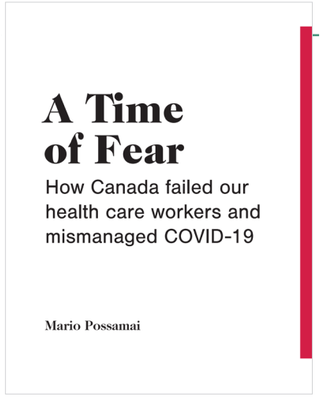
"It happened during SARS and it happened during COVID-19: the expertise and perspective of nurses were sidelined," concluded Possamai. "During SARS, nurses were on the right side of science and history."

During COVID-19, something similar happened. As nurses saw the evidence of aerosol transmission grow – and as they pleaded for the proper PPE to protect themselves – their concerns were dismissed.

"It breaks my heart to realize the position this put nurses in – who know better – who knew better than the [health] authorities about what was going on and what needed to be done to protect themselves, their patients and their residents."

"Government and public health leaders had opportunity after opportunity to follow the precautionary principle and change course — but they didn't. They should be held accountable. The victims of COVID-19 and their families deserve nothing less."

To read more on this topic:
A Time of Fear, an independent investigation into Canada's management of COVID-19 and the safety of the nation's health care workers, details Canada's experience during the first wave. The investigation delineates Canada's systemic preventable failure to adequately prepare and urgently respond to the gravest public health emergency in a century. The findings highlight major flaws in Canada's approach to public health, and a dangerous and irresponsible outlook on worker safety in response to the pandemic.



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CANADIAN FEDERATION OF NURSES UNIONS

We are Canada's nurses.

We represent close to 200,000 frontline care providers and nursing students working in hospitals, long-term care facilities, community health care and our homes. We speak to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis, and First Nations people that call this land home. The Canadian Federation of Nurses Unions is located on the traditional unceded territory of the Algonquin Anishnaabeg people. As settlers and visitors, we feel it's important to acknowledge the traditional custodianship of these lands, which we each call home. We do this to reaffirm our commitment and responsibility in improving relationships between nations, to work towards healing the wounds of colonialism and towards improving our own understanding of local Indigenous peoples and their cultures.

CFNU – Canadian Federation of Nurses Unions / La Fédération canadienne des syndicats d'infirmières et infirmiers

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Nova Scotia Nurses Union

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