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Health Services, Management and Policy Research
Services de santé, gestion et recherche de politique

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Data Matters • *Discussion and Debate* • *Research Papers*

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Healthcare Policy/Politiques de Santé seeks to bridge the worlds of research and decision making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision makers.

We publish original scholarly and research papers that support health policy development and decision making in spheres ranging from governance, organization and service delivery to financing, funding and resource allocation. The journal welcomes submissions from researchers across a broad spectrum of disciplines in health sciences, social sciences, management and the humanities and from interdisciplinary research teams. We encourage submissions from decision makers or researcher–decision maker collaborations that address knowledge application and exchange.

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Politiques de Santé/Healthcare Policy cherche à rapprocher le monde de la recherche et celui des décideurs en présentant des travaux de recherche, des analyses et des renseignements qui s'adressent aux deux auditoires. Ainsi donc, nos processus rédactionnel et d'examen des manuscrits font intervenir à la fois des chercheurs et des décideurs.

Nous publions des articles savants et des rapports de recherche qui appuient l'élaboration de politiques et le processus décisionnel dans le domaine de la santé et qui abordent des aspects aussi variés que la gouvernance, l'organisation et la prestation des services, le financement et la répartition des ressources. La revue accueille favorablement les articles rédigés par des chercheurs provenant d'un large éventail de disciplines dans les sciences de la santé, les sciences sociales et la gestion, et par des équipes de recherche interdisciplinaires. Nous invitons également les décideurs ou les membres d'équipes formées de chercheurs et de décideurs à nous envoyer des articles qui traitent de l'échange et de l'application des connaissances.

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EDITORIAL

From Talking to Action: Changing Healthcare in Provinces and Territories

There is no doubt that healthcare systems in Canada's provinces and territories are under duress – staffing problems, costly technology adoptions and barriers to accessing care are endemic. Among those who are already ill, the systems' problems create frustration, anxiety and even unchecked disease progression for some people. The worst instances are seen in the media almost daily; the result is an erosion of trust among the Canadian public who had been assured that high-quality medically necessary services would be accessible when needed.

There is enough blame to go around for why things are the way they are.

Looking forward, the volume and vigour of repeated calls for federal, provincial and territorial governments to respond to the crises are hard to ignore. Some are calling for more privately funded options, some are calling for more privately delivered for-profit healthcare and some are calling for both, using the common refrain that the publicly funded system is stretched so thin that it is beyond repair. In contrast, the global evidence base regarding health system structures finds that the presence of privately funded or privately delivered healthcare does not fix these problems (Bambra et al. 2014; Crampton et al. 2005; Footman et al. 2014; Goodair and Reeves 2024; Lee et al. 2021; Longhurst and McGregor 2016).

Before throwing the baby out with the bathwater in terms of publicly funded healthcare, provinces and territories should adopt evidence-based interventions that have been shown to improve staffing and increase access and quality. Fortunately, the amount of public spending on healthcare is high and money is not the problem – Canada is a high-spender on healthcare – it is a question of how funds are spent and on whose services.

The federal government and provinces should be taking action and thankfully, there is much that can be done to improve publicly funded healthcare.

Set the Vision

The quadruple or quintuple aim provides a reasonable framework for prioritizing actionable reforms (Nundy et al. 2022; Sikka et al. 2015). The aim's focus on improving population

health, reducing costs, improving experiences and improving healthcare provider's well-being provides a balance between competing initiatives and a roadmap regarding where to begin. Adoption and commitment to furthering the aims will improve Canadians' health and their healthcare systems. To do so means setting a long-term vision, such as the one being done in England, a similarly publicly funded health system (NHS 2019). Canadian healthcare systems need a long-term vision to orient efforts to address underlying problems – instead of "issues management"-led and reactive policies.

Focus on Population Health

Provincial and territorial governments should set targets for population health and prioritize linking the social determinants of health with health status. Our governments should establish clear lines of authority and accountability for population health with appropriate incentives and consequences for underachievement. They also need to allow health systems to budget across fiscal years and assume responsibility for planning and executing strategic efforts.

The basket of publicly insured services outside the remit of the *Canada Health Act* (1985) needs to be updated. Many Canadians are not able to pay for needed services, therapies or devices to improve their health and well-being. Provincial and territorial governments should expand the scope of the *Canada Health Act* (1985) or provide extended health benefit insurance to all Canadian families, including access to mental healthcare and better aging-in-place strategies for seniors.

Slow Growth or Reduce Cost

Health spending is almost one-half of provincial budgets in many provinces and territories. It is imperative to long-term sustainability that growth in healthcare spending slows. Reduce avoidable care by improving access to team-based care. Eliminate spending on ineffective care; for instance, do not pay for ineffective services and therapies highlighted by Choosing Wisely Canada.

There are unacceptably wide variations in cost efficiency, quality and health status across the country. The federal government should set national targets similar to those of Australia's Productivity Commission to reduce variability in healthcare, improve value from spending and support communities most in need (Productivity Commission 2024).

Provincial and territorial governments should align payment methods with population health goals. Payment methods are powerful incentives; use fee for service when increasing throughput is the objective. Governments and healthcare providers should be transparent in their financial transactions so as to improve the assessment of value for money. Where possible, collect health outcomes and the costs associated with achieving the outcomes.

Improve Experience

Governments and healthcare providers should use legislative and regulatory mechanisms to

ensure interoperable electronic medical records (EMRs) between settings and sectors. They should use EMRs to reduce duplicate tests or images and appropriately fund telehealth and virtual care for patients for whom it works effectively.

Our governments need to mandate evidence-based practices of centralized waitlists and triaging processes for reducing wait times to see a specialist and receive treatment. Evidence-based clinical pathways should be adopted across settings, providers and time. They should expand efforts to collect information regarding care experiences and incorporate findings into practice and policy.

Improving Healthcare Providers' Well-Being

Initiatives that improve providers' health and well-being, including mental health services and exercise-based interventions, should be measured and supported. Barriers to interprovincial licensure and scopes of practice need to be reduced. Cost-effective care innovations such as Enhanced Recovery After Surgery (ERAS) in acute settings need to be adopted and patients' perspectives must be incorporated into reforms.

A Laundry List of Things to Do

The public should not have to get into the weeds or micromanage health systems. The public should expect that the government hires the most capable and effective managers and strategists to get the most bang for their buck in terms of improving their provinces' health, reducing cost growth and improving experiences with healthcare and providers' well-being. It is critical that Canadians stop being so patient with governments' health sector leaders. The public needs governments and their managers to act quickly and adopt meaningful reforms before trust is irrevocably damaged.

In This Issue

This issue begins with a Discussion and Debate article that focuses on the expansion of medical assistance in dying (MAiD). The authors describe bioethical, philosophical and practical issues associated with advance requests for MAiD (ARM) (Espericueta 2025) and explore other jurisdictions' use of ARM. The article concludes that competent professionals and trusted persons need to be involved as safeguards in order for ARM to be effectively implemented.

A rejoinder by Cattell and Mack (2025) extends the preceding article's discussion of ethical issues associated with the expansion of MAiD. The authors highlight that some reversible trajectories of health status create uncertainties associated with not being able to meet the standard of informed consent. The rejoinder concludes that, in the context of the patient with dementia, additional legislation is needed to protect patients, their surrogates and healthcare providers from adverse effects of ARM.

This issue's second Discussion and Debate article expresses that there are more challenges than ever to the *Canada Health Act* (1985). The article points out that the *Canada*

Health Act (1985) was not able to predict all of the variations in healthcare delivery modalities or technology advancements that led to unexpected private and out-of-pocket payments for needed medical treatment or access to technologies (Milinkovic and Hurley 2025). The authors propose that a multi-pronged approach by provinces for better policy responses, new regulations and more comprehensive data collection is needed to maintain equity and access to healthcare.

A rejoinder to the preceding Discussion and Debate article concurs that privatization of provinces' healthcare delivery systems will not remedy provinces' healthcare systems woes. The rejoinder proposes that provincial health systems have the opportunity to arrest the erosion of their public health systems by focusing on improving the efficiency and effectiveness of their current systems and reducing interprovincial variations in utilization and spending (Duckett 2025).

This issue of *Healthcare Policy* includes a Data Matters article. The article focuses on methods for creating a single list of essential medicines to serve as the basis for a national universal pharmacare program (Murphy et al. 2025). The article synthesizes lists in order to generate a list of medicines recommended for a Canadian essential medicines list.

The impact of federal advisory bodies on health and healthcare is unclear. This issue's first research manuscript uses qualitative methods to identify factors associated with the implementation of healthcare advisory bodies' recommendations (Quinn et al. 2025). The study concluded that advisory bodies often wielded influence inside and outside government but participants perceived that their recommendations were often not implemented by the federal government.

This issue's concluding research manuscript measures temporal changes in healthcare workers' protest events. The results found that protest events were most often attributable to compensation-related issues and vaccination mandates (Sriram et al. 2025). The authors conclude that there are a myriad of issues expressed by Canadian healthcare workers and there are no one-size-fits-all solutions to address healthcare workers' concerns.

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De la parole aux gestes : transformer les soins de santé dans les provinces et les territoires

Il ne fait aucun doute qu'au Canada, les systèmes de santé des provinces et des territoires sont sous pression : les problèmes de dotation, les adoptions coûteuses de technologies et les obstacles à l'accès aux soins sont endémiques. Pour ceux qui sont aux prises avec la maladie, ces problèmes créent de la frustration et de l'anxiété et causent même, chez certains, une progression incontrôlée de la maladie. Les pires cas paraissent dans les médias presque tous les jours. Il en résulte une érosion de la confiance du public canadien, à qui on avait assuré que des services médicalement nécessaires de haute qualité seraient accessibles quand ils en auraient besoin.

Il y a plusieurs mauvaises raisons pour lesquelles les choses sont comme elles sont.

Il est difficile d'ignorer le volume et la vigueur des appels lancés aux gouvernements fédéral, provinciaux et territoriaux pour qu'ils réagissent face aux situations de crise. Certains réclament une plus grande part pour le secteur privé, d'autres plus de soins de santé privés à but lucratif, ou encore les deux à la fois; on répète souvent que le système subventionné par l'État est tellement étiré qu'il en est devenu irréparable. En revanche, la base de données mondiales concernant les structures des systèmes de santé permet de conclure que la présence de soins de santé financés par le secteur privé ou dispensés par celui-ci ne règle pas les problèmes (Bambra et al. 2014; Crampton et al. 2005; Footman et al. 2014; Goodair et Reeves 2024; Lee et al. 2021; Longhurst et McGregor 2016).

Avant de jeter le bébé avec l'eau du bain, en ce qui concerne les soins de santé financés par les fonds publics, les provinces et les territoires devraient adopter des interventions fondées sur les données probantes et qui se sont avérées efficaces pour améliorer la dotation en personnel ainsi que l'accès aux soins et leur qualité. Heureusement, le montant des dépenses publiques consacrées aux soins de santé est élevé et l'argent n'est pas le problème – le Canada dépense beaucoup pour les soins de santé –, il s'agit plutôt de savoir comment les fonds sont dépensés et pour quels services.

Le gouvernement fédéral et les provinces doivent prendre des mesures et, heureusement, il y a beaucoup de place pour l'amélioration dans les soins de santé financés par l'État.

Définir la vision

Le quadruple ou quintuple objectif fournit un cadre raisonnable pour hiérarchiser les réformes réalisables (Nundy et al. 2022; Sikka et al. 2015). L'accent mis sur l'amélioration de la santé de la population, sur la réduction des coûts, sur l'amélioration de l'expérience et sur l'amélioration du bien-être des fournisseurs de soins de santé permet d'assurer l'équilibre entre des initiatives concurrentes et une feuille de route quant à savoir par où commencer. L'adoption et l'atteinte de ces objectifs seront bénéfiques pour la santé des Canadiens et permettront d'améliorer les systèmes de santé. Pour ce faire, il faut établir une vision à long terme, comme celle de l'Angleterre qui possède un système de santé similaire financé par l'État (NHS 2019). Au Canada, les systèmes de santé doivent se doter d'une vision à long terme pour orienter les efforts visant à résoudre les problèmes sous-jacents, plutôt que de mettre en place des politiques réactives axées sur la « gestion des problèmes ».

Accent sur la santé de la population

Les gouvernements provinciaux et territoriaux devraient fixer des cibles pour la santé de la population et établir un lien entre les déterminants sociaux de la santé et l'état de santé. Les gouvernements devraient établir des lignes de responsabilité claires en matière de santé de la population, avec des mesures d'incitation et des conséquences appropriées pour les résultats médiocres. Ils doivent également permettre aux systèmes de santé d'établir un budget pour l'ensemble des exercices financiers et d'assumer la responsabilité de la planification et de l'exécution des efforts stratégiques.

Il faut mettre à jour l'ensemble des services assurés par le secteur public qui ne relèvent pas de la *Loi canadienne sur la santé* (1985). De nombreux Canadiens ne sont pas en mesure de payer les services, les thérapies ou les appareils dont ils ont besoin pour améliorer leur santé et leur bien-être. Les gouvernements provinciaux et territoriaux devraient élargir la portée de la *Loi canadienne sur la santé* (1985) ou offrir des prestations d'assurance maladie étendues à toutes les familles canadiennes, notamment l'accès aux soins de santé mentale et de meilleures stratégies pour que les aînés puissent vieillir à domicile.

Croissance lente ou réduction des coûts

Les dépenses de santé représentent près de la moitié des budgets provinciaux dans plusieurs provinces et territoires. Il est impératif de freiner leur croissance afin d'assurer la durabilité à long terme. Réduire les soins évitables en améliorant l'accès aux soins en équipe. Éliminer les dépenses consacrées aux soins inefficaces; par exemple, ne pas payer pour des services et des thérapies inefficaces, tel que dévoilé par Choisir avec soin.

Il existe des écarts inacceptables en matière de rentabilité, de qualité et d'état de santé dans l'ensemble du pays. Le gouvernement fédéral devrait fixer des objectifs nationaux, semblables à ceux de la Commission de productivité australienne, pour réduire la variabilité dans les soins de santé, améliorer le rendement des dépenses et soutenir les collectivités qui en ont le plus besoin (Productivity Commission 2024).

Les gouvernements provinciaux et territoriaux devraient harmoniser les méthodes de paiement avec les objectifs en matière de santé de la population. Les méthodes de paiement sont de puissants incitatifs; utiliser les frais de service lorsque l'objectif est d'augmenter le débit de traitement. Les gouvernements et les prestataires de soins de santé devraient être transparents dans leurs transactions financières afin d'améliorer l'évaluation du rapport qualité-prix. Dans la mesure du possible, il faudrait recueillir les résultats en matière de santé et les coûts associés à l'atteinte de ces résultats.

Améliorer l'expérience

Les gouvernements et les fournisseurs de soins de santé devraient utiliser des mécanismes législatifs et réglementaires pour assurer l'interopérabilité des dossiers médicaux électroniques (DME) entre les établissements et les secteurs. Ils devraient mettre à profit les DME pour réduire la duplication des tests ou des images médicales et ils devraient financer de manière appropriée la télésanté et les soins virtuels pour les patients chez qui ce type de soins est efficace.

Nos gouvernements doivent imposer des pratiques fondées sur les données probantes pour les listes d'attente centralisées et pour les processus de triage afin de réduire les temps d'attente pour consulter un spécialiste. Il faut adopter des trajectoires de soins fondés sur les données probantes provenant de tous les types de milieux, de fournisseurs et de périodes de temps. Le gouvernement devrait intensifier ses efforts pour recueillir des renseignements sur l'expérience en matière de soins et intégrer les résultats dans la pratique et les politiques.

Améliorer le bien-être des professionnels de santé

Les initiatives qui améliorent la santé et le bien-être des fournisseurs, y compris les services de santé mentale et les interventions axées sur l'exercice physique, devraient être mesurées et préconisées. Il faut réduire les obstacles à l'obtention d'un permis interprovincial et aux champs de pratique. Il faut adopter des innovations en matière de soins rentables, comme le programme de récupération optimisée après une chirurgie (ERAS) dans les milieux de soins de courte durée, et intégrer les points de vue des patients dans les réformes.

Liste de choses à faire

Le public ne devrait pas avoir à s'occuper de la microgestion dans les systèmes de santé. Le public s'attend à ce que le gouvernement embauche les gestionnaires et les stratèges les plus compétents pour tirer le meilleur parti de l'argent en améliorant la santé des provinces, en réduisant l'augmentation des coûts et en améliorant l'expérience des soins de santé ainsi que le bien-être des fournisseurs de soins.

Il est essentiel que les Canadiens cessent de se montrer aussi patients envers les dirigeants gouvernementaux du secteur de la santé. Les gouvernements et les gestionnaires doivent agir rapidement et adopter des réformes significatives s'ils veulent éviter que la confiance de la population ne soit irrévocablement ébranlée.

Dans ce numéro

Le présent numéro s'ouvre avec un article de la section Discussions et débats sur l'expansion de l'aide médicale à mourir (AMM). Les auteurs décrivent les questions bioéthiques, philosophiques et pratiques associées aux demandes anticipées d'AMM (Espericueta 2025) et explorent l'utilisation de l'AMM dans d'autres États. L'article conclut que des professionnels compétents et des personnes de confiance doivent être impliqués pour que les demandes anticipées d'AMM soient effectivement mises en œuvre.

Une réplique à cet article, par Cattell et Mack (2025), prolonge la discussion sur les questions éthiques associées à l'expansion de l'AMM. Les auteurs soulignent que certaines trajectoires réversibles de l'état de santé peuvent donner lieu à des incertitudes quant au respect de la norme du consentement éclairé. La réplique conclut que, dans le contexte d'un patient atteint de démence, une législation supplémentaire est nécessaire pour protéger les patients, leurs mandataires et les fournisseurs de soins de santé contre les effets indésirables de la demande anticipée d'AMM.

Le deuxième article de la section Discussions et débats indique que la *Loi canadienne sur la santé* (1985) fait face à plus de défis que jamais. L'article souligne que la *Loi* n'a pas permis de prévoir toutes les variations des modalités de prestation des soins de santé, ou encore les avancées technologiques qui ont entraîné des paiements privés et directs inattendus pour un traitement médical nécessaire ou pour l'accès aux technologies (Milinkovic et Hurley 2025). Les auteurs arguent que pour maintenir l'équité et l'accès aux soins de santé, les provinces devront adopter une approche multidimensionnelle qui leur permette d'élaborer de meilleures réponses politiques, d'établir de nouveaux règlements et d'assurer une collecte de données plus complète.

Une réplique à cet article confirme que la privatisation des systèmes de prestation de soins de santé provinciaux ne remédiera pas aux problèmes. La réplique laisse entendre que les provinces pourraient stopper l'érosion des systèmes de santé publique en se concentrant sur l'amélioration de l'efficience et de l'efficacité des systèmes en place et sur la réduction des variations interprovinciales dans l'utilisation et les dépenses (Duckett 2025).

La section Questions de données du présent numéro de *Politiques de Santé* présente un article qui porte sur les méthodes pour dresser une liste unique de médicaments essentiels, laquelle servirait de base à un programme national universel d'assurance-médicaments (Murphy et al. 2025). L'article synthétise les listes déjà en place afin de produire une liste de médicaments recommandés pour une liste canadienne des médicaments essentiels.

L'impact des organismes consultatifs fédéraux en matière de santé et de soins de santé n'est pas clair. Le premier article de recherche du présent numéro a recours à des méthodes qualitatives pour cerner les facteurs associés à la mise en œuvre des recommandations des organismes consultatifs en matière de santé (Quinn et al. 2025). L'étude conclut que ces organismes exercent souvent une influence à l'intérieur et à l'extérieur du gouvernement, mais les participants indiquent que leurs recommandations ne sont pas souvent mises en œuvre par le gouvernement fédéral.

Le dernier article de recherche de ce numéro mesure les changements temporels dans les mouvements de protestation des travailleurs de la santé. Les résultats révèlent que les mouvements de protestation étaient le plus souvent attribuables à des questions liées à la rémunération et aux mandats de vaccination (Sriram et al. 2025). Les auteurs concluent qu'il existe une myriade de problèmes exprimés par les travailleurs canadiens de la santé et qu'il n'y a pas de solution universelle pour répondre à leurs préoccupations.

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Advance Requests for Medical Assistance in Dying in the International Context: Some Legal Issues for the Canadian Case

Demandes anticipées d'aide médicale à mourir dans le contexte international : enjeux juridiques pour le Canada

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Abstract

An advance request for medical assistance in dying (MAiD) (ARM) is a document that allows individuals to request euthanasia if they lose their decision-making capacity. Currently, it is available in all countries where MAiD is permitted for individuals suffering from a serious and incurable illness whose natural death is not reasonably foreseeable, except in Canada. In this country, various citizen and parliamentary initiatives are considering the inclusion of this document in national legislation. This article presents for the first time a compilation of all ARM regulations worldwide. Analysis of the international framework suggests that the requirements for drafting an ARM could influence the effective implementation of patients' wishes.

Résumé

La demande anticipée d'aide médicale à mourir (AMM) est un document qui permet aux personnes de demander l'euthanasie si elles perdent leurs capacités décisionnelles. Actuellement, cette mesure est disponible dans tous les pays où l'AMM est autorisée pour les personnes atteintes d'une maladie grave et incurable dont la mort naturelle n'est pas raisonnablement prévisible, sauf au Canada. Dans ce pays, diverses initiatives citoyennes et parlementaires envisagent l'inclusion de ce document dans la législation nationale. Cet article présente pour la première fois une compilation de l'ensemble des réglementations concernant la demande anticipée d'AMM dans le monde. L'analyse de ce contexte international laisse croire que les exigences

relatives à la rédaction d'une demande anticipée d'AMM pourraient influencer la mise en œuvre efficace de ce que souhaitent les patients.

Introduction

Medical assistance in dying (MAiD) has been legally allowed in Canada since 2016. Over the past eight years, this medical practice has undergone continuous modifications through court rulings and legislative amendments (Downie 2022). Initially, it was available only to individuals whose death was reasonably foreseeable, but it has since been extended to those not facing imminent death but experiencing severe suffering.

In this context, one of the most debated changes was the amendment allowing persons suffering solely from a mental disorder to be eligible for MAiD (MAiD MD-SUMC), although its implementation has been postponed to 2027. Nevertheless, this recent expansion of criteria for MAiD contrasts with the legal impossibility of using advance requests for its application. This discrepancy is particularly notable when we consider that some may view the use of advance requests for MAiD (ARM) as less controversial. For example, a 2021 survey of Canadians found that 17% of respondents opposed the use of ARM, while 35% were against the implementation of MAiD MD-SUMC, which is double (IPSOS 2021). Support for ARM was also reflected in a 2015 survey, in which 62% of a representative sample of Canadians agreed, and 22% disagreed, that they should have access to MAiD if they suffer from advanced dementia and have an ARM outlining their desire for assisted death at that stage of the illness (EPOLRCC 2015).

An ARM is a document "created in advance of a loss of decision-making capacity, intended to be acted upon under circumstances outlined in the request after the person has lost decisional capacity" (The Expert Panel Working Group on Advance Requests for MAID 2018: 5). The use of this document is especially important in cases of severe dementia[1] and impaired consciousness. However, with the exception of Quebec[2], it is not permitted in Canada, as the law requires the patient to explicitly confirm their consent immediately before receiving MAiD. Only when a person is at risk of losing capacity and their natural death is reasonably foreseeable does the law allow them to waive final consent through a written agreement with their healthcare provider (Parliament of Canada 2021). It is notable that of the six countries in the world where euthanasia is currently practised without the requirement of terminal illness, only Canada does not permit the use of ARM.[3]

Although bioethical and philosophical issues are varied (Wijsbek and Nys 2022), some health professionals in Canada appear to support the legal use of ARM by patients with advanced dementia. According to a survey conducted in Vancouver, most dementia care specialists favour allowing ARM for these patients, although they express ethical and logistical concerns about its use (Nakanishi et al. 2021). There is also political interest in addressing the use of ARM safely. Senator Chantal Petitclerc's remarks during the second reading of *Bill C-7* are illustrative:

> It requires us to consider safeguards for two completely distinct acts that may be many years apart – the making of the document setting out the wish for MAID and the provision of MAID for a person who can no longer consent on the basis of the earlier document (Petitclerc 2020: 672).

For this reason, it is useful to examine the procedures followed in the six jurisdictions (the Netherlands, Belgium, Luxembourg, Colombia, Spain and Quebec) where access to ARM is permitted.

Who can draw up an ARM in other jurisdictions?

Regarding the profile of individuals, we found that two of the six jurisdictions studied allow minors to make an ARM. Specifically, the minimum age in the Netherlands is 16 (Law Bank 2002), while in Colombia, it is 14. In Colombia, however, this is only permitted if the minor has a "diagnosis of terminal illness or life-threatening condition" (Ministerio de Salud y Protección Social 2018). Once the individual reaches the age of 18, they must create a new document without diagnostic restrictions. In both Colombia and the Netherlands, MAiD is available for minors. In Spain, by contrast, the age of majority is required to complete an ARM. In some autonomous communities, emancipated minors or those aged 16 and over can make advance requests for situations outside of MAiD (BOE 2002). Nevertheless, MAiD is prohibited for minors throughout the country without exception (BOE 2021).

A different situation exists in Belgium, where an emancipated minor can make an ARM (Moniteur Belge 2002). However, regardless of age, an ARM applies only if the patient, in addition to suffering from a serious and incurable illness or injury, is in a state of irreversible unconsciousness according to current scientific knowledge. As a result, while Belgian law does not explicitly address the case of dementia, it indirectly excludes it. A similar situation occurs in Luxembourg, where an ARM can only be used when the patient has irreversibly lost consciousness (Ministre de la Santé et de la Sécurité sociale 2009). In Luxembourg, only adults, not emancipated minors, can complete this document. With respect to the province of Quebec, only individuals of legal age are allowed to make an ARM (Assemblée Nationale du Québec 2023).

Regarding the health status of the person, it is important to note that, with the exception of Quebec, no jurisdiction explicitly requires a prior diagnosis. This means that an ARM can be made by an individual who is not ill and can cover any scenario in which they wish to express their will. In contrast, Quebec law stipulates that, in order to complete an ARM, a person must suffer "from a serious and incurable illness leading to incapacity to give consent to care" (Assemblée Nationale du Québec 2023: 10).

In addition, although the ARM document must be in writing in all countries, the requirements for its preparation differ. In the Netherlands, for example, it is recommended that it be drawn up with the assistance of a medical professional (Supreme Court of the Netherlands 2020). In contrast, both Spain and Colombia offer three options: to formalize

the document in the presence of a notary, medical personnel or witnesses (in Spain, two or three depending on the region; in Colombia, two). Both countries have different criteria for witnesses concerning their relationship to the person signing the ARM. In Spain, witnesses cannot be related up to the second degree of kinship or affinity, nor can they have any economic relationship with the person. In Colombia, anyone can be a witness unless they have been disqualified by a court decision or have an economic or employment relationship with the person. In Belgium and Luxembourg, however, an ARM must be signed in the presence of two witnesses of legal age. In Belgium, "at least one of them will have no material interest in the death of the declarant" (Moniteur Belge 2002).

In Quebec, on the other hand, the law requires that a patient making an ARM be assisted by a competent professional during the drafting process. The ARM must then be formalized in the presence of either a notary or two witnesses. The witnesses must be of legal age and capable of giving informed consent.

How long is an ARM valid in other jurisdictions?

The validity of an ARM is unlimited in the Netherlands, Colombia, Spain, Belgium and Quebec. Nevertheless, it is important to note that, according to the Regional Euthanasia Review Committees (2022: 38), in the Netherlands, "the older the directive, the more doubt there may be as to whether it still reflects the patient's actual wishes." Meanwhile, in Colombia, as previously mentioned, an ARM made by individuals aged 14 to 18 must be replaced once they reach the age of majority. In Belgium, an ARM had to be renewed every five years until April 2, 2020. However, the "Loi du 15 mars 2020 visant à modifier la législation relative à l'euthanasie" (Moniteur Belge 2020) stipulates that ARMs issued after this date are valid indefinitely. Luxembourg is the only country where ARMs must be renewed every five years (Ministre de la Santé et de la Sécurité sociale 2009).

Who can invoke an ARM in other jurisdictions?

Once the person is in the situation described in the document, the procedure can vary significantly from country to country. In Spain and Colombia, there is no complete certainty about the effective implementation of an ARM. Indeed, depending on how the document is signed, there may be unforeseen complications if the patient is unable to indicate the existence of an ARM. For example, a document formalized in front of witnesses would rely on one of them delivering it to a physician in time. Similarly, if it were notarized, it would be essential for the patient to have informed someone of its existence so that it could be retrieved and presented in a timely manner. Therefore, since it is not mandatory to register the ARM or include it in the patient's medical record nationwide, the proper fulfilment of the patient's wishes would depend on various circumstances. As a result, the regulations in these countries do not provide sufficient certainty regarding who can invoke the existence of an ARM.

In Belgium and Luxembourg, an ARM must be completed in the presence of two witnesses. The laws emphasize that one or more "trusted persons" can be designated when

drafting the document to communicate the patient's wishes to the attending physician. Belgian law also suggests that it is preferable to designate several persons and rank them in order of preference. In this way, "each trusted person replaces the one who precedes them in the declaration in the event of refusal, incapacity, disability, or death" (Moniteur Belge 2002). It should also be noted that Belgium explicitly prohibits doctors familiar with the patient's case from being designated as a "trusted person." Only in Luxembourg does the law require that an ARM be registered with the *Commission Nationale de Contrôle et d'Évaluation*. Any doctor treating a patient in a medical situation eligible for MAiD under the law must consult this register.

In the Netherlands, in cases where the ARM is prepared with the attending physician, it is understood that this document will be included in the patient's medical record. This helps avoid unnecessary delays and intermediaries that could compromise the effectiveness of the ARM. In addition, it is recommended that the document be prepared with the involvement of someone close to the patient and that the patient communicates their wishes to their family (KNMG 2021). This safeguard ensures that the patient's trusted persons can verify that the medical staff appropriately carries out the patient's wishes in a timely manner.

In Quebec, the law requires that all ARMs be recorded by the professional assisting the patient or by the notary in a register established by the ministry of health (Assemblée Nationale du Québec 2023). In addition, the law recognizes the role of trusted persons, who are not permitted to serve as witnesses at the same time. These provisions serve as safeguards, allowing both professionals and individuals close to the patient to invoke an ARM in a timely manner.

What events trigger an ARM in other jurisdictions?

Finally, concerning the elements justifying the activation of an ARM, in Belgium and Luxembourg, it is the irreversible loss of consciousness. In the Netherlands and Colombia, it is the finding of unbearable suffering in the patient – which may exclude cases where the person with dementia appears happy (Asscher and van de Vathorst 2020). Whereas in Spain, it must be proven that the patient has limitations in his physical autonomy and ability to relate to others as well as constant physical or psychological suffering (BOE 2021). In Quebec, on the other hand, the law specifies that the patient must be incapable of giving consent to care due to a serious and incurable illness. In addition, the patient must consistently exhibit the clinical manifestations related to their illness described in the request; be in a state of advanced, irreversible decline in capability; and experience, in the judgement of the competent professional, "enduring and unbearable physical or psychological suffering that cannot be relieved under conditions considered tolerable" (Assemblée Nationale du Québec 2023: 16).

What advice can we draw from international framework?

Since the question of allowing MAiD for minors is under consideration in Canada (Comité mixte spécial sur l'aide médicale à mourir 2023), it would be important for the country to determine the minimum age required to sign an ARM and to develop appropriate safeguards

if this right is extended to this population. In addition, legislators must carefully consider whether to require a specific health condition to draw up an ARM, as is the case in Quebec, which contrasts with international practices. In this context, the possibility of making an ARM without a prior diagnosis is a controversial issue, as there are concerns about an individual's ability to accurately project current preferences onto future events or situations (van den Bosch et al. 2021).

Another essential point will be specifying the appropriate way of signing an ARM and the individuals involved. There are at least four models for policy makers to consider: the Hispanic–American model, which we consider to be less protective; the Belgian–Luxembourg model, which reduces uncertainty by clearly defining the roles of the witnesses and trusted persons involved in the effective implementation of the ARM (Luxembourg, in particular, provides a key safeguard by establishing a dedicated ARM register); the Dutch model; or the Québécois model, which incorporates several of the safeguards of the other models and is considered by us to be more protective. Indeed, clearly defining who can activate an ARM could significantly influence whether key logistical and ethical issues, such as the timing – the precise moment to administer MAiD (Mellett et al. 2021) – can be effectively addressed.

Finally, Canada should consider how to verify the elements that must be met in order to access MAiD through the ARM. In particular, it will need to address how to apply the criterion of "physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable" in the current law (Parliament of Canada 2016: 6). One option could be to follow Quebec's approach, considering both the patient's personal circumstances under which they wish to receive MAiD and the medical judgement of the competent professional. The correct wording of the ARM and effective communication between the patient, family and healthcare professionals will be crucial in this task.

Conclusions

Considering the various international models, the requirement that the advance request be drafted with the assistance of the competent professional and trusted persons seems to offer one of the best safeguards. The more thoroughly and precisely the ARM is prepared, the more reliable and effective its implementation could be. The competent professional, the caregivers and the patients' trusted persons play a key role in the drafting and eventual interpretation of the ARM. Therefore, it is also essential to record this document in a traceable and searchable register. Finally, the inclusion of appropriate safeguards will help not only to ensure that the rights and wishes of patients are respected in all circumstances but also to strengthen public trust in the system.

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Ethical Approval

Ethics committee approval is not required.

Notes:

1. Dementia generally progresses through three main stages: mild, moderate and severe. In the severe stage, individuals experience significant cognitive decline, marked functional limitations and noticeable behavioural changes. In addition, advanced dementia often results in difficulties with eating and swallowing, requires assistance with walking and demands continuous support for personal care. It also increases the susceptibility to infections (Clifford et al. 2024).
2. In June 2023, the Assemblée Nationale du Québec amended the law regulating medical assistance in dying (MAiD) to allow individuals to make an advance request of MAiD (ARM) under certain conditions. This new provision took effect on October 30, 2024.
3. In 2024, Ecuador judicially decriminalized MAiD for individuals with terminal or serious chronic illnesses (Espericueta 2024). Soon, the Ecuadorian parliament will need to pass a law, at which point we will know whether it will allow ARMs.

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Commentary: Ethics and Advance Requests for MAiD: Thresholds and Applicability

Commentaire : Éthique et demandes anticipées d'AMM : seuils et applicabilité

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Abstract

We seek to highlight key ethical considerations that arise as Canada considers an expansion of medical assistance in dying (MAiD) to include advance requests. To do so, we will first highlight the ethical and practical concerns that arise with advance care planning and advance directives in general and then draw attention to the unique considerations that arise with advance requests for MAiD. Finally, we will take a closer look at the concerns that will arise with an expansion to include the population with dementia. We will argue that the stakeholder concerns for a vulnerable population such as dementia patients are significant. Legislative frameworks will need to address these concerns to ensure the safety of individual patients and support the role of surrogates and healthcare providers in this process.

Résumé

Nous cherchons à mettre en évidence les principales considérations éthiques qui se posent alors que le Canada envisage d'élargir l'aide médicale à mourir (AMM) pour y inclure les demandes anticipées. Pour ce faire, nous soulignons d'abord les préoccupations d'ordre

éthique et pratique qui découlent d'une planification préalable de soins et de directives anticipées, en général, puis nous attirons l'attention sur les considérations particulières aux demandes anticipées d'AMM. Enfin, nous examinons de plus près les préoccupations qui découlent de l'élargissement de la demande anticipée aux personnes atteintes de démence. Nous soutenons que les préoccupations des intervenants concernant les populations vulnérables, comme les patients atteints de démence, sont importantes. Les cadres législatifs devront répondre à ces préoccupations pour assurer la sécurité des patients et pour mieux soutenir le rôle des mandataires et des fournisseurs de soins de santé dans ce processus.

Introduction

Advance care planning is an integral part of facilitating future medical care that aligns with a patient's values, life goals and preferences (Sudore et al. 2018). Advance care planning is not limited to persons who are facing complex medical journeys and a possible life-limiting diagnosis. As such, they can be written well in advance of any changes in a person's health status. Advance directives are legal documents that can be written in isolation from, or as part of, a more comprehensive advance care plan. Both advance care plans and advance directives are designed to support surrogates and healthcare teams tasked with making decisions in the patient's best interests. In theory, these documents help develop a patient-centred philosophy of care that extends autonomous decision making when a patient has lost the capacity to communicate their preferences.

An advanced request for medical assistance in dying (MAiD) (ARM) is a special form of advance directive but with a focus on the request for, and the timing of, an end-of-life (EOL) intervention. In Quebec, an ARM cannot be made as part of an advance directive and is subject to a distinct process (Government of Quebec 2024). An ARM can only be made by a person who is diagnosed with a "serious and incurable illness leading to incapacity" (Government of Quebec 2024), such as Alzheimer's disease. ARMs, while giving rise to distinct ethical considerations, are subject to many of the concerns that have been raised with both advance care planning and advance directives.

Strengths and limitations of advance care planning and advance directives

There are practical challenges to advance care planning and advance directives that stem from the non-contemporaneous nature of decisions being made. In any complex medical journey, there is a level of uncertainty involved in the construction of an advance care plan. At best, the patient can be informed about what that journey "might" look like based upon similar, but never identical, experiences. This limitation means that an advance directive cannot reach the standard of an informed consent. Surrogates and medical teams are often required to rely upon judgement to interpret the applicability of an advance directive in the context of a particular decision. This can lead to disagreements regarding levels of care being provided (Hall 2015; Pope and Richards 2015).

It is not uncommon for acute, potentially reversible changes in health status to occur

alongside a more progressive palliative diagnosis. In such circumstances, it may be reasonable for an advance directive to be revisited and potentially adjusted in a time-limited manner. It may also be the case that some previously expressed preferences, taken together, may not be compatible and choices will have to be made. Ideally, any adjustments or choices occur with as much involvement from the patient as possible. The intention of revisiting an advance care plan is to help ensure that goal-concordant care is being provided.

Such challenges mean that studies looking at the outcomes associated with advance care plans have yielded mixed results (Jimenez et al. 2018; Malhotra et al. 2022; McMahan et al. 2021). Part of this concern arises from the types of patient outcomes that are used as key indicators and a mixed methodology that has often relied upon retrospective approaches. Given the role of advance care plans in extending autonomy, preference congruence with care delivery should be a priority goal (Rietjens et al. 2017; Sudore et al. 2018). However, as highlighted, mixed results will be expected to arise from the inherent complexity of health that is difficult to capture via the nature of advance care planning: a longitudinal process that involves a complex and uncertain medical trajectory, many stakeholders and a cross-section of clinical environments (Cohen et al. 2019; McMahan et al. 2021; Udelsman et al. 2020).

Regardless of these challenges, there is consistent evidence that advance care planning is considered important by critical stakeholders (Fulmer et al. 2018; Johnson et al. 2016; McMahan et al. 2013). Working through possible scenarios with knowledgeable healthcare providers can help patients articulate their current preferences and ask difficult questions. These conversations are an opportunity for building trusting therapeutic alliances between a patient and their caregivers. Advance care planning should be best understood as an ongoing process of shared decision making (Malhotra et al. 2021, 2022; McMahan et al. 2021; Sudore and Fried 2010).

Advance requests for MAiD: specific considerations

The importance of safeguards as protective measures for the effective implementation of an ARM is a key consideration (Espericueta 2025). Importantly, what is being safeguarded against must be clarified. We will concentrate on the concerns that arise fundamentally from the nature of an ARM, focusing on patients with dementia. These concerns would need to be addressed by any framework that will be developed to support the implementation of ARMs.

Understandably, facing an uncertain future of progressive illness and cognitive decline is distressing for patients and their carers (Yates et al. 2021). An ARM potentially relieves the existential suffering that can accompany a capacity-diminishing illness (Mellett et al. 2021). As it currently stands in Quebec, there is no necessity for ARMs to be integrated into discussions that will develop into a more comprehensive advance care plan. For such patients, it is important to inform them that an ARM represents just one final decision along a care path that likely will require many weighty decisions to be made. Without this integration, patients will still be vulnerable to a number of potentially burdensome, life-prolonging

medical interventions that may not be concordant with their overarching philosophy of care. Without attention to all the domains of caring, other key preferences that will play a role in a patient's overall quality of life may be missed (Wehrmann et al. 2021).

The ability to articulate preferences on what constitutes an acceptable quality of life and make plans for the timing of MAiD when that threshold is lost is a key consideration that supports ARMs. However, with the proposal of an ARM, further autonomy concerns arise in the context of cognitive decline, particularly what ought to be within one's decisional scope. This scope cannot become so limited as to force people to live out their remaining days in an intolerable state, but simultaneously, there is a need for protections so that the vulnerable are not placed into a position of coercive, unwanted or ad hoc MAiD provisions.

The possibility of preference instability occurring alongside cognitive decline and capacity loss is an autonomy concern that will arise in ARMs. The experience of illness and cognitive decline can be transformative, with the potential to fundamentally alter our interests in ways that likely no document can account for (Walsh 2020). Evidence has demonstrated that EOL preferences can be unstable and change over time even when patients face serious, life-altering illness (Malhotra et al. 2022). The loss of capacity does not necessarily equate to a loss of valuing. How should surrogate decision makers and healthcare providers weigh the preferences and evaluations documented in an ARM if they no longer align with what is being expressed or demonstrated by the patient?

We must consider the well-being, interest and needs of the patient in front of us. This requires that we communicate with the patient and involve them as much as possible in the care they are receiving. This patient-centred care is consistent with the professional obligations of healthcare providers and with the duties of surrogate decision makers (Mellett et al. 2021). Prior capable wishes are respected but also need to be applicable in the context they are going to be applied. Relevant context to consider is whether the MAiD provision will conflict with the expressed wishes of a not wholly competent patient who nonetheless demonstrates opposition. It may be a "no," pulling away or simple facial expressions that lead us to question whether this is something the patient wants. Unless we arrive in a room wherein the patient is no longer an experiencing subject, our obligation to the patient in front of us, and their preferences, demands further exploration.[1] In these situations, what work does the ARM do? It seems that an advanced consent in many cases may be insufficient.

ARMs: safeguards

A robust system of safeguards would seek to protect first and foremost the interests of the patient but also the interests of surrogates and healthcare providers involved. Yet, critically, what has not been settled is how to understand the interests of the patient with dementia (Hall 2015; Pope and Richards 2015). How are surrogates and healthcare providers supposed to understand their obligations? Who is the patient is a legal question, but ethically it is clear; it is the patient in front of us. How we view and care for persons with dementia at the EOL impacts caring beyond this context. Valuing the patient in front of us is not a trivial

obligation to be decided in a moment or in a court of law. Do we see a way forward? It seems an ARM ought best to be understood as a request for future MAiD consideration – a permission for a consultation triggered by the parameters identified within the document. The applicability of the request can then be assessed. This assessment would likely require input from healthcare providers with expertise in the patient population, clinical ethicists and legal professionals. Essentially, it would also seek to include input from the patient in front of us. Ultimately, the scope of the parameters in an ARM, the threshold setting itself, will require a broader discussion of what constitutes reasonableness, given a recognition that the interests of a person with dementia matters.

Note:

1. While the ability to have preferences and to be subject to one's life is paramount for decision making, the practicalities of communication mean that while some may be subjects, they may lack any ability at all to communicate preferences. As such, there is some threshold wherein barriers may modify the obligations we have to explore and what can reasonably be accommodated.

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DISCUSSION AND DEBATE

The Fraying at the Edges of the Public Healthcare System in Canada

Érosion du système de santé public au Canada

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Abstract

Since the passage of the *Canada Health Act* (CHA) in the mid 1980s, advocates for private finance in Canada have challenged the CHA and its underlying access and equity principles. Such challenges have grown in recent years to encompass, among other things, facility fees, membership fees, private virtual care, private interprovincial surgery clinics and private practice nurse practitioners. The continued technological and organizational evolution of healthcare will expand and complicate this further over time. A multipronged approach is needed that includes expanded data to support research on the impacts of such activity, new regulatory frameworks and coordinated action across levels of government.

Résumé

Depuis son adoption au milieu des années 1980, la *Loi canadienne sur la santé* (LCS) fait l'objet de contestations de la part des défenseurs du financement privé qui en contestent les principes sous-jacents d'accès et d'équité. La situation a pris de l'ampleur au cours des dernières années et concerne, entre autres, les frais d'établissement, les cotisations d'adhésion, les

soins virtuels privés, les cliniques de chirurgie interprovinciales privées et les cabinets privés d'infirmières praticiennes. L'évolution technologique et organisationnelle des soins de santé continuera d'élargir et de compliquer cette situation au fil du temps. Pour mieux comprendre la situation, il faut adopter une approche multidimensionnelle qui comprend : des données élargies pour étayer la recherche sur les répercussions de telles activités, de nouveaux cadres réglementaires et des mesures coordonnées à tous les niveaux de gouvernement.

Introduction

Fraying at the edges of Canada's public healthcare system is not new. The *Canada Health Act* (CHA) (1985), after all, was triggered by physicians' and institutions' extra-billing practices that undermined the 1966 *Medicare Act*'s principle of universal access (Health Canada 2023; Taylor 1986; Vayda and Deber 1992). Challenges to the CHA principles by both private actors and provincial governments have arisen regularly in the four decades since its passage (*CBC News* 2023; Flood and Thomas 2020; Glauser 2011; Gray 2000; Health Canada 2023; Minister of Health Diane Marleau 1995; Minister of Health Jane Philpott 2016; Silversides 2008). Currently, however, challenges to the CHA – and more generally to access and equity – appear to be greater in number and variety than ever before (CMA 2024a). It is useful to catalogue some of the most prominent challenges today and discuss some of their implications.

We focus on private financing that challenges first-dollar public financing for medically necessary medical care. This issue is analytically and legally distinct from private, for-profit delivery of medical services. The CHA (1985) is silent on the private/public, profit/nonprofit status of providers of care, and multiple provinces publicly finance the delivery of medical care by for-profit providers. In practice, however, these two issues become entangled because many of the financing challenges noted below emanate from private, for-profit providers of care. Furthermore, because private capital seeks greater financial returns, an increased presence of for-profit providers, especially equity-owned for-profit providers, can increase pressure to expand private financing that generates increased profits. This is true even if a for-profit provider's core activity is the delivery of publicly financed care. Indeed, some of the efforts to integrate private financing arise alongside and as part of the delivery of publicly financed, medically necessary care. This practical entanglement of financing and delivery modalities means that, even though our primary focus is private financing, one cannot avoid some discussion of the role of for-profit providers. It is beyond the scope of this short commentary, however, to discuss evidence regarding the relative performance of public and private for-profit providers with respect to quality of care and efficiency (see, e.g., Devereaux et al. [2002]; Goodair and Reeves [2024] and Schneider et al. [2005] for reviews of such evidence).

The Fraying Edges

Despite Health Canada's 1995 interpretation letter clarifying that facility fees linked to the delivery of medically necessary care violate the CHA (1985) (Health Canada 2023; Minister

of Health Diane Marleau 1995), such fees persist and, indeed, patients seeking care through private clinics have faced an array of other, similarly spirited fees – block fees, fees for surgical supplies (e.g., drugs) and accessory fees (e.g., eye drops, extra tests, bandages) – for services linked to medically necessary care (Armstrong 2000; Health Canada 2023; Longhurst 2023; Ontario Health Coalition 2024; Quesnel-Vallée et al. 2020). Concierge medicine offered through private physician-led executive wellness clinics use private-pay membership or enrollment models that entitle members to a basket of insured and noninsured services for a defined period of time, usually one year (Bodner et al. 2022; Reid 2017), charging fees that can range from a few hundred dollars per year to over $9,000 per year (e.g., Clinique de santé 2024; MEDCAN 2024). These private clinics claim that the membership fees apply only to services not covered by provincial health insurance (e.g., advanced wellness checks), but in some instances, membership fees are mandatory for all services, including insured physician services (Health Canada 2023, 2024). Regardless of the true obligatory nature of the membership fee, patients may believe the membership is mandatory for any access to healthcare or they may believe the membership is necessary to access the same quality of care as those who pay the membership. Furthermore, many patients are unable to distinguish between medically necessary, insured services and alternative, uninsured health services and are therefore dependent on their healthcare provider who is in a position of trust with access to information the patient does not have or does not understand (Bodner et al. 2022). This asymmetric relationship leaves patients vulnerable to manipulation through exaggerated wait times, pressure to purchase upgrades for fear of losing access to expedited care and the provision of unnecessary tests, procedures and goods (Armstrong 2000; Flood et al. 2015; Longhurst 2023; Ontario Health Coalition 2024).

Although the private delivery of publicly funded surgical and other services is fully compatible with the CHA (1985), as provincial governments increasingly contract with private, for-profit healthcare providers, the problem of "upselling" grows (Longhurst 2023). Upselling refers to the practice of recommending, sometimes with considerable pressure, unnecessary and even inefficacious options and upgrades not covered by the public plan (Bodner et al. 2022; Ontario Health Coalition 2024). Public–private ophthalmology clinics in Ontario and Alberta, for example, have been accused of pressuring patients – at times with the promise of shorter wait times – to purchase expensive upgrades, including excessive fees for "premium" lenses, tests and procedures, and even warranties and registration fees (Cuttler 2023; Health Canada 2023; Ontario Health Coalition 2024).

The evolution of technologies and healthcare delivery methods makes it possible to exploit "loopholes" in the CHA (1985) not anticipated in 1984. Advances in the provision of diagnostic services represent one of the earliest examples of this. As early as 1982, Quebec began delisting certain diagnostic tests such as mammograms, thermography and ultrasonography if delivered outside a hospital (Quesnel-Vallée et al. 2020). In the 1990s, the advances in diagnostic technology facilitated the delivery of computed tomography (CT) and magnetic resonance imaging (MRI) diagnostic services in free-standing clinics and provinces

moved to restrict publicly insured CT and MRI diagnostic services to those delivered to hospital in-patients and outpatients, opening the door for private clinics to charge fees for diagnostic services outside the hospital (Brooks 1993; CADTH 2023). The set of such services expanded over time until the federal government finally responded in 2020 with the Diagnostic Services Policy that formalized its position that diagnostic services are insured services (Health Canada 2024; Library of Parliament 2019). Most provinces now prohibit out-of-pocket fees for medically necessary diagnostic services. Saskatchewan, however, continues to fight the federal government on this issue despite reductions in their health transfer payments due to its 2016 *Patient Choice Medical Imaging Act*, which allows private for-profit MRI clinics to charge private patients for medically necessary imaging as long as for each private-pay scan, a scan of equal complexity is provided to a public patient (Government of Saskatchewan 2016; Ontario Health Coalition 2017; Sciarpelletti 2024).

Virtual care and interprovincial surgical centres have emerged as another opportunity to expand private finance. In 2016, the virtual healthcare app Maple became one of the first private-pay virtual healthcare modes for accessing physician services in Canada (Frangou 2023). The absence of billing codes for virtual care in provincial insurance plans implied that virtual care was not an insured service. The COVID-19 pandemic initially gave these private-pay virtual clinics a boost. However, as provincial insurance plans introduced virtual-care billing codes to facilitate remote physician visits during pandemic restrictions and social distancing measures (CMA 2022), the private virtual clinics pivoted to care models based on the use of out-of-province physicians or nonphysician providers such as nurse practitioners (Crawley 2023). Interprovincial care models exploit the limitations in provincial insurance plans that restrict a provincial resident's insured coverage to only those medically necessary services delivered in their home province, except for out-of-province emergencies or when such services are preapproved (Crawley 2023; Government of Canada 2019; Taylor 2019). Private interprovincial surgery clinics, therefore, charge out-of-province patients privately for otherwise insured physician surgeries in the patients' home province, facilitated through virtual consultations (see, e.g., Surgical Solutions Network [2024]). For patients, the private-pay interprovincial options provide expedited surgeries for common wait-listed procedures (e.g., cataract surgery, knee replacement surgery, hip replacement surgery, hernia repair).

Nurse practitioners were rare when the CHA was enacted in 1984. Hailed as a potential solution to the primary care shortage in remote and underserved areas, nurse practitioners were paid a salary and worked primarily in remote locations under the supervision of a physician in publicly funded clinics (Klemmer-Lamoureux n.d.). The first publicly funded, independent nurse practitioner-led clinic was established in Sudbury, Ontario, in 2007 (Contandriopoulos et al. 2023; Heale and Butcher 2010), and most provinces now have publicly funded nurse practitioner-led primary care clinics. Recently, however, private-pay nurse practitioner-led wellness clinics have begun to pop up (Macdonell 2018; Mantyka 2022; Mitchell 2024), charging private fees, for care that can range from $90 to $200 for a single visit (e.g., The Village Health Clinic 2024). The nurse practitioners argue that, as

nonphysician providers, the CHA (1985) does not apply to them. As such, they can charge private fees even for services publicly insured when delivered by a physician (e.g., health assessments and diagnosis, ordering and interpreting diagnostic tests, referrals to specialists, prescriptions [CIHI 2020]).

These diverse initiatives all share the common element of requiring private, out-of-pocket payment to obtain insured healthcare services, in violation of the CHA (1985), which calls for reasonable *access* to insured health services on *uniform terms* and *without charge* (Government of Canada 2024). Membership fees, enrollment fees, private fees for insured services, interprovincial surgeries and fees for premium goods and services all violate the intent of this access principle. They also compromise the core equity tenet of Canada's publicly funded healthcare system – the allocation of healthcare based on need rather than ability to pay. Indeed, the central purpose of interprovincial surgery clinics and executive clinics is preferred or expedited access based on the ability to pay. But these practices do more than simply violate a few principles. They have real, detrimental impact on access to care and equity within our healthcare system. It is well established, across many care contexts, that private out-of-pocket fees reduce access for those with limited ability to pay, resulting in greater inequity of care (Armstrong 2000; Duckett 2005; Fusco et al. 2023; Grignon et al. 2010; Longhurst 2023; Mueller and Socha-Dietrich 2020; Shmueli and Savage 2014), and have broader system impacts, including longer wait times in the public system and related impacts (Hurley and Johnson 2014; Reid 2017).

Discussion

These private financing challenges to the CHA (1985) and to the access and equity principles at the foundation of Canada's publicly financed healthcare system have material consequences. Yet, the magnitude and costs of such activity are unknown as no association, agency or government tracks this information (Glauser 2011).

At present, researchers struggle to even just document the nature of such private activities (Bodner et al. 2022; CMA 2024c). Without much-improved data on these activities, it is impossible to evaluate their effects on both those seeking care and on the public system. At present, these activities fall largely outside dominant Canadian administrative and survey health data systems. Compiling the data required to enable high-quality research on these activities requires a three-pronged approach. First, where possible, governments and regulators need to strengthen and expand reporting requirements for providers and organizations (e.g., clinics, insurers) operating in these spaces. Second, researchers and others need to better exploit data sources developed for other purposes, such as the Statistics Canada Business Registry or the census, that may provide insights into such private activities. Third, governments, data agencies and researchers themselves need to undertake special-purpose, primary data collection through surveys and other approaches to fill gaps that will never be filled by existing administrative and survey data. For instance, such basic information as the number and type of private clinics is not readily available; much less information is available on the

full range of services they offer, their providers, the fees they charge, their sources of payment (e.g., private out-of-pocket, private insurance, public insurance) and the volume of services they provide. Moreover, there is no good information on organizations, such as Maple, that facilitate and organize privately financed care. Without progress in these data efforts, and the high-quality research it will enable, evidence-informed policy is impossible.

Private finance activities such as those documented earlier call for multiple policy responses. The first, and perhaps the most important, is to improve the performance of the publicly funded health system. Many seek – and are willing to pay for – care privately only because of frustrations with a publicly financed system characterized by inadequate access to primary care, excessive wait times for speciality and surgical services and other deficiencies (CMA 2024b). In some cases, this may require better funding and delivery of existing services; in others, it may call for integration of some of the emerging private practices. For example, at a time when Canada is struggling to provide meaningful access to primary care, publicly funded nurse practitioner-led clinics and care teams could play an important role in addressing our primary care challenges (CIHI 2022; Contandriopoulos et al. 2024; Tremayne-Lloyd 2022). This is consistent with the expanded scope of other nonphysician providers, such as Ontario's recent expanded scope for pharmacists to prescribe medicines within Ontario's public insurance system (Ontario 2024).

Second, the federal and provincial governments need to implement new regulatory approaches that address the more complex and nuanced regulatory challenges presented by the evolving health landscape. The CHA (1985) relies on financial penalties (via reduced transfer payments) to prompt provincial action, but Health Canada is often slow to provide the needed guidance and impose such penalties where appropriate (e.g., it is yet to address private virtual care clinics and is yet to clarify the standing of "physician-equivalent" providers such as nurse practitioners). Importantly, it is not obvious that the financial penalties are sufficient to motivate provincial action, especially when there is a political advantage to a provincial government in letting a targeted private activity continue.

Third, effective regulation requires provincial action. Provinces have the authority to revise their respective health acts and other relevant legislation to bring new providers such as nurse practitioners into the public system, enforce the long-standing prohibition on user fees for insured services and prohibit the linking of uninsured services to the delivery of insured care (Quesnel-Vallée et al. 2020).

The continued technological and organizational evolution in healthcare, communications technology and related areas will only complicate this picture over time as new niches emerge for private finance to expand. Without a multiprong approach that starts with the collection of the appropriate data to support research and extends to decisive and cooperative action on the part of provincial and federal lawmakers, the fraying at the edges of Canada's public healthcare system will continue to compromise the access and equity principles at the foundation of our healthcare system.

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Commentary: Fixing Fraying? A Response to Milinkovic and Hurley

Commentaire : Stopper l'érosion? Une réplique à l'article de Milinkovic et Hurley

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Abstract
Privatization – either of funding or provision – is not a solution to Canada's health system woes. However, access issues abound, and part – but only part – of the solution should be to look to improve efficiency of service delivery so that better access can be achieved with the same money.

Résumé
La privatisation – que ce soit pour le financement ou l'approvisionnement – n'est pas une solution aux problèmes du système de santé observés au Canada. Cependant, les problèmes d'accès sont nombreux et une partie – mais seulement une partie – de la solution devrait consister à améliorer l'efficacité de la prestation des services afin d'améliorer l'accès avec les mêmes montants de dépenses.

Introduction
Milinkovic and Hurley (2025) rightly call attention to the insidious siren calls of those who see privatization, especially privatization of funding, as part of the solution to the woes that have beset access to healthcare in Canada. Importantly, they recognize the current information vacuum in this area and highlight the need for better data to track the current extent of privatization, be it user pays or, more fundamentally, the extent of private provision. Their proposed policy responses – to improve the current health system, more agile regulation and updated regulations to cover new providers – are all appropriate.

Renowned Canadian health economist Bob Evans long ago pointed out the limited policy options in the face of an imbalance between demand for, and supply of, public funding.

One option is "shear," shifting costs from taxpayers onto consumers of healthcare (Evans 1990). Such a policy adversely impacts poorer people, who tend to need more healthcare, and benefits richer people, who tend to pay more tax. It is often supported by providers, as private funding and provision is typically less regulated, allowing professionals more autonomy and opportunities to increase their wealth.

Milinkovic and Hurley (2025) trip lightly over their first policy proposal, the need to "improve the performance of the publicly funded health system" (p. 36). They rightly highlight the need for workforce reform to improve access, including the need to allow other providers to complement the work of physicians. As they point out, the downside risk here is that this might create a regulatory void, allowing some providers to circumvent the current *Canada Health Act* (1985) restrictions. Addressing this gap requires more adaptive regulation than seen in the past.

Unfortunately, Milinkovic and Hurley (2025) do not use up their valuable word count to draw attention to the opportunities that exist to improve the efficiency of healthcare provision, and this is an important omission. Better healthcare – including addressing access gaps – does not mean more expensive healthcare. There is good evidence of interprovincial efficiency variation in technical efficiency across Canada, such as in cost per hospital admission, with Alberta, home to some of the most egregious privatization experience, being a high outlier in cost of provision (Duckett 2015; Duckett et al. 2012). Addressing its own efficiency issues would have reduced the opportunities for private provision inroads but is not consistent with the clientelist ideological position of the traditional Albertan government (Duckett 2015). However, all provinces have the potential to improve their performance on this dimension. National agencies, including Health Canada and the Canadian Institute of Health Information, should facilitate benchmarking and identification of opportunities for efficiency improvement.

In addition, all provinces probably have the potential to reduce intraprovincial variation in costs and thus create room to expand provision at no additional cost to taxpayers. This, of course, is easier to say than do as it requires shifting resources from one location to another or one profession to another and, hence, as all health spending is someone's income, inevitably moves income opportunities from one group to another (Evans 1997, 2016; Reinhardt 2012) or one political riding to another.

Harder still is addressing allocative or social efficiency, such as no- and low-value care and ensuring that all care is indeed "medically necessary" to use the language of the *Canada Health Act* (1985) (Caulfield 1996). Measurement issues abound here and the voice of those who gain income from providing low-value procedures will be loud in opposition, citing the need for patient choice and the importance of providing a private outlet in the face of the evil rationalizers.

However, while waiting for this nirvana of a perfectly efficient health system, policy makers should heed the warnings of the risks of privatization and pursue the prescriptions Milinkovic and Hurley (2025) have so usefully outlined.

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Medicine List for Public Funding From Existing Lists

Dresser à partir des listes existantes une liste de médicaments financés publiquement

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Abstract

A Canadian list of essential medicines to be publicly funded is crucial for implementing national universal pharmacare. The federal government maintains multiple medicine lists of publicly funded medicines for specific populations in Canada. Despite significant overlap across these lists, Canada does not yet have a single list that defines a minimum set of publicly funded medicines for everyone in Canada. Instead of creating a list from scratch, extant federal lists could form the basis for a harmonized list for all Canadians. We examined seven federal lists of publicly funded medicines and made recommendations for a potential future Canadian essential medicines list.

Résumé

Dresser une liste de médicaments essentiels financés par le secteur public est crucial pour la mise en œuvre d'un régime d'assurance-médicaments national et universel au Canada. Le gouvernement fédéral tient à jour de multiples listes de médicaments financés par l'État pour des populations particulières. Malgré un chevauchement important entre ces listes, le Canada n'a toujours pas de liste unique définissant un ensemble minimal de médicaments financés par l'État pour tous les Canadiens. Au lieu de créer une liste à partir de zéro, les listes fédérales existantes pourraient constituer la base d'une liste harmonisée pour tous les Canadiens. Nous avons examiné sept listes fédérales de médicaments financés par des fonds publics et nous formulons des recommandations pour une éventuelle liste canadienne de médicaments essentiels.

Introduction

A list of essential medicines to be generally publicly funded was a core recommendation of the 2019 National Advisory Council on Implementing Pharmacare (Health Canada 2019), and An act respecting pharmacare (*Pharmacare Act* 2024) calls for the development of such a list. Despite various efforts, Canada still does not have such a list (CADTH 2024). International guidance indicates that countries should have a rigorous and transparent process of creating and maintaining a list of essential medicines that meet the "priority care health needs" of the population because decisions about which medicines to prioritize for access can have important effects on health and implications for health spending (Laing et al. 2003; WHO 2001, 2024, p. ix). Purposes of such a list include ensuring equitable access to effective treatments or "pharmacoequity," promoting appropriate prescribing and use of medicines and avoiding overpaying for medicines (Essien et al. 2021, p. 1793). *Bill C-64* calls for the creation of "a list of essential prescription drugs" to inform a future national pharmacare program (*Pharmacare Act* 2024, p. 5).

Here, we compare the existing Canadian lists of publicly funded medicines at the federal level to create a synthesized list of medicines that could define a minimum set of medicines that would be publicly funded for everyone in Canada. Our focus is outpatient medicines since medicines for in-patients are generally publicly funded in Canada.

What Lists of Publicly Funded Medicines Are Used in Canada Now?

The federal government has seven lists of publicly funded medicines for some Indigenous People, military personnel, military veterans, Royal Canadian Mounted Police (RCMP) personnel, refugee claimants and people incarcerated in federal institutions (Table 1). Provinces and territories also maintain their own lists that determine which medicines are publicly funded for specific populations, including older adults and people incarcerated in provincial institutions, and these provincial lists are similar to each other (Patented Medicine Prices Review Board 2017).

TABLE 1. Description of federal drug benefit programs

Program	Beneficiaries	Medicines included	Latest formulary version	Notes
IFHP	Resettled refugees, refugee claimants, in Canada protected persons and certain other groups that are not eligible for provincial or territorial health insurance	All medicines covered in provincial and territorial formularies + additional drug benefits	Provincial formularies usually updated at least annually	
Public Service Health Care Plan	Eligible employees and retirees of the public service (including RCMP and CAF) and their partners/ children	All approved medicines	Not applicable	
CAF Drug Benefit Program	CAF personnel	995 + 360 (special authorization)	2019	Includes standard benefits and special authorization
VAC Prescription Drug Program (POC 10)	Eligible veterans with a VAC Health Identification Card	969 + 450 (special authorization)	2012	Includes regular benefits and special authorization
Indigenous Services Canada NHIB Program	Eligible First Nations and Inuit clients	1,003	2020	Includes limited use benefits
CSC	Federal inmates	642	2023	Includes medicines that require reason for use
Pan-Canadian Advisory Panel on a Framework for Prescription Drug List	Recommendation	179	2022	

CAF = Canadian Armed Forces; CSC = Correctional Services Canada; IFHP = Interim Federal Health Program; NHIB = Non-Insured Health Benefit; RCMP = Royal Canadian Mounted Police; VAC = Veterans Affairs Canada.

How are medicines added to Canadian lists?

The medicine lists maintained by the federal government are informed by recommendations made by the Canadian Agency for Drugs and Technologies in Health (CADTH) about whether medicines should be publicly funded based on health technology assessments of newer medicines. The final recommendation is made by a committee comprised of clinicians, researchers, patients and other members of the public.

Indigenous Services Canada's Non-Insured Health Benefits (NHIB) Program, Veterans Affairs Canada's (VAC) Health Benefit Program and the Canadian Armed Forces' (CAF) Drug Benefit Program are guided by recommendations by the CADTH as well as their own internal formulary review committees. The Interim Federal Health Program (IFHP) provides access to medicines included in provincial lists for refugee claimants and some others. The RCMP are included in the Public Service Canada Health Plan that does not have a formulary but instead covers all approved medicines (as such the RCMP is not included in the analyses below).

What medicines could be on a list of medicines publicly funded in Canada?

Seven federal lists were included in our analysis to synthesize a set of commonly listed medicines. Of these seven, we considered four to be the most important for our purposes of comparing lists as they are used by the largest number of people: Indigenous Services Canada's NHIB Program, Correctional Services Canada (CSC) National Formulary, VAC's Health Benefit Program and CAF Drug Benefit Program. We also considered the special authorization lists of the VAC and CAF formularies but viewed these as separate lists, as the medications included required a higher level of authorization and overview than those on the standard benefit formularies. We considered the recommended essential list from the pan-Canadian Advisory Panel on a Framework for Prescription Drug List, a partial list that covers only three therapeutic areas: cardiovascular, diabetes and mental health treatments (CADTH 2024).

We identified a total of 1,572 unique medicines included in at least one list and 511 medicines that are listed in more than half of national formularies that could be considered the core of a synthesized list (Appendix 1, available online at www.longwoods.com/content/27563). Of the remaining 1,061 that were not included based on being frequently listed, 41 medicines were commonly prescribed, such as dementia treatments, and thus were added back (Morgan et al. 2014). We removed one medicine (for thyroid gland preparations, which is not needed now because levothyroxine is available).

Of the 1,020 candidate medicines included in at least one list but not commonly prescribed, we included 72 based on our judgements about their importance to some populations (Appendix 3, available online at www.longwoods.com/content/27563). For example, we added famotidine, which was listed in the CAF Drug Benefit Program, VAC Health Benefit Program and Indigenous Services Canada's NHIB Program. Famotidine is used to treat peptic ulcer and gastroesophageal reflux disease, and given that both famotidine and ranitidine were already added, we did not deem it necessary to also add cimetidine (Berardi et al. 1988). In addition, cromolyn, or cromoglicic acid, was listed in only the CSC National Formulary and NHIB Program, but it was added due to its role as a noncorticosteroid treatment for asthma and allergies (Kuzemko 1989).

Finally, we reviewed each class of medicines to remove unnecessary or "me too" medicines and removed 67 medicines, while adding six. Many of the removed medicines were

cancer treatments that are generally publicly funded through other drug plans or used for in-patients. Five medications were added: vitamin B6, calcium gluconate, insulin detemir, magnesium sulfate, benserazide and rituximab. We left some duplicative medicines within the same class as described later.

Our synthesized list included a total of 562 medicines (Appendix 2, available online at www.longwoods.com/content/27563). Diabetes treatments included in the synthesis list include metformin, gliclazide, sitagliptin, saxagliptin, linagliptin and various types of insulin. Seven statins are listed, including atorvastatin and rosuvastatin. Nine angiotensin receptor blockers (ARBs) and 10 angiotensin-converting enzyme inhibitors were included. More than 10 options for depression and anxiety were listed. Abatacept and etanercept were included and so were infliximab, adalimumab, golimumab and ustekinumab. Treatments for multiple sclerosis, including fingolimod and teriflunomide, were included.

The synthesized list could be shortened by reducing the number of medicines in classes where differences are relatively unimportant (Li et al 2014). The ultimate length of the list may strike a balance between acceptability to clinicians and patients (who may prefer more options or for their own favoured medicine to be listed) against evidence that fewer medicines are sufficient and the fact that lists tend to grow over time. The synthesized list is around four times longer than the list of medicines used in a clinical trial of providing free access to essential medicines, mostly because the synthesized list contains more medicines within each class; for example, candesartan was the only ARB provided in the trial while nine are in the synthesized list (Persaud et al. 2020). The shorter list was acceptable to patients and clinicians although qualitative studies showed that more options within classes for diabetes and mental health treatments were suggested (Ally et al. 2022). Providing free access to the shorter list in the trial showed improved medicine adherence to appropriately prescribed medicines, improved financial well-being and reduced overall healthcare costs (Persaud et al. 2020, 2021, 2023). During the trial, patients and clinicians could suggest changes (additions, removals and substitutions) to the list that was peer reviewed by clinicians in different disciplines; such input is also needed on the synthesized list. Provincial, territorial and First Nations health authorities should also provide input on revisions of the list.

How Would a Canadian List Compare With Lists in Other Countries?

The medicines included in the synthesized list were commonly included in lists used in 158 other countries based on an updated international database (median number of countries listing each medicine 47, range 1–154) (Persaud et al. 2019). Those other lists ranged in length from 39 to 955 (median 345.5) and the synthesized list would be ranked at the 85th percentile in length. The synthesized list that could have inherited deficiencies from existing lists and specific medicines, including those rarely listed by others or not recommended by international guidance, could be flagged for further review. Medicines infrequently listed by other countries included brexpiprazole (listed by one country), almotriptan (listed by two countries) and asenapine (listed by three countries). The synthesized list also includes

medicines that were not listed by any other country, such as colestipol, methazolamide, nabilone and sulfinpyrazone. There were some medicines that were commonly listed by other countries but not included in our synthesized list: albendazole (85% or 135 countries), benzylpenicillin (81% or 128 countries), chloramphenicol (80% or 127 countries) and doxorubicin (77% or 122 countries). The synthesized list includes 279 medicines that are in the 2023 World Health Organization (WHO) model list of essential medicines, while 254 were listed by the WHO but not the synthesis list and 255 in the synthesis list but not the WHO list (WHO 2023). The synthesized list was more inclusive than the national formulary of the US Veteran's Administration that, for example, lists five ARBs (as opposed to nine in the synthesized list), but overall the two lists are quite similar (U.S. Department of Veterans Affairs 2024).

Conclusion

Creating a list of medicines to determine which medicines should be publicly funded as part of a national pharmacare program should be relatively easy – a reasonable but imperfect list based on extant lists maintained by the federal government is shown in Appendix 2, available online at www.longwoods.com/content/27563. It is unclear why there are so many separate lists in Canada for populations with similar or the same medicine needs and yet no list for the general population. Presumably, there were historical reasons for different medicine coverage regimes, and all this could eventually be replaced by a national pharmacare program built on a unitary list for everyone.

A rigorous and transparent process must be established to make needed changes to the list and the process can be informed by international experience and guidance (WHO 2001). Based on international experiences and research in Canada, threats to a list of medicines include the perception that the list is a government cost-cutting measure that tends to list cheap or substandard treatments, lack of support by clinicians, skepticism by patients and advocacy or lobbying from the pharmaceutical industry (Ally et al. 2022; Jarvis et al. 2019; Laing et al. 2003). An independent decision-making body is needed to determine which medicine will be publicly funded and which will not, and this could be achieved by appointing an executive director and a selection committee that are insulated from political decision makers (Persaud 2020). The effects of implementing the list within a policy on health outcomes, health equity and healthcare expenditures should be carefully tracked.

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Conflict of Interest

We have no conflicts of interest to declare.

Ethical Approval

The study did not involve any human participants and therefore did not require ethics approval. Nonetheless, the study fully adhered to the Declaration of Helsinki. The underlying data are available upon request.

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RESEARCH PAPER

The Role and Influence of Federally Established Health Policy Advisory Bodies in Canada

Rôle et influence des organismes consultatifs en matière de politiques de santé établis par le gouvernement fédéral au Canada

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Abstract

Since the passage of the *Canada Health Act* (1985), there have been many advisory bodies established by successive federal governments, each tasked with providing advice and making recommendations about where and how to improve the health system. Our analysis of interviews with advisory board members and implementers (e.g., ministry of health leaders, staff

and consultants) addresses why participants perceived their advice and recommendations were generally not implemented and informal strategy groups used to facilitate implementation. We recommend that future health system advisory bodies focus on coalition building during policy development, integrate implementation plans into policy recommendations and evaluate the impact of policy recommendations.

Résumé

Depuis l'adoption de la *Loi canadienne sur la santé* (1985), de nombreux organismes consultatifs ont été créés par les gouvernements fédéraux successifs et chacun d'entre eux est chargé de fournir des conseils et de formuler des recommandations sur les façons d'améliorer le système de santé. Notre analyse d'entrevues menées auprès de membres et de responsables d'organismes consultatifs (p. ex., représentants, employés et consultants du ministère de la Santé) vise à savoir pourquoi les personnes interviewées estiment que leurs conseils et recommandations ne sont généralement pas mis en œuvre et pourquoi des groupes de stratégie informels sont employés pour faciliter la mise en œuvre. Nous recommandons que les éventuels organismes consultatifs du système de santé se concentrent sur la formation de coalitions lors de l'élaboration des politiques, intègrent les plans de mise en œuvre dans les recommandations d'ordre politique et en évaluent l'impact.

Introduction

As healthcare and the needs of Canadians have evolved, both federal and provincial/territorial governments have frequently established ad hoc health policy advisory bodies to guide health and healthcare decision making. Ad hoc advisory bodies, which are used across policy domains, use topical experts (Halffman and Hoppe 2005) and operate within the government sector, unlike policy institutes or think tanks (Lindquist 1993).

The use of royal commissions has been a popular policy tool in Canada and other commonwealth countries, particularly Australia (Mintrom et al. 2021); while presidential commissions have been used in the US (Zegart 2004). Commissions and other similar ad hoc advisory bodies can be conceptualized as primarily serving one of three core functions: (1) influencing the policy agenda; (2) providing evidence and information; or (3) building coalitions (Zegart 2004). Agenda commissions generate support for initiatives and target a mass audience; information commissions provide new facts and thinking about policies and target government officials; and coalition commissions seek to foster consensus among competing interests and coalition members (Zegart 2004). While commissions and similar advisory bodies are often viewed as deflecting blame from the government or giving the appearance that the government is taking action (Zegart 2004), many are intended to and succeed in shaping public policy (Mintrom et al. 2021; Zegart 2004). For example, the Royal Commission on Health Services led by Justice Emmet Hall was instrumental in the design and passage of key healthcare legislation, the *Medical Care Act* (1966), in Canada.

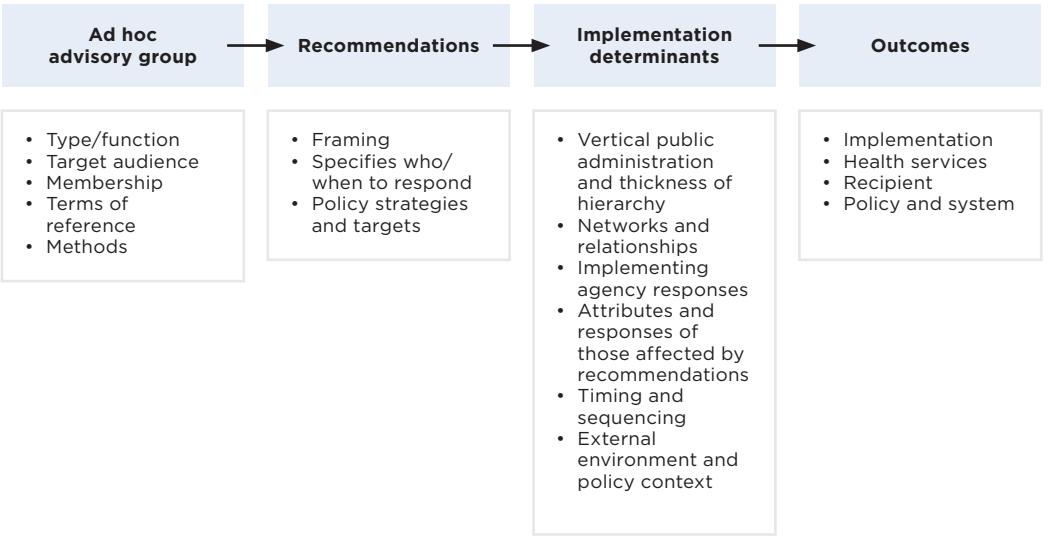
Since the passage of the *Medical Care Act* (1966) and the *Canada Health Act* (1985), there have been many federally established ad hoc healthcare policy advisory bodies that have addressed broad health system design challenges, including the National Forum on Health (1997), Romanow Commission (Commission on the Future of Health Care in Canada 2002), Kirby Committee (Standing Senate Committee on Social Affairs 2002), Advisory Panel on Healthcare Innovation (Advisory Panel on Healthcare Innovation 2015) and Advisory Council on the Implementation of National Pharmacare (2019). While each was national in scope, the Kirby Committee was established by the senate while the prime minister's office established the others. Despite the activities and their impact, there has been limited research on the role and influence of ad hoc advisory bodies in Canada. We aimed to understand the processes used to develop advice and recommendations as well as barriers, facilitators and outcomes of the implementation of advice and recommendations.

Methods

Conceptual framework

The conceptual framework guiding this study is based on Bullock et al.'s (2021) recent synthesis of policy implementation literature and implementation science literature. Our conceptual framework (Figure 1) integrates two parts of a policy implementation framework, namely, the policy process and determinants, developed by Bullock et al. (2021).

FIGURE 1. Conceptual framework representing the process of ad hoc advisory bodies developing recommendations, making recommendations, implementing recommendations and the outcomes of the recommendations, including implementation determinants



Source: Bullock et al. 2021.

The implementation process framework includes the advisory body's policy development process, the policy package (i.e., the group's recommendations), active implementation and outcomes. The advisory body's policy development process would be influenced by the

external context as well as their internal context, including intended and unintended functions of the group, group members and methods. The recommendations themselves could be influential based on how they were written; what types of policy strategies and targets were included; number and specificity. The implementation of recommendations could be influenced by the characteristics of recommendations and group processes as well as identified determinants of implementation, such as timing and sequencing, external environment/policy context, use of top-down or bottom-up approaches and relationships and responses of policy actors. In the healthcare sector, in particular, the attributes and responses of those affected by recommendations are critical implementation determinants due to the joint jurisdiction of healthcare. A range of outcomes are possible, including implementation of recommendations; impact on Canadians; and impact on health policy, healthcare services and the health system.

Participant selection and recruitment

We identified advisory body members and implementers through reports prepared by each advisory body, including the National Forum on Health (1997), Romanow Commission (Commission on the Future of Health Care in Canada 2002), Kirby Committee (Standing Senate Committee on Social Affairs 2002), Advisory Panel on Healthcare Innovation (2015) and Advisory Council on the Implementation of National Pharmacare (2019). We included these advisory bodies because they were ad hoc groups with a mandate from the federal government to provide advice and make recommendations about structural health and healthcare system policies, predominately related to healthcare funding, coverage and delivery, after the passage of the *Canada Health Act* (1985). We excluded inquiry-focused advisory bodies that addressed a specific health issue, such as the Krever Inquiry and the National Advisory Committee on SARS and Public Health.

After we created a sample frame of advisory body members and implementers (e.g., ministers of health when reports were released, the federal government staff who supported the advisory bodies), we recruited participants using a combination of purposive and snowball sampling. We aimed to recruit at least one advisory body member and one implementer from each advisory body for a total of at least 10 interviews. We initially contacted advisory body members and implementors in leadership positions in the advisory body or government of the time using publicly identified e-mail addresses. When unsuccessful, we reached out to the other advisory group members or attempted other communication strategies, such as LinkedIn messages. Furthermore, at the end of each interview, we asked the participants whom they would recommend we interview. Recruitment and data collection took place from May to October 2022.

In-depth interviews

We conducted interviews with participants over Zoom. Interviews ranged in length from 50 to 90 minutes. An interview protocol based on our conceptual framework was used to guide the interviews (Appendix 1, available online at www.longwoods.com/content/27502).

Interviews addressed the advisory body's mandate and processes (e.g., how the group worked together and with the government and what methods they used to solicit information from experts and citizens) as well as the implementation and impact of the advisory body's recommendations, including what the participant considered the greatest success of their report and what the barriers and facilitators were of implementing the report's recommendations. Interview proceedings were audio recorded, transcribed, deidentified and imported into NVivo 12 software (Lumivero 2017).

Analysis

Two authors (Amity E. Quinn [AEQ] and Rachelle Drummond [RD]) conducted a reflexive thematic analysis (Braun and Clarke 2006, 2019; Byrne 2022). Reflexive thematic analysis is a theoretically flexible type of thematic analysis to identify patterns of meaning that are not concerned with coding reliability or structured codebooks. It involves a process of data familiarization, data coding and theme development and revision. Themes, created from both codes and researchers' active engagement with data, are the output of the analysis.

AEQ and RD each participated in the interviews and independently reviewed the transcripts. They discussed the initial codes and agreed upon a first draft codebook based on our conceptual framework. After coding the first four transcripts, AEQ and RD refined the codebook. RD then independently coded the subsequent transcripts. Initial coding was predominantly deductive, following the conceptual framework. RD summarized the results within each code and subcodes. AEQ and RD engaged in a series of conversations to discuss the coding and to develop themes using an inductive process. These discussions led to substantial consolidation of themes through the consideration of both authors' interpretations of the data until themes were finalized.

This study was approved by the University of Calgary Conjoint Health Research Ethics Board (REB22-0156).

Results

We invited 22 individuals to participate. Twelve agreed to participate, one declined and the others did not respond to initial and follow-up messages. Of the 12 participants, nine were members of advisory bodies and three were implementers. Advisory body members included physicians, professors, policy experts and politicians. Implementers included political and civil service leadership and consultants to the federal ministry of health. Three of the participants were women, and nine participants were men. Because two of the implementers were involved in multiple reports, there were at least two interviews that addressed each of the five advisory groups of interest, which included the National Forum on Health (1997), Romanow Commission (Commission on the Future of Health Care in Canada 2002), Kirby Committee (Standing Senate Committee on Social Affairs 2002), Advisory Panel on Healthcare Innovation (2015) and Advisory Council on the Implementation of National Pharmacare (2019).

We identified three themes: (1) individuals have different interpretations of the policy impact of their recommendations; (2) conflict between different levels of government was a major implementation barrier; and (3) informal implementation strategies can facilitate implementation at different levels of government.

Individuals have different interpretations of the policy impact of their recommendations

Participants had different interpretations of the success or failure of their advice and recommendations. Most participants perceived a lack of implementation of their recommendations as a failure (based on personal interpretation) and were disappointed with how little concrete federal health policy change there has been in Canada since the 1990s.

Some participants did view the creation of the advisory bodies and their reports as a success. For example, even when most of their recommendations had not been implemented, these reports "shaped the [health policy] discussion for a generation" (P3, Advisory Body Member). The concept of the report as an influential idea was also articulated by a participant:

> One of the things I learned with public policy is that sometimes it can take a long time before anything gets adopted. I always look at public policy as what the *idea* is. It's kind of like a dripping. When a report comes out, there's an idea there. It takes many, many years, and then all of a sudden, swoosh, something gets adopted (P6, Advisory Body Member).

Participants highlighted that resistance to change remained despite the formation of the advisory body by the government, extensive research directed or solicited by the advisory body and extensive consultation with various levels of government and Canadians. One participant involved in the Romanow Commission expressed their frustration with the failure of implementation and lack of change:

> You look at the [National Forum on Health] table of contents and those are all the issues that we grappled during the Romanow Commission. There's some of the same issues we're grappling with in 2022. So, there is that level of frustration that we did all that work and commissioned all of that research to make the case and so little of it got taken up (P10, Advisory Body Member).

Furthermore, participants noted that many recommendations have been repeated in multiple reports, yet never implemented. Thus, when implementation does take place, it is difficult to attribute one advisory body as responsible for the success. Moreover, some participants reported that implementation was not part of the mandate or welcomed. And, in one case, the advisory body was terminated early and before implementation was considered.

Some participants, however, viewed the lack of implementation of repetitive recommendations as a necessary component of subsequent implementation. These participants noted that policy change can require a continuous push from experts and citizens over time. This perspective was reflected in the following statement:

> When you look at some of these reports, we get frustrated that this has been said three times, but in truth, if it wasn't said three times, the fourth one wouldn't have the frustration of saying, "Enough is enough" (P9, Advisory Body Member).

In addition, some participants thought that repetitive recommendations provided insight into what Canadians or Canadian institutions want and, thus, influenced the political agenda. As one participant said:

> It is interesting that the policy reforms advocated for in that report are the same that have been reinforced for the last 10 years, but it also is reflective of what Health Canada is interested in (P12, Implementer).

Conflict between different levels of government was a major implementation barrier

Prominent ongoing conflict was identified by all participants as one of the largest barriers to implementation. Participants discussed three distinct categories of conflict: (1) between provincial/territorial governments and the federal government; (2) within the federal government; and (3) between Canadians and the federal government.

Conflict between provincial/territorial governments and the federal government was the most frequently discussed type of conflict. Participants described this conflict as primarily stemming from the long-standing mistrust between the two levels of government arising from the division of power in the *Constitution Act* (1867) or resulting from cutbacks to federal healthcare spending contributions, such as those seen in the 1994–95 federal budget, which one participant referred to as a "bomb" (P10, Advisory Body Member).

Participants discussed that even when the federal government may want to move forward with the implementation of advisory body recommendations, the shared jurisdiction of healthcare relies on cooperation from provincial/territorial governments. One participant discussed that the lack of cooperation between provinces/territories and the federal government on healthcare reform is due to political differences. For example, when speaking about pharmacare, this participant explained:

> I think that Health Canada would probably like to make progress on pharmacare, but there are a number of provinces that don't want any part of it … the political ideologies of the different provinces … that are not aligned with the federal government pose these really tricky problems (P12, Implementer).

Conflict within the federal government was the second most frequently discussed type of conflict. At this level, participants identified conflict within advisory bodies themselves (e.g., priority disagreements) as well as between the advisory body and ministries and between ministries themselves, particularly health and finance. Changes in ministry leadership had the potential to substantially impact the advisory body's process. For example, during the National Forum on Health, the change of health minister led to the reduction of the group's budget, timeline and potential for implementation and distribution of their report. Similarly, initiatives championed by the ministry of health without support from the ministry of finance (indicated by allocated funds in a budget) or the prime minister's office, such as the Advisory Panel on Healthcare Innovation, are unlikely to be implemented. For example:

> I also met the health minister of the day … And she also seemed very interested and engaged in the process. The only thing that would seep out from time to time was, although she was very engaged, it really wasn't clear that the conservative cabinet was very engaged. So there was sort of a feeling that she was a bit of an outlier, or it was kind of a personal mission rather than it was supported by the government of the day. So, that was a bit concerning (P7, Advisory Body Member).

Conflict between the federal government and Canadians was the least frequently discussed type of conflict. Participants emphasized the importance of minimizing this type of conflict to generate citizens' support for healthcare reform. This type of conflict could arise from citizens' seemingly contradictory perspectives that the federal government did not follow through on promises of change and that change could threaten the current healthcare system, of which Canadians are very protective. As one participant explained:

> I think the protection of the status quo as it exists is more damaging and actually will unravel the system. Our biggest enemy are those that are protecting the status quo (P3 Advisory Body Member).

Informal implementation strategies can facilitate implementation at different levels of government

As several participants discussed, advisory body members were typically not legally permitted or welcomed to have an explicit role in implementing their proposed recommendations. These ad hoc federal advisory bodies dissolved following the submission of a report. Despite having no explicit role, participants shared a range of informal strategies they used within the federal government, with provinces/territories and with the public both during and after the development of their recommendations to facilitate implementation.

Implementation strategies at the federal government level included the prime minister chairing the advisory body (e.g., National Forum on Health), recurring meetings with the minister of finance and the ministry of health or parliamentary staff serving on the

advisory body. Bureaucratic staff serving in the advisory body had the role of "le fonctionnaire" (P1, Implementer), which provided a bridge between the group's recommendations and the government's reassessment of the recommendations and potential implementation. Implementation strategies at this level also included activities within and between advisory bodies, such as (1) meetings between members of the National Forum on Health and the Romanow Commission and (2) the Romanow Commission's very detailed recommendations that included timelines and designated responsibility, which participants explained were intentional because advisory body members had worked in government and were aware of the governmental process to implement policy recommendations.

Efforts to engage provinces and territories to foster implementation while developing their recommendations included consultation and coalition building, such as travelling to each province or territory for meetings. The Romanow Commission included an intergovernmental affairs officer on its small staff specifically for this purpose. A couple of participants discussed how advisory body members with personal relationships with provincial/territorial governments continued to meet informally with provinces and territories after the report was released.

All participants noted the public as invaluable to the implementation process, both during and after the development of the report. Efforts to engage Canadians while writing the report included gatherings and presentations, often in the form of town halls. Following the publication of their reports, several former advisory board members took it upon themselves to further disseminate the report to the public through presentations, media and follow-up reports.

Discussion

Based on interviews with members and implementers of federally established advisory bodies on health system design since 1990, we identified three themes: (1) individuals have different interpretations of the policy impact of their recommendations; (2) conflict between different levels of government was a major implementation barrier; and (3) informal implementation strategies can facilitate implementation at different levels of government.

Participants perceived that the federal government generally did not implement the recommendations of ad hoc health system-focused advisory bodies. As such, our detailed conceptual framework ultimately was not useful because there was too little implementation of the advisory body's recommendations to allow us to probe into implementation processes, determinants and outcomes. Matland's (1995) ambiguity-conflict model of policy implementation provides a more useful lens to understanding advisory body function and actions, the lack of implementation of recommendations and strategies to promote change. Matland's (1995) model describes the implementation processes along two axes: ambiguity and conflict. Ambiguity can exist around policy goals as well as policy means (e.g., external context, policy actor roles in implementation). Conflict occurs when there is interdependence between actors and is often evoked by symbolic policies. In areas with high ambiguity

TABLE 1. Summary of implementation barriers and facilitators across different levels of government

Implementation barriers	Level of government	Implementation facilitators
Lack of alignment between the advisory body, prime minister, ministry of health and ministry of finance	Within the federal government*	Group membership Recurring meetings with the minister of finance Meetings between members of different advisory bodies Detailed recommendations, including timelines and designated implementers
Shared jurisdiction of healthcare High level of mistrust due to continued reductions in federal healthcare spending contributions Political differences	Federal government* and provincial/territorial governments	Consultation Coalition building Intergovernmental staff role Members continued meetings with personal connections in provinces and territories after advisory bodies dissolved
Perception that federal government did not follow through on promises of change Perception that change could threaten the current healthcare system Symbolism of medicare	Federal government* and citizens	Engagement in the development of recommendations (e.g., townhalls and focus groups) Presentations, media and publications following the report

*Because advisory bodies are considered part of the federal government, this includes actions the advisory body themselves undertook during or after the development of the recommendations as well as advisory body actions related to the broader federal government's relationships.

and high conflict, defining successful implementation is difficult and implementation is less likely. Furthermore, when implementing policy in areas of high ambiguity and high conflict, the role of policy actors with professional training – such as advisory body members – and the role of coalitions are essential (Matland 1995).

As is clear from our results and current news, health system reform in Canada is an area with high ambiguity and high conflict. Health policy is complex and highly symbolic, and there is interdependence between federal and provincial/territorial governments with a lack of clarity around specific implementation roles and responsibilities. Advisory bodies are composed of public members as well as professionals and experts with a range of relevant training and are able to navigate ambiguous policy goals and means as well as conflict between policy actors. To do this, the advisory bodies that we studied appeared to play multiple functions, including agenda setting, information gathering and coalition building (Zegart 2004) in an effort to reduce ambiguity and conflict, including their engagement with experts as well as the federal government, provinces/territories and citizens and creation of specific staff roles such as an intergovernmental affairs officer. Nevertheless, the policy advice and recommendations that they proposed ended up being successful as ideas for health policy experts or future policies.

Based on our findings, we propose three strategies for policy advisors to consider to improve the outcomes of future health system advisory bodies: (1) prioritize coalition building; (2) integrate implementation plans; and (3) require evaluations of advisory body reports and processes. These strategies are supported by findings on the influence of royal commissions in Australia, which found successful reports from royal commissions included coalition building, particularly listening to people and recognizing the power of emotion holding coalitions together, detailed implementation plans and required monitoring and reporting on the implementation process (Mintrom et al. 2021). Moreover, these strategies could be used by individual health policy experts when advising decision makers.

1. Prioritize coalition building

Conflict at different levels was the major barrier to the implementation of advisory bodies' recommendations. Advisory bodies were not only aware of that but also attempted numerous strategies to build coalitions in order to overcome the conflict, such as citizen engagement (McIntosh and Forest 2010). Because conflict will likely remain an issue in national health policy considering the joint provincial and federal jurisdiction, coalition building could facilitate the implementation of future advisory group recommendations.

There are several advantages of coalitions, specifically in the health context, including involvement without direct responsibility for the solution, demonstration of public support for an issue and maximization of power of each member as they come together through joint action (Butterfoss et al. 1996). Together, these advantages can promote policy implementation through goal alignment (Butterfoss et al. 1996). Strategies used by advisory groups in this study to engage both citizens and private industry in coalitions include engagement in the development of recommendations (e.g., town halls and focus groups) and presentations, media and publications following the report. Coalition members could also be integrated into implementation and evaluation plans.

2. Integrate implementation plans

Advisory body members do not have an explicit role in the implementation process. Final reports typically had no or few stated implementation plans, which relates to the interview findings regarding the lack of government mandate to implement advice and recommendations. In contrast, the Romanow Commission – which is arguably the most successful advisory body we studied because of the subsequent passage of the 2004 Health Accords (Health Ministers of Canada 2004) – intentionally included implementation details, such as timelines and responsible parties. Implementation plans that identify timelines, goals and clearly defined roles and responsibilities can reduce ambiguity to facilitate the implementation of the recommendations.

Implementation plans can be informed by political science, implementation science or policy implementation science literature. Bullock et al. (2021) provide suggestions for implementation strategies based on policy targets and strategies. Creating dedicated funding

sources that align with the time required for implementation is an example of an implementation strategy for system-level policy change that targets financial arrangements. From the implementation science literature, the Long Term Success Tool (Lennox et al. 2017) or the Intervention Scalability Assessment Tool (Milat et al. 2020) can inform health policy implementation plans, including an assessment of acceptability, setting and workforce; implementation infrastructure; and sustainability.

3. Require evaluations of advisory body reports and processes

Evaluations of the advisory bodies that we studied were not required. Our interviews regarding the success or failure of the implementation of recommendations often seemed to be the first assessment of the report, coming decades after most of the groups we studied. More recent ad hoc federal advisory bodies have been required to conduct evaluations, including the Task Force on Cannabis Legalization and Regulation (2016). Evaluations have the potential to facilitate implementation by creating an accountability mechanism while allowing for an assessment of the implementation process and outcomes. Furthermore, evaluations of advisory bodies can improve our understanding of their purpose and the role that they play in policy implementation.

A range of evaluation approaches could be considered. A 2017 Royal Commission in Australia recommended strategies to monitor the implementation of their report, which could be adapted as follows (Mintrom et al. 2021): First, national, provincial and territorial governments could be required to indicate if they accepted, rejected or wanted further discussion with respect to an advisory body's recommendations. Second, the federal government could publish annual reports on implementation progress for a certain number of years immediately following the advisory body activity. Third, other institutions or groups (e.g., coalition members or advisory body members) could also make annual reports on implementation progress. Last, a review of the implementation could be conducted after approximately 10 years of the advisory body report.

There are several limitations to this study, particularly around the understanding of the advisory bodies themselves and our analytic approach. First, the intention of a specific advisory body is challenging to determine. While we did ask participants about the intention behind their advisory group, there was a range of perspectives among participants if their recommendations were expected to be adopted, either when the group was formed or during the process. Conducting interviews or using other evaluation methods closer to the advisory body's activity could provide a clearer understanding of the advisory group's intention and impact. Second, in focusing on the implementation of the advisory body's recommendations, we assumed that the recommendations of the advisory body were reasonable. It was beyond the scope of this paper to evaluate the appropriateness of the recommendations themselves. Third, we did not beta-test the interview guide. However, the interview guide was designed to be semistructured and refined before and during data collection to reflect suggestions from our research team and our experience in initial interviews (Appendix 1, available

online at www.longwoods.com/content/27502). Last, we conducted 10 interviews about five advisory bodies and did not attempt to achieve saturation (of data or meaning). While the number of interviews and absence of saturation may impact the external validity of our findings, our approach to data collection and analysis (reflexive thematic analysis) was selected intentionally to acknowledge the subjectivity of advisory group members' and researchers' perspectives.

Conclusion

Participants perceived that the federal government generally did not implement the recommendations of ad hoc health system-focused advisory bodies. Despite the implementation strategies that groups used to engage federal ministries, provincial/territorial governments and citizens, the persistent conflict surrounding the highly symbolic policy of medicare ultimately resulted in a symbolic implementation of the reports as influential ideas for health policy experts or future policies. To improve the outcomes of future health system advisory bodies or other policy development processes, policy advisors should prioritize coalition building during policy development, integrate implementation plans into policy recommendations and evaluate the impact of the policy recommendations.

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RESEARCH PAPER

Health Worker Protests in Canada: A Descriptive Analysis of Protest Events From 2021–2022

Manifestations des travailleurs de la santé au Canada : analyse descriptive des événements de protestation en 2021 et 2022

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Abstract

Objectives: We analyzed protest events undertaken by health workers in Canada in 2021 and 2022. Our analysis focused on the quantity and distribution of protests within Canada, policy demands expressed by organizers and the temporal sequence of protest events.
Methods: Our data came from the Armed Conflict Location and Event Data (ACLED) project, which includes a dataset with all health worker-involved protest events in specific jurisdictions, including Canada. Using an existing taxonomy of policy demands for protest events, we analyzed specific types of protests, protest demands and temporal trends.
Results: Over our study period, ACLED identified 157 health worker protests. Events took place in all provinces, with Ontario recording the highest proportion (~40%). The majority of protests focused on working conditions and remuneration (57%), followed by public policy (26%) and health services delivery (21%). The most frequent subcategories were

compensation (n = 48), anti-vaccination mandates (n = 38) and understaffing/patient overload (n = 19).
Conclusion: Canadian health workers expressed concerns on policy issues ranging from opposition to COVID-19 mitigation to underinvestment in health systems. Identifying and recognizing these drivers and developing targeted policy to address them through inclusive and sustained engagement with health workers will contribute to long-term solutions.

Résumé

Objectif : Nous avons analysé les mouvements de protestation organisés par des travailleurs de la santé au Canada en 2021 et 2022. Notre analyse s'est concentrée sur la quantité et la répartition des manifestations au Canada, sur les revendications politiques exprimées par les organisateurs et sur la séquence temporelle des manifestations.
Méthode : Nos données proviennent du projet ACLED (*Armed Conflict Location and Event Data*), qui comprend un ensemble de données sur tous les événements de protestation qui impliquent des travailleurs de la santé dans certains États, dont le Canada. Au moyen d'une taxonomie déjà en place sur les revendications politiques, nous avons analysé des types précis de manifestations, de revendications et de tendances temporelles.
Résultats : Pour la période visée par notre étude, l'ACLED recense 157 manifestations de travailleurs de la santé. Toutes les provinces ont connu ce type de manifestations, l'Ontario ayant enregistré la plus forte proportion (~40 %). La majorité des manifestations portaient sur les conditions de travail et la rémunération (57 %), suivies par les politiques publiques (26 %) et la prestation des services de santé (21 %). Les sous-catégories les plus fréquentes étaient la rémunération (n = 48), l'opposition aux obligations vaccinales (n = 38) et le manque de personnel ou la surcharge des patients (n = 19).
Conclusion : Les travailleurs de la santé au Canada font état de préoccupations en matière de politique publique, préoccupations qui vont de l'opposition aux mesures d'atténuation de la COVID-19 au sous-investissement dans les systèmes de santé. L'identification et la reconnaissance de ces facteurs, ainsi que l'élaboration d'une politique ciblée pour y faire face grâce à un engagement inclusif et soutenu auprès des travailleurs de la santé, contribueront à trouver des solutions à long terme.

Introduction

The roles and influence of health workers in health policy processes – and public policy more broadly – are gaining increasing attention in health scholarship (Ahmed et al. 2022). Representative health worker organizations, such as unions and professional associations, play a key role in health policy processes, facilitating dialogue between government, employers and health workers (Sriram et al. 2023). Furthermore, health worker engagement with policy processes through activities such as voting, organized lobbying, collective bargaining and protest activity plays an important role in shaping public policy (Sriram et al. 2023). These activities have implications beyond labour concerns, including patient well-being,

healthcare financing, resource allocation and other public health, healthcare and public policy domains (Brophy and Sriram 2021; Lasco et al. 2022; Laugesen 2019). A current strand of research has sought to understand the political preferences of health workers – especially physicians (Ahmed et al. 2022; Bonica et al. 2014; Jena et al. 2018). Simultaneously, recent research on the politics of representative health worker organizations in more diverse contexts than previously studied has begun to theorize about the strategies used by these organizations to advance their policy agendas (Brophy and Sriram 2021; Sriram et al. 2023). Still, many questions remain regarding policy preferences within and across the health workforce and the modes by which health workers make those preferences known (Hagedorn et al. 2016).

Health workers belong to a heterogeneous group of occupations (including those delivering clinical care such as doctors and nurses as well as those delivering non-clinical services such as long-term care workers and custodial staff) with diverse concerns and demands regarding both the conditions of their occupations and larger healthcare systems (WHO 2019). Protests and strike action are an important window into understanding the policy preferences of various constituencies of health workers. The use of protest and strike action by health workers in particular has received greater public attention due to the COVID-19 pandemic. Since the earliest stages of the pandemic, numerous countries experienced protests and strikes led by health workers calling for improved compensation and benefits, better working environments and resources needed to perform their roles (Brophy et al. 2022; Mavis Mulaudzi et al. 2021; Trappman et al. 2022). Beyond the specific challenges imposed by COVID-19, protests and strikes signalled that health workers have wide-ranging grievances and concerns about issues including (but not limited to) healthcare systems, public health and public policy (Jane et al. 2022).

Canada – similar to countries around the world – is experiencing a health workforce crisis. Employment vacancies in the healthcare sector have been high, particularly in nursing and residential care facilities (Drummond et al. 2022). The impacts of COVID-19 on health workers in Canada include immediate concerns related to pandemic response (i.e., resource constraints and safety concerns) as well as longer-term challenges (i.e., declining trust in healthcare and scientific expertise). The pandemic also exacerbated workforce and system delivery challenges in health sectors across Canada. For example, in April 2020, the Canadian Armed Forces were deployed to senior care facilities in Ontario and Quebec to assist medical care and support staff who were overwhelmed by the onset of the pandemic in the midst of a workforce crisis and reported dire conditions in the facilities (Brewster and Kapelos 2020). Attrition within the workforce is increasing, as practitioners exit the workforce in part due to burnout (Drummond et al. 2022; Duong and Vogel 2023; Gajjar et al. 2022; Leo et al. 2021), compensation, understaffing and challenging working conditions (Drummond et al. 2022; Stewart 2022), which were concerns driven by or made worse due to the pandemic. Some health workers are exiting the public sector to pursue employment in private agency staffing models (Grant 2023), contributing to ongoing constraints

and challenges with health worker supply (Drummond et al. 2022). These trends have been fuelled by public policy decisions – several of which predate the pandemic – that have negatively impacted health workers' remuneration, benefits and job security. For example, the Ontario government passed *Bill 124* in 2019, which limited public sector wage increases to 1% per year for three years (Jones 2019), prompting legal action and protests by public sector employees, including health workers (Wilson 2022).

It has become increasingly apparent that more research is needed to understand the policy demands of health workers in Canada within a global context. The health workforce crisis in Canada has ripple effects on other countries; migration of internationally trained health workers, largely from the Global South, to Canada has been actively promoted as a policy solution to addressing the national shortage (Government of Canada 2023; Tasker 2023), creating challenges for resource-constrained countries experiencing their own workforce shortages (WHO 2023). The World Health Organization has estimated that there will be a global shortage of 10 million health workers by 2030, primarily in low- and middle-income countries (WHO n.d.). Policy issues that demand collective action and global solidarity, such as the climate crisis and racial injustice, have also recently become more prominent in the advocacy of Canadian health workers (Jane et al. 2022; Kalifa et al. 2022).

Approximately 54% of Canadian health workers are unionized (Statistics Canada 2024), with heterogeneity across occupational groups. Canadian health workers have a long history of engaging in resistance, including protests and strikes (both legally sanctioned and non-sanctioned) (Heron and Smith 2020). For example, doctors in Saskatchewan organized a 23-day strike in 1962 in opposition to single-payer health financing in the province (Marchildon and Schrijvers 2011). Following mediation, a compromise was reached that enabled physicians to secure concessions around reimbursement and for the *Saskatchewan Medical Care Insurance Act* to move forward (Marchildon and Schrijvers 2011). Nurses in Canada – 90% of whom are unionized – have also engaged in multiple forms of resistance, including protests and strikes in multiple provinces over several decades, catalyzed by myriad concerns, including working conditions, compensation and labour rights (Briskin 2011). In 2004, the Hospital Employees' Union in British Columbia launched an unauthorized strike resisting privatization and contracting of food, housekeeping, laundry and other services to for-profit transnational companies (Isitt and Moroz 2007). In recent years, Canadian medical students have advocated for urgent attention to the climate crisis and other key social movements, such as Indigenous Peoples' rights and racial justice (Jane et al. 2022). These examples illustrate the important role of protest and strike action as platforms for the Canadian health workforce to express concerns and demand change in the absence of consistent and inclusive mechanisms for policy dialogue. However, it is important to recognize that health workers are heterogeneous, with considerable diversity in the workforce in terms of factors such as gender, race, country of origin and levels of unionization (CAHS 2023; Statistics Canada 2024), and hold diverse values and perspectives, resulting in varied drivers of protest and strike action that are in need of scholarly attention.

Health worker protests therefore provide a vital lens into the policy demands put forward by health workers and suggest important learnings for the influence of these groups on health policy processes. Despite the growing public attention to healthcare workers' protests, little scholarly attention has been paid to these forms of labour protests in interdisciplinary health scholarship (for exceptions, see Brophy et al. 2022; Russo et al. 2019; Trappman et al. 2022). In Canada, these dynamics are a crucial aspect of health workforce governance and health policy processes provincially and nationally, but it is yet to be investigated comprehensively. This paper begins to address this gap through a descriptive analysis of healthcare worker protests in Canada between January 2021 and December 2022 included within the ACLED project database. We focus on the following dimensions of health worker protests and strike action: (1) the quantity, clustering and distribution of protest and strike action in Canada; (2) policy demands expressed by organizers; and (3) the temporal sequence of protests in 2021 and 2022. We conclude with a discussion on the health workforce crisis as a policy issue arising, in part, from the culmination of these unmet demands.

Data and methodology

Data for this article come from the ACLED database (Raleigh et al. 2010), a comprehensive database of event-level information on protest action and political violence sourced from local, national and international media sources; non-governmental and governmental organizations' reports; and vetted social media. Events are defined as an occurrence involving designated actors, which occurs at a specific location on a specific day (ACLED 2024a: 9). Furthermore, ACLED defines a protest as "a public demonstration in which the participants do not engage in violence, though violence may be used against them" (ACLED 2024a: 13). For example, ACLED captures public protest rallies by health workers but does not capture non-public lobbying activities by advocacy groups (such as that described by Glynn 2023). Since ACLED specifies the actors involved in given events, we were able to isolate events involving health workers. ACLED defines health workers as "all civilians who engage in actions with the primary goal of providing health services to a community," including doctors, nurses, long-term care workers, midwives and other health professions (ACLED 2024b). The reliability and validity of events included in ACLED is ensured by in-house data collection review, test intercoder reliability and methodological consistency (ACLED 2023a, 2023b).

We used a dataset from ACLED that captured all health worker-involved protest events in Canada between January 2021 and December 2022. Our data are limited to this time frame as ACLED only began coverage of Canada in 2021. We applied an existing protest event coding framework to classify the different types of health worker protest events in Canada (Brophy et al. 2022). This framework classifies the drivers of health worker protest events into five major categories: (1) resources (RES), (2) working conditions and remuneration (WCR), (3) health service delivery (HSD), (4) public policy (PUBPOL), and (5) other. RES refers broadly to material supplies needed for health workers to perform their duties,

such as personal protective equipment (PPE). WCR captures protests regarding compensation, worker safety and other related concerns. HSD refers to issues within the health system more broadly and the ability of health workers to provide care within the system, including underfunding of healthcare, infrastructure and quality of care. PUBPOL includes other government programs and policies not explicitly related to healthcare delivery, such as stay-at-home orders and environmental concerns. The final category, other, captures the small number of protest drivers that do not readily fit into the other categories, such as protests of solidarity with other workers and demanding recognition for work. In addition, we included subcategories of each primary category to further illuminate the nuances of each protest event. For example, one of the subcategories under WCR is compensation, which includes delayed pay, unemployment pay, risk allowances and related concerns. A complete codebook is available as an online supplement.

The initial codebook was applied to a subset of protest events, with additional subcategories added to categorize protest demands that were not accurately captured in the existing codebook. The coding of protest events was conducted independently and in duplicate to ensure accuracy. One analyst was the primary coder and classified all protest events independently. Two other analysts each coded approximately 20% of the dataset independently to ensure accuracy. All discrepancies in coding were resolved through discussion within the team.

Data preparation and descriptive analyses were run in Microsoft Excel. We computed counts of protests in specific provinces, counts of specific types of protests and counts of protests according to categories in the codebook and created a timeline of protest count over time. In addition, we used Tableau to produce a map of health worker protest locations across Canada using the longitude and latitude coordinates provided in the ACLED database. Ethics approval was not required for this observational study of aggregated data.

Results

In total, our dataset includes 157 unique events. We categorized each event based on its method of protest (armed conflict, peaceful gathering, etc.) using the ACLED (2024a: 26–28). The majority of recorded protests (n = 151) were one-sided and peaceful events. Seven protests – all concerning anti–COVID-19 mitigation approaches – involved counter protesters. Five protests were categorized as two-sided peaceful events due to the presence of counter protesters, some of whom were identified as healthcare workers in support of public health measures. Two protests involving both protesters and counter protestors (the latter including healthcare workers) were a part of the 2022 Freedom Convoy and involved some element of police involvement in managing safety of attendees. While all events captured within our dataset are coded as a type of protest event, there was one event in Ontario that is described in the ACLED database as a strike and picket line.

Overall, there were 0.42 protest events per 100,000 population within Canada (Statistics Canada 2023). The province of Ontario saw the highest number of unique protest events,

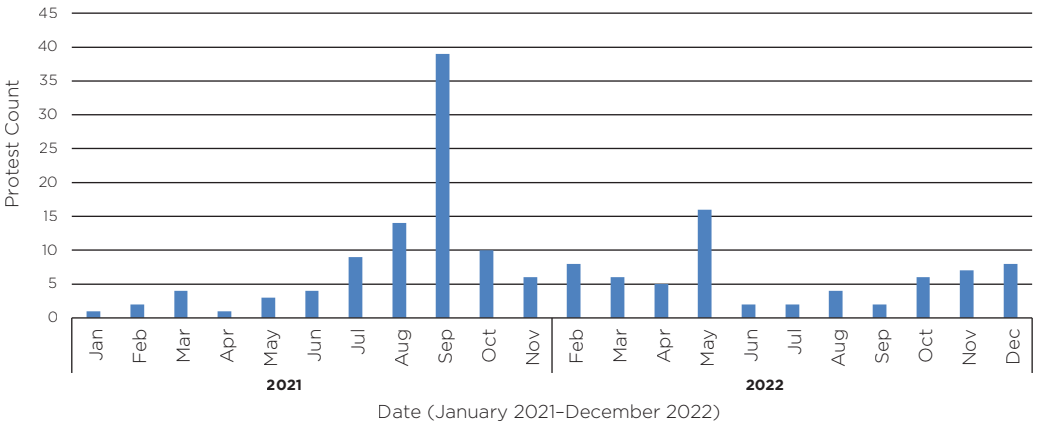
with 63 events captured within our time frame. Quebec and British Columbia saw the second-highest number of protest events, with 25 recorded in each province. Alberta recorded the next highest number of events with 18. The remaining provinces experienced six or fewer events over the same period, and there were no recorded protest events in the three territories. Of the 157 events captured in our database, 74 (47.1%) were identified as having union involvement, that is, any event within the database that identified a union or union members as participants or organizers of the event.

The timeline in Figure 1 outlines a temporal account of the number of unique protest events by date. While most datapoints indicate single-site events, a few clusters of protests occurred. By cluster event, we mean a group of more than one protest event that occurred on the same day that are connected through a shared organization and protest aim. The first cluster took place on September 1, 2021, as part of a "worldwide walk" (Worldwide Walkout for Health Freedom) and included 12 protests in four provinces led by the Canadian Frontline Nurses network, a group focused on advocacy against various COVID-19 mitigation strategies (vaccine mandates, mandatory masking, etc.) (*CBC News* 2023). The Canadian Frontline Nurses network was not affiliated with recognized labour unions and was, in fact, denounced by these same unions (*CBC News* 2021; Junker 2021). The second cluster that occurred on September 13, 2021, where protesters demonstrated against COVID-19 lockdowns in 13 cities across eight provinces (mostly concentrated in British Columbia but also in Alberta, New Brunswick, Ontario, Prince Edward Island, Quebec, Manitoba and Saskatchewan), was also organized by Canadian Frontline Nurses. Small groups of counter protesters supporting public health measures were present at multiple sites in this second cluster – Calgary, Edmonton, Saskatoon, Toronto and Winnipeg.

The final cluster occurred on December 12, 2022, across Ontario, where protesters demonstrated against the governing Conservative Party's handling of the health system crisis and the ongoing privatization of healthcare within the province, exacerbated by the introduction of *Bill 124*. This cluster of events was organized by the Ontario Health Coalition, a network of over 400 grassroots organizations in Ontario that supports progressive health policy and action. Some protest events in this cluster involved union members and leaders, particularly from the Canadian Union of Public Employees (CUPE).

Overall, WCR was the largest category with 91 protest events. HSD and PUBPOL also featured prominently, with 41 and 33 coded cases, respectively. Fewer cases were coded in the other category, numbering only seven cases total. There were no cases coded under the RES category. The number of primary categories exceeds the number of events due to select protest events focusing on more than one primary area of concern. For example, some protests were coded as both WCR and HSD, such as a motorcade protest organized by the United Nurses of Alberta on September 17, 2021, against understaffing (captured under HSD) and underfunding (captured under WCR). Protests involving unions focused on demands such as compensation (n = 31), contract negotiation (n = 7) and privatization (n = 7), while protests organized without explicit union presence or involvement included a dominant focus

FIGURE 1. A count of health worker protest events in Canada, 2021–2022

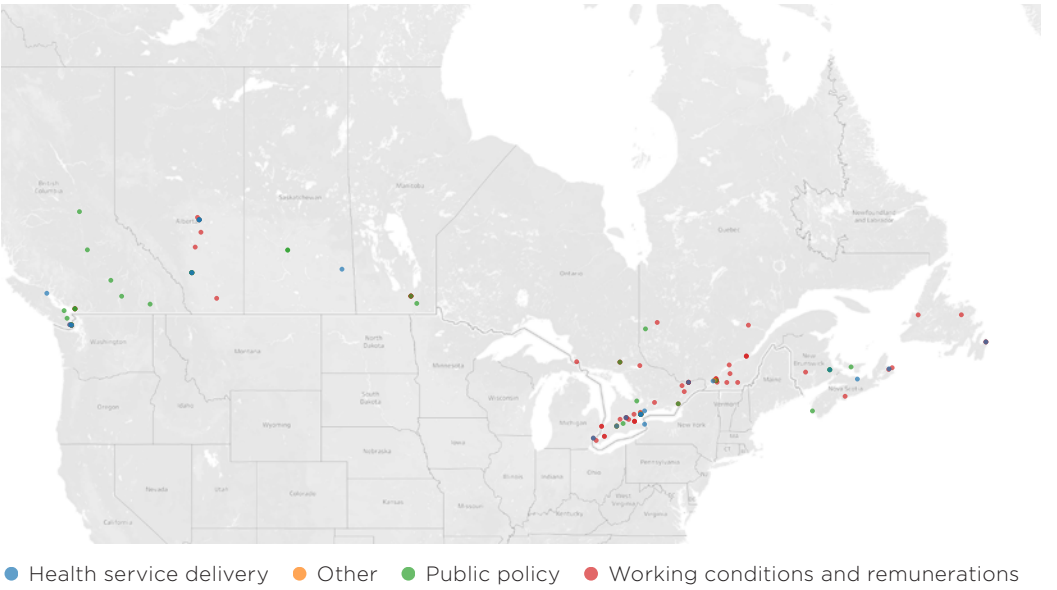


on anti-vaccination advocacy (n = 34), compensation (n = 16) and understaffing or patient overload (n = 6).

Figure 2 outlines the distribution of protest events by policy demand across Canada. The distribution of protest events appears to reflect provincial population densities, with most protest events occurring in Ontario, Quebec and British Columbia. However, the distribution of protest categories varies between provinces. For example, the majority of protest events in British Columbia focused on PUBPOL, while protests in Quebec were primarily concerned with WCR. One example of a remuneration-focused protest in Quebec occurred on February 11, 2021, when a small group of healthcare workers staged a protest outside of Quebec Premier Francois Legault's office to demand hazard pay during the COVID-19 pandemic and recognition of their work throughout the pandemic. Provincial variation may be indicative of contextual realities between the provinces during the period of analysis, such as the dispute over *Bill 124* in Ontario, which prompted 11 protest events explicitly against the legislation.

Table 1 examines our coding at the secondary category level, analyzing the specific area of focus for each protest event. Overall, compensation was the largest category of targeted issues within our cases, followed closely by vaccination. Notably, all vaccination-focused protests expressed anti-vaccine sentiment rather than demonstrating for increased vaccination rates, accessibility of vaccinations or other expressions of support for vaccination. Understaffing/patient overload, privatization, anti–COVID-19 mitigation strategies and union contracts/negotiations also occurred frequently within the dataset. There were eight protests concerning unspecified working conditions (i.e., the case description within the ACLED dataset did not specify which working conditions were being protested) and six expressing solidarity with other workers. The remaining issues were featured in less than five protest events each throughout the time frame included in this dataset. Similar to the primary level of coding, our total number of coded events exceeds 157 due to select cases focusing on multiple issues simultaneously. Table 2 displays data on healthcare worker

FIGURE 2. A map of protest events in Canada by primary category



populations by province. An analysis of event data by protest demands and provinces is available in Appendix 1, available online at www.longwoods.com/content/27564.

TABLE 1. Counts of primary and secondary protest demands

Main category of protest demand	Subcategory of protest demand	Count
WCR	Compensation	48
PUBPOL	Anti-vaccination	38
HSD	Understaffing/patient overload	19
HSD	Privatization	13
PUBPOL	Anti–COVID-19 mitigation strategies	13
WCR	Union contracts/negotiations	11
WCR	Working conditions	8
Other	Solidarity	6
HSD	Spending/underfunding	4
HSD	Quality of care/facilities/healthcare system	4
PUBPOL	Anti-masking policies	3
HSD	Health system capacity	3
Other	Recognition of work/sacrifice	3
HSD	Health infrastructure	3
PUBPOL	Mitigation strategies	3
	All other subcategories (< = 2 counts each; e.g., provincial health coverage, health disparities, dismissal, violence toward health workers, job security, social and living supports, worker protections)	19

HSD = health service delivery; PUBPOL = public policy; WCR = working conditions and remuneration.

TABLE 2. Provincial analysis of protest events

Province	Number of health workers by CIHI definition (2017–2021 average)	Number of health workers per 100,000 population (2017–2021 average)	Number of protests	Protests per 1,000 health workers
Newfoundland and Labrador	25,458	4,860	5	0.196
Prince Edward Island	7,078	4,498	1	0.141
Nova Scotia	46,088	4,749	6	0.130
New Brunswick	35,530	4,571	5	0.141
Quebec	335,119	3,953	25	0.075
Ontario	523,005	3,607	63	0.120
Manitoba	56,260	4,123	6	0.107
Saskatchewan	48,874	4,182	3	0.061
Alberta	185,859	4,270	18	0.097
British Columbia	180,239	3,547	25	0.139
Yukon	1,909	4,619	0	N/A
Northwest Territories	637	1,410	0	N/A
Nunavut	451	1,169	0	N/A

CIHI = Canadian Institute for Health Information.

Discussion

This paper presents descriptive evidence regarding the scale and scope of protest action by health workers in Canada during 2021 and 2022. Events were reported in every province during the time period studied, though no events were captured in the Northwest Territories, Yukon or Nunavut. The highest absolute numbers of protest activity were seen in Ontario, with the Maritime provinces seeing the least protest activity during the period of analysis. Protest activity appears to follow population density trends, with the most populous provinces (Ontario, Quebec and British Columbia) seeing the most activity in terms of absolute numbers. Nearly half of all protests involved unions as participant organizers of the event (47.13%). Protest demands were heterogeneous. Overall, more than 57% of protests focused on WCR broadly understood, and compensation (n = 48) and understaffing/patient overload (n = 19) were the most frequently occurring secondary categories. Protests organized by unions were primarily concerned with remuneration, working conditions and healthcare systems as opposed to those organized by non-union organizations, which included a sizable focus on anti–COVID-19 mitigation measures, such as anti-vaccination (n = 38), other anti-mitigation measures (n = 13) and anti-masking policies (n = 3).

Existing research on protests and strike action by health workers in Canada has tended to focus on particular occupational groups or has applied a historical analysis of incidents from across Canada (Briskin 2012; Heron and Smith 2020). Our study contributes to this literature by providing a comprehensive measure of health worker protest activity in a two-year time period, capturing commonalities across protest demands and connections between

protesting groups. The distinctive nature of contextual factors during this time period (2021–2022) resulted in a focus on protest demands that might not have otherwise emerged as salient, that is, COVID-19 mitigation measures. That said, external shocks such as COVID-19 are often the site of emergent social movements, serving as a window into issue identification and framing (Pleyers 2020). While the anti–COVID-19 mitigation protests were organized by a small number of individuals with explicit disapproval and denunciation from unions, emerging research is indicative of the social movement potential of anti-vaccine and COVID-19–denialist groups such as Canadian Frontline Nurses (Rohlinger and Meyer 2024; Wolf and Theunissen 2023; Zajak 2023). The potential harms of such advocacy – arguably more potent due to the involvement of health workers – are now readily apparent in rising vaccine hesitancy and mistrust of public health advice in Canada and globally. This finding provides an impetus for further research and analysis on the nature of healthcare workers' involvement in opposing public health measures. Practice implications could include the development of efforts to counter misinformation and periodic awareness building programs around public health programs, such as immunization campaigns, for the health workforce.

Our findings align with research on protest demands, which demonstrate the dominance of concerns regarding compensation and working conditions. A review of protests by health workers in the first year of the pandemic (March 2020 to March 2021) found that of the 6,589 protests by health workers in 149 countries, 66% concerned working conditions and compensation (Brophy et al. 2022). Research on health worker protests in 90 countries during the COVID-19 pandemic (Trappman et al. 2022) similarly found that the majority of protests concerned compensation, followed by PPE and safety concerns. Russo et al. (2019) similarly highlighted that prior to COVID-19, in low-income countries, many events were motivated by compensation and working conditions. Our study builds on previous research by highlighting the diverse concerns voiced by health workers in Canada, such as several protests regarding healthcare systems and reform (e.g., privatization).

Our research has identified key areas of concern for Canadian health workers, including compensation, working conditions and systemic challenges pertaining to healthcare access and quality. Engaging with the workforce and systems-level concerns expressed by health workers through dialogue and policy development provides a pathway for the federal and provincial governments to make sustainable progress toward addressing the health workforce crisis. There are growing concerns among the public regarding provincial health systems; a recent poll indicated that 86% of people surveyed are worried about the state of healthcare in their province (Canadian Press 2023). Failing to act on long-term policy concerns expressed by the health workforce may exacerbate the health workforce crisis, driving further discontent from health workers and the public.

Nearly half of the protest events examined here had union involvement, further strengthening the case for investigating health worker organizations as highly relevant policy stakeholders. In addition to expressing policy preferences, protests may also impact

government policy directly; following mobilization by Ontario labour forces, the government repealed *Bill 124* after a lengthy legal challenge (Casey and Jones 2024). Examples of protests and strikes shaping health policy in Canada are found throughout the trajectories of healthcare policy in Canada, most notably, the 1962 Saskatchewan doctors' strike (Marchildon and Schrijvers 2011). However, disentangling the precise causal relationship between protest activity and policy amendment, particularly given the context specificity of labour organizing across the provinces, requires further in-depth study.

Our results yield a few notable outcomes, which prompt questions for future research. First, a significant number of protest events focused on vaccine mandates, or COVID-19 mitigation more broadly. The descriptions of these protests in ACLED indicated that they were primarily negative in sentiment, protesting *against* rather than in favour of vaccines or other mitigation measures. Asymmetry in sentiments toward vaccinations and mitigation measures may also be due to pro-vaccination and pro–COVID-19 mitigation strategies with health worker coalitions being less likely to attend gatherings in person within the study period. Future research on the sentiment of the COVID-19 era healthcare worker protests could illuminate the stances of healthcare workers on COVID-19 mitigation measures across regions, countries and fields of practice. Second, certain unions organized multiple protest events, occurring over consecutive days and in different locations. Future in-depth research could examine such episodes in order to identify changing organizational practices and strategies over time. Third, our findings on the drivers of health worker protests suggest that further comparative research, within Canada and between Canada and other jurisdictions, will yield important insights regarding broader structural challenges in the health sector.

For example, while compensation was a secondary category identified in this study, it may help to investigate geographic differences in protest distribution with this demand across provinces. An inter-provincial examination of health worker protests in Canada may illuminate key differences or similarities between provinces' experiences with these protest events, such as their thematic focus, strategies and catalysts for mobilization. Furthermore, the Canadian case reflects previous international findings, which indicate that health worker protests during the COVID-19 pandemic have predominantly focused on compensation and working conditions. This similarity prompts the opportunity to explore the impact of large-scale catalysts on health workers' demands during protests and strikes, and whether such events present differently in various contexts. Lastly, some provinces have legislation, which prevents certain sectors from engaging in legal strikes. In Ontario, nurses do not have the right to strike as per the *Hospital Labour Disputes Arbitration Act* (CanLII 1990). A deeper exploration into the relationship between anti-strike legislation and protest and strike activity may yield important insights into labour mobilization (or non-mobilization) to express policy preferences.

Limitations

There are certain limitations to our study that must be considered in interpreting the results.

First, while the ACLED database is the most comprehensive available source for identifying health worker protests, it is possible that certain events were not captured by their data collection methods. ACLED acquires data from four sources: traditional media, reports, local partner data and new forms of media (e.g., WhatsApp). Traditional media includes "all subnational, national, regional, and international media outlets that are governed by journalistic principles of verification" (ACLED 2023c, p. 2). A protest event that received no media coverage would not be included within the ACLED database and would be subsequently uncaptured by our coding. Because information about protest actors is sourced from media as opposed to surveys, important attributes such as identity demographics, wage levels of protesters and accurate standardized estimates of protest sizes are not included in the database. Union and organized participation were typically mentioned in media sources, and thus, we could further examine them in our coded dataset. We are unaware of linkable sources for other potential variables of interest, which should be the focus of future work in this area. Second, the ACLED definition of health workers includes a broad range of occupations; however, certain occupational groups in the health sector that are not more directly engaged in various aspects of HSD, such as planners or decision makers, might have been omitted from data collection and therefore are not included in this analysis. Third, we deduced the motivating forces for protest events from short summaries included in the ACLED database, and therefore, additional protest categories might not have been identified. Finally, protests must be seen as only one vehicle for expressing policy demands; future research may examine how protest aligns with policy preferences of health workers and overall policy agendas of organizations representing health workers.

Conclusion

Policy preferences of health workers are an important influence on health policy, and public policy more broadly. The role of health worker protests and strikes in shaping these processes is underexamined within the public health literature. Many of the policy preferences expressed by health workers in our study reflect issues that underpin the ongoing health workforce crisis, a major policy issue. Our research addresses part of this gap by examining Canadian health worker protests during the COVID-19 pandemic to identify spatial and thematic trends in protest activity. Our results indicate thematic similarities between Canada and international jurisdictions, wherein health worker protests have predominantly focused on compensation and other working conditions. However, protest demands were also diverse, including protests against COVID-19 mitigation strategies and protests supporting health system reform. Addressing the health workforce crisis will require continued engagement with health workers as stakeholders and the recognition that protest demands can help identify solutions to the workforce crisis. Future comparative studies of health worker protests may further illuminate the causes and strategies of these protest events, analyzing both inter- and intra-national cases. Furthermore, additional examinations of health worker protests and their sentiment regarding COVID-19 mitigation may yield insight into variations between

regions, countries and medical professions. It is unclear how protest activity will evolve in future years, prompting the opportunity for longitudinal research on health worker protests.

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