Transcript
Episode 05 – It's not Healthcare without Pharmacare, with Doret Cheng

Intro

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Hi! I'm Rosie Yeung, your host on Changing Lenses. In this podcast, we change our lens, to change what we see. Because seeing differently, lets us live differently.

I'll be honest with you. I didn't realize, until I lost my job, just how much I relied on my employer's health insurance plan. Did you know that if you don't have private health insurance, if you got cancer, you'd have to pay for the drugs yourself? Canada's universal healthcare system is not healthcare, it's medical care. Thankfully, our government actually has a plan to bring national pharmacare to our country – but it's a long way off, and you can help advocate to make it happen faster.

In Part 2 of our healthcare series, Doret Cheng, a practicing pharmacist and university lecturer on global health, explains why healthcare equality is NOT equity; that national pharmacare is necessary AND affordable; and why Canada's healthcare ranks second last out of 10 countries. Spoiler alert – the 10th country is not the United States.

Please join us for this important discussion that impacts every Canadian. As a bonus, I ask Doret her thoughts on how a COVID vaccine should be equitably distributed.

You can find the shownotes, transcript, and every podcast episode on my website, changinglenses.ca/podcast.

Thanks for listening!

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Welcome and Introduction

Rosie: Welcome everyone to part two of our discussion with Doret Cheng, a pharmacist who has worked in healthcare systems for over 20 years. Doret joined us in part one, if you haven't already listened to part one, you don't need to in order to listen to this part of the podcast. But of course we do encourage you to do so because it certainly gives a lot more context and background about her work with communities that are low income or suffering from mental illness. And we talk actually a bit about in the first episode around why we change the terminology and how to discuss these things, in a way that's more specific about issues that people are facing and not just putting a broad label on people.

And Doret, in part one of our episode, you ended by making this really powerful statement around our Canadian healthcare system, which gets touted very loudly by the Americans as, "Oh, you know, Canada's known for their great health care system." And probably because they don't know anything else about Canada or can't say anything else nice about Canada.

And I think most of us are appreciative of the fact we can see our doctors for free. We also complain about our healthcare system. I think Canadians complain about healthcare and weather, almost the same amount. So of course we know that our healthcare system is flawed and it does vary, province by province, but probably similar issues and similar benefits in every province.

So let's get right into what you were saying at the end of the last episode around equity and equality not being the same in healthcare. Can you dig more into what you mean by that?

Doret: Yeah, I think what I was trying to get at is that the universal healthcare that we have here in Canada was based on a premise of equality as a primary principle, especially when it came to developing some of the processes, some of the protocols that is also seen as a benefit. And the principle of equality is basically that all people ought to be treated in the same way and ought to have access to healthcare, right? That's a basic human right. And that's what it's based on. But it can pose somewhat of a challenge when it comes to an ethics perspective. This is where it leads to equity, because essentially equity suggests that a person's maybe, individual vulnerabilities, maybe their life circumstances really should be taken into account when it comes to providing care in the most ethical way.

When equality is not equity: patient discharge stories

I will give an example. So most of our hospitals try to discharge people as quickly as possible.

Rosie: Yep!

Doret: Right? Let's say there's a strict policy. As soon as they're clinically ready, we discharge them and no other considerations will be taken into account. If they're clinically healthier, great, discharge them. Right? And the justification for this is that everybody's clinically ready gets discharged. That's equal, isn't it? As soon as you're getting better and there's no other reason for why you shouldn't be in hospital, then you get discharged. While this is legally permissible, it may not be the most appropriate for different patients, right? Because different people may have different vulnerabilities.

So if you, Rosie got admitted and you're clinically better now, but going home, you are able to have some caregivers that are at home that can continue to support you that may have the understanding of how you can continue to follow up, and access other specialists that you might need to see. And you have the kind of transportation that you would need to get to these appointments. Great! Right? Perfect. Discharge. But there might be someone like me, for example, who is also clinically better, but I don't have anybody at home. I'm an elderly person. I'm going home. I'm going to be alone. I don't have any services or any family that would be able to take care of me. I don't also have income, or the

ability to understand that I need to go see a specialist, follow up in this way, or even how to take the medications that I was prescribed, to know what to do after I get discharged.

So accessibility is equal, but it's not equitable if we were to discharge you and me exactly at the same time without the extra supports that I would need. So a more equitable approach would be OK, I'll discharge you, but I'll discharge you with maybe some more supports. So I'll provide you with some home care. Or I would provide you with a home visit from your family doctor. Or if none of that is available, I will need to keep you longer in the hospital, which often happens.

Rosie: OK. So, and I would have thought that Canada has those, supports in place to figure that out. And I know exactly what you're talking about, around the discharge. And, I've heard stories from friends about when they gave birth and how quickly they were told to go home, depending on the situation around their birth.

Or, one story in particular that stuck with me is a friend of mine who is a very capable person, and has a good job. Also has three kids. Her oldest kid is just graduating from university. Her youngest kid is still in middle school. And she had to have hip replacement surgery. She's also an immigrant to Canada, has been in the country for a couple of years, but you know, like knew how things worked, but I think still not totally familiar with the Canadian system specifically. And ended up getting discharged from the hospital, I think it was the next day after her surgery. And they asked her apparently whether she had anyone at home to take care of her. And she said, "Well, I have three children". And they're like, "OK, great, then you can go home." But the thing is, her oldest child needed to go work cause he needed to make some money. And then her other kids, one was in university and the other one's still in school. They couldn't take care of their mother who is bedridden on the third floor, unable to get around.

And then when I went to visit her, just to make sure she was OK, I was like, "Oh, and where are the post discharge instructions?"

"Oh, she's good. She doesn't have any pain. She has these, these drugs that were opiates." And I didn't know much but that was especially at a time where I was like - OK, I'm sure the doctors must know what they're doing, but there's huge dangers and risks around being addicted to opiates. And why are you even like, you can't take care of yourself, how come you're here at home?

So, because I happened to know people like you and other people in the system who then I'm talking to them and, oh, there's rehab hospitals. So I'm trying to help. It's like, you could try and get into a rehab hospital. And she went through efforts but basically told: "No, you only had one hip surgery. If you had both hips operated on, then you could maybe qualify for a rehab hospital paid for by the government. But since you don't, then you have to pay for it yourself." Which she couldn't afford to do.

And that's a person who's, I would say, not marginalized. Like some of the people you've described that come to your clinic. Like, not some of your patients. She had a home. She had kids. She had access to income, but she wasn't super wealthy. But like even she, I would say it's like, just felt like she was pushed out of the hospital as fast as possible because of cuts to funding and other things. I

understand the needs and I'm sure there's other people waiting for beds. But at the same time, I was like, this person's not getting the care that she needed. And I think because she is also an immigrant, she wouldn't have known as well what she could ask for. Forget about being immigrant, I don't know. I've lived here my whole life. I don't know what I could ask for, without talking to people in the system. Therefore I don't really know if I'm being treated equitably or not.

Doret: Exactly. And so I think that although all of these services are available, it's not that in Canada, it's not available. But when it's identified is actually if it's identified not when, right? And so how do we cut down on the if is the biggest vision that I think that we need to think about is how do we get to a point where we have this equity lens? And that is actually first and foremost in our minds, when we are providing care at whatever level. That we say, "Well, what does this individual need?" And we need to be asking the right questions in that case. And we need to be framing, let's say, post-op care, or discharge care. We need to be framing that in a way that is helpful, that is going to provide better outcomes for our patients.

And that's, I think, something that we're doing better than we were 20 years ago. But all at the same time, it also can be political, right? Because you know, 20 years ago, when there were all these cuts, guess what they cut first? They cut healthcare. They cut some of the social benefits that were available with the PC government at that time.

And so that has had its obvious ramifications in now driving care to the more expensive acute level versus a more preventative level. So I have a lot of patients who would benefit from more access to physiotherapy, for example, or psychology, counseling, for their mental illness. Or accessibility to even dental care. But because they don't necessarily have a job, or they don't have private insurance, that is not as accessible to them.

Thankfully, they have access to our family health team, which has more of an equity lens, but not all family doctors office or healthcare centres are like ours, where we have physios hired to be within our family health team to provide physio for those who don't have private insurance and who can't afford on their own. But guess what? I mean, even then the waiting list is so long for them to even see our physiotherapist or even psychology or dentistry.

Rosie: So your clinic has these services like the physiotherapy, sociology, you provide them for free to your patients?

Doret: Absolutely. So, all of it falls under our family health team. And basically as long as you can see the doctor, you get referred through our doctor to our family health team based physio. But obviously we always ask the question of the patients. Do you have private insurance? Because we obviously don't want to use these resources for people who already have insurance. So we would be using it for people who don't have access normally. Yeah.

Rosie: Yes.

Doret: There are clinics, you know, around, Ontario that are OHIP funded physio, but for the majority of the population, like even you and I, if we lost our job, we wouldn't be able to get OHIP covered physio very easily. We would have to kind of pay out of pocket for it because it's not publicly funded.

Rosie: Yup. And I did lose my job for the first time in my life this year. And I did not really fully appreciate just how much I relied on my health insurance, through my employer to pay for some of this stuff. And it's so expensive that it doesn't even cover most of it, like for the stuff that I need. Including drugs.

Like for the first time, I am now starting to think about, Oh, if I get sick with some kind of illness, that's going to require drugs, then I wonder how much it's really going to cost me. Cause I've always had it subsidized by my employer. And I think it's really cool that everything we've talked about so far hasn't been directly drug-related or pharmacologically related, which I think speaks a lot to that holistic approach that your care teams takes. But what are your thoughts on, I guess, like equity within pharmacare as well, right? Like, your patients also have access to free drugs? Not in the bad way, but in a good way.

Canada's healthcare is second worst out of OECD countries

Doret: Yeah. And I am very supportive of national pharmacare. Just based on, the patients that I've seen and the number of patients that I see fall through the cracks, and the number of questions I get from the providers about, you know, how can we get this patient these drugs, cause they don't have any other coverage.

And the number of questions I get about that, and the need and the time that I spend in navigating the system with the patient for the patient, along with our social workers, is phenomenal. And so I see it firsthand, and I've read quite a bit also about the pros and cons of pharmacare.

And we are one of the only, actually the only, out of all of the countries, high income countries that have universal healthcare, excluding the U.S. because they don't have universal healthcare.

Rosie: Right, yup.

Doret: We are the only country that does not have medication coverage as part of that.

Rosie: Seriously?!

Doret: Exactly. Yes.

Rosie: How many countries is that out of?

Doret: Let's say out of the, you know, Top 11 countries. So let's say, OECD countries. So we're talking about the high-income European countries, like the UK, Austria, Australia, the Netherlands, Germany, Switzerland. So a lot of the higher income OECD countries. And if we look at how Canada actually performs on a healthcare system performance point of view, out of the top 11, maybe top 10 let's say, excluding the U.S., we actually rank number 9 out of 10.

Rosie: 9 out of - so, almost the bottom.

Doret: Almost the bottom. And one of the biggest reason for that is because we don't have the kind of access and equity that these other countries provide and pharmacare factors into that.

So I was surprised when I saw that, because you know, we're always touted as - "We're Canadian! We have universal health care!" We have universal medical care, but we don't have universal health care. And medications and pharmaceuticals actually form a very important part of health, doesn't it? Obviously you need medications to treat whatever diseases. And so without access to that, it's very difficult to get further up in the performance scale. If we are to do that.

Rosie: So, this is really interesting because you would have this global perspective, cause you also teach, global health right? At the University of Toronto.

Doret: Yep.

Rosie: So I think this is really eye-opening for me as a Canadian, for sure. I guess I've only really heard it from either within Canada, and we don't really have other comparators if we don't ask. And the U.S. who always say that we're better just because we're better than them. But like the other well-off countries that I've never even thought about their healthcare, I don't seem to have heard about their healthcare. But now I'm learning that actually we, we suck [laughs], comparing to those guys who have great healthcare systems, we're at the bottom pretty much.

The case for national pharmacare: we actually SAVE money

Doret: Yeah, we are. And actually, for the amount we spend on Canadians healthcare, we're not getting the same value as someone living in the UK or someone living in Australia would be getting. We are probably, one of the top countries paying a lot of money for the healthcare that we get.

Rosie: OK. So I was going to - I don't expect you to have an answer, cause if we had the answer this would have been solved. But the first thing that people will say - of course everyone would like to have their drugs paid for free, but where's the money going to come from?

So what do you mean by we're paying a lot of money, but not getting much value? Because I don't see how we can find more money to pay for more coverage for healthcare.

Doret: Yeah. I mean, there have been a lot of modeling and studies that have been done about pharmacare. You know, one of the myths is that Canada can't afford universal public pharmacare. That's a myth. Because actually, if you actually calculated all the costs and what we're spending right now, pharma can, would actually save Canada billions of dollars. Every year. Billions.

Rosie: Billions in people not having to go to hospitals and stuff because they would -

Doret: Absolutely. So you're taking in direct and also indirect costs.

We currently pay the third highest prices in the world for medications. So right now, drug companies actually negotiate separately with each province. Think about us having a national team of people, negotiating prices with these pharmaceutical companies, how much do you think we could get? Instead of being a bargaining unit, we're actually getting quoted different prices in each province. Right? And so, if it -

Rosie: Wait, wait, wait, wait - cause I've been like literally speechless as you're saying this because I had no idea, I genuinely had no idea until you said this. Cause the comparison I would make is when COVID hit and we were all saying how did we didn't have enough PPE, personal protective equipment. We didn't have enough masks. And all the countries, and then all the states and provinces were crying out about how they were trying to negotiate and having to pay really, really high prices for PPE. So you're saying that because we have separate provincial healthcare systems, each of the provinces are negotiating with the drug companies on what the prices are? And so -

Doret: Yes.

Rosie: - the prices are all probably higher across the board than if we got together as a whole country and negotiated this?

Doret: Exactly. Yep. So, the same cancer drug could cost someone zero in Nunavut versus $8,000 in PEI and maybe $2,000 here in Ontario.

Rosie: Wait, if I had cancer and I don't have private insurance, I might have to pay for this life-saving drug?

Doret: Yep. And it depends the province that you're living in, right? So there are some social assistance programs that are available to help people with high drug costs. For example, in Ontario, we have Trillium and in BC it might be managed differently for high cost drugs, but it's not all the same.

And so, I think that if we're able to have universal pharmacare, we could negotiate much lower by bulk buying medications for the whole country. It's just like bulk buying PPE. And pharmacare would actually save us money. It would save money for employers. So that employers would no longer pay for private insurance for their employees. It would save money for households who could no longer afford high out-of-pocket costs for medication.

It would bring savings to the entire healthcare system cause you could take all of these things into account. And maybe eventually, if you have access to medications, then you wouldn't get admitted to hospital with an acute crisis because you weren't treated, for example, right? It would be direct and also indirect costs. So I think it's somewhat of a myth to say that we can't afford because we're going to be saving billions of dollars.

Rosie: So, OK. So before I get in trouble with my own government [laughs], talking about this in the podcast. Because there are, contrary to some people's beliefs, there are smart people in government. I am sure that this discussion must have come up before and people must have seen some kind of information. Or maybe not, I don't know, but - am I missing something? Like what insights can you

provide, if any, as to why we wouldn't have done this, or what potential downsides there are to having national pharmacare?

The government's plan for national pharmacare – there is one?!

Doret: Yeah. And thankfully, I mean, the government is working on it.

Rosie: Oh, OK!

Doret: It started in, I think probably around 2015. Like, I'd be surprised - I am surprised as to why it took so long [laughs] for this to come up. But, the hopeful thing is that people are working on it and that there's a report that has been published, I think November of last year, where there's a plan rolling forward.

Because I think that the numbers are there. There's no need to talk about more research that needs to be done anymore. That pharmacare does and needs to happen, because it's a no brainer. It will save us money. And it looks like the government is working on it. But it took a lot of advocacy. It took a lot of advocacy for that to happen.

Rosie: No kidding!

Doret: You know? Yeah.

Rosie: And was it like pharmacy, pharmacy groups? Or like a pharmacist association?

Doret: Nope. All kinds of different groups. In fact, I wish our colleges and our pharmacy associations were a bit more proactive. But they haven't been. And in fact, this has been coming from all kinds of different healthcare organizations, nurses, doctors. People who work in the healthcare system. Social organizations who work with people in the community who have been advocating for this for a very, very long time.

There is a Canadian health coalition that is kind of like a citizen group, that has been working on a lot of this stuff. And so I think it's so important for us to bind together and continue to push this forward and support it.

Rosie: And is there anything that we as public citizens can, I mean, it sounds like the wheels are already turning, so maybe we don't have to do anything right now. But is there like a petition that we could sign that would help move this forward?

Doret: Yeah. And there was a petition.

Rosie: OK.

Doret: And many of us signed it. And I think because it's in the Liberal government right now, as a way to move forward, it's been very helpful to have that. So their objective is to be able to roll out pharmacare by 2027.

Rosie: 2027!

Doret: [laughs] Yes.

Rosie: We're in 2020, right? We're saying 7 years from now?! We're going to...

Doret: Yeah, yeah. Because guess what? It's so fragmented. Our healthcare is so fragmented. Every province takes care of its own people. Right? So Ontario, for example, one of the kind of close to pharmacare examples that I can give was when Kathleen Wynne was able to roll out OHIP+.

And so OHIP+ was for everybody under the age of 25, would have access to our Ontario public formulary. So -

Rosie: Like, like drugs?

Doret: Drugs, exactly. And that set of drugs that would be covered are essential drugs, you know, that are included. So they would be the same set of drugs that seniors, people who are on Trillium, people who have Ontario works or have disability. The public would have access too. So anybody under the age of 25 who doesn't have private coverage would have access. So this is kind of similar to what we're talking about here is, if you lost your job, you would be, if you were under the age of 25, be able to have your medications covered. Unfortunately, if you're over the age of 25, right now, you fall through the cracks, right? So...

Rosie: Yeah unfortunately I fall through the cracks in that case [laughs], cause that's just a few years too late for me to take advantage of that policy.

Doret: Yeah, yeah.

Rosie: Wow. OK. So do you think that there's maybe some opportunity with COVID? Like this seven years thing. What I really saw with COVID and I think many of us saw was, when there's some fire under our butts, things can happen quite quickly. Like beyond any speed that we would have ever said possible before. So when there was no crisis, I could see it takes seven or eight years or whatever, to roll out a national pharmacare.

But I don't expect them to take seven years to administer a national vaccine for COVID. Which I bet you that's going to have to be negotiated for nationally, or I sure hope it'll be negotiated for nationally. Because I wouldn't want to see us held up because 10 different provinces and then plus territories have to go negotiate for this.

So, I don't know. Like what are your thoughts on how COVID might positively impact changes to our system going forward?

Doret: Yeah, absolutely. And I think all the things that have happened over the last five months, six months, right since COVID happened, has really highlighted. And so the discourse on equity, the discourse on diversity, the discourse on the people who are falling through the cracks, are exactly the people that we need to actually be focusing on when it comes to healthcare.

And so I think that the political will, when it's there, it can happen. You're right. Really pharmacare was all about political will. It is. And if we would have the same sort of urgency that we had with COVID, I think that it would get rolled out. And just like this, like with COVID, if and when the vaccine comes, we need to be thinking about who are the population of people that we need to be providing access first to the COVID vaccine. Right? And -

Rosie: Definitely

Doret: Also on a global level, how should we be participating and collaborating with other countries, with the WHO, to ensure that our most marginalized and the most low-income countries who don't have the kind of infrastructure that we do, can also have the ability to access the vaccine.

Because we don't live in a silo. And so, yes, as much as I think that we do need to take care of our population and focus on our population. But we also need to take a broader lens to think about the other people in the world that also need access as well.

COVID vaccine – who gets it first?

Rosie: So, and I'll ask you a, kind of a challenging question. And because it's challenging, I'm not asking you professionally, it's just purely from your personal point of view, your personal values or philosophy.

Thinking about equity and access to the vaccine when it comes ready. At least in Canada, do you think it would be more equitable, not equal, but equitable, to be first giving the vaccine then to people who are the most at risk? Like people who have to say it's wintertime and they they're crowded together in the homeless shelters, versus people who can live in their own homes with their family bubbles. Or people who have to work at the grocery stores and they're exposed frontline every day versus people who can work from home. Like, what are your personal thoughts on what would be fair around the vaccine?

Doret: Yeah, I think so. I mean, I think we can look at some of the stats of which population here in Canada has been the most affected. And mostly we do see in the shelters, those who are in close quarters, maybe who have vulnerable housing situations, those who maybe are in the outskirts . Those who are in the long-term care homes, the elderly who are home-bound, and who have lots of different healthcare providers going in and out of their homes all the time. So primarily, the population that have been the most affected, we need to focus on that. Versus saying everybody should have equal access. No, we need to take an equity lens in looking at who we should provide the vaccine to first.

So as a society as well, I think that we need to educate ourselves and each other about what does equity mean? What does fairness mean when it comes to health care and taking care of each other as a society and as a citizen? If you have the resources to be able to self-isolate and care for yourself and not have as much exposure to the COVID virus, then why should the COVID vaccine not go to

somebody else first over you? So, I don't know, that's just my opinion about that. Just knowing that if we take care of each other and look at others first, we are better off as a society.

Rosie: I feel the same as you. It'd be very interesting to see how we as a society would answer that question. That like, why shouldn't it go to someone else before it goes to you? I'll be the first to confess. It's easy to sit here, for me in my cozy little apartment. And I'd be like, yeah, yeah, you know, that's what I would say now. But push comes to shove, the vaccine comes. And they say, well, you could get it now, or you could wait a year and give it to someone else who might need it more than you. And then you'll get it a year later, but then you're not vaccinated for a year. I would hope that I would give that away to someone, but I have to be honest with myself and with you who are listening and saying, well, I don't know what I would really decide in that moment. But like, if you're a human being who cares about other human beings, hopefully that would be the decision that you would make.

Doret: Yeah. And I hope that those who are making the decisions: public health, the leaders in our country and various provinces, right. That there's policy, there's criteria, so that in order to get the vaccine, we would have to fulfill certain criteria. And that's, the most equitable way to make it, right? Instead of making it a more individual decision.

I mean, we're human beings, and we're flawed, and obviously we're always looking out for our own best interests. But if we can somewhat educate ourselves on what does this mean? What does the bigger picture look like? Then hopefully we can feel better about, you know, not getting the vaccine first, you know? [laughs] Yeah.

Rosie: Yeah. Well, if we are all staying at home for the most part, like we should be, if we have the privilege to be able to stay at home. And are washing our hands and wearing face masks when we go out, then, you know, hopefully we'd be very very low risk to get it even without a vaccine.

Doret: Mm-hm, absolutely. Yeah.

Rosie: Yup. Plug for Dr. Theresa Tam there. You're welcome, Dr. Tam.

Both: [Laughs]

Thank you so much, Doret, for two episodes of just amazing discussion. And, you know, I think really speaking to the heart of us as community and neighbours in Canada. We all share one country, we're sharing 10 or 12 healthcare systems so really , you know, we all need to be healthy together. And we all have only the same number of limited resources, whether you split it up 10 ways or one big way.

So I really appreciate the new insights that you shared. I've definitely learned a lot. You've definitely given me new lenses to look through. And before we close off this part two of our series on global health care and pharmacy care specifically, I kind of want to go back to something you mentioned earlier about everybody taking a chance to learn. And I know that you said that you've been on a journey yourself.

Doret's lessons learned – listening to patients results in better health outcomes

So I wonder if there is any parting thoughts that you'd really like us to leave with based on things you've learned in your own journey, around caring for your patients who are going through something. Whether it's dealing with mental illness, or maybe they're in an abusive relationship, or maybe they don't have access to housing or whatever it is that is putting them at a disadvantage and they don't have the privileges that many other Canadians do.

How can we as Canadians care more for these populations that are not doing very well?

Doret: Yeah, I think the biggest thing that I've learned is to not just look at doing my job and being efficient in doing my job. And that actually I'm caring for people. And so knowing people's stories and talking to them and actually learning and being interested in them as people really provides a lot of insight into how best to provide that care. It actually ends up being even more efficient, to be honest, if we take the time to learn people's stories instead of just making assumptions and looking at the surface. So I can't even count how many times I've actually learned from my patients so much more. And learned about how, despite the circumstances, what survivors they are and so much resilience that they've had . Instead of providing all this advice that I think, you know, research says this and the evidence says this. But rather contextualizing it to the patients and what they need.

And that has really helped me actually in my job to be better at it. And be able to get better health outcomes because I'm trying to learn what would work for that particular patient and not just ask them very basic surface level questions. But really care for them as individuals and what their needs are. And ask questions instead of providing advice right away.

So I think that I've learned a lot. Had I not been exposed to different people and practice in different settings, I think that I wouldn't have the kind of lens that I do now. I hope it's a better lens. I think it is. But I'm still on a journey, you know.

And so if there's any way to try to be open-minded and learn more. Don't look just at the surface, but look beyond the surface and look at the person and what they've experienced and what's going on in their life. It actually helps us to be a bit more empathetic and compassionate in our care.

And in fact that actually makes the care even better. The patients do better when we focus more on the social aspects of health. And when we focus on equity.

Rosie: Thanks for sharing that, Doret.

Thank you so much for the time that you've taken to be with us, and just sharing so much about your work and your life. And inspiring us to think about healthcare and pharmacare in Canada in a different way. I am actually going to take this away and look up how we can continue to push our, maybe it's our MPs, or I don't know who it is. But if there's something we can do to get a national pharmacare program in before seven years from now, I'd be happy to write an email to somebody to encourage to do that.

So to you who's listening right now, if that's something that you are curious about as well, anything I find out I'll make sure to post either on my website, changinglenses.ca. Or we'll put that in the shownotes if I get that in time for the podcast. Again, thank you, Doret, for being with us today. Really appreciate you.

Doret: Thank you Rosie. It's a pleasure. Thanks for giving me the opportunity to have a voice and bringing these important issues forward. And I hope that we can continue to learn together and continue changing our lenses and grow.

Rosie: Absolutely.

Outro

[outro music plays]

Thanks for joining us – I hope today's episode helped to change your lens and expand your worldview. If you enjoyed listening, please rate and subscribe to Changing Lenses, available wherever you get your favourite podcasts. For more about how I'm changing my lens, please check out my website at changinglenses.ca. You'll also find the shownotes and transcripts for each episode, and you can leave comments or questions, or send me a message – I would love to hear from you!

I'm Rosie Yeung, inviting you to join me for the next episode of Changing Lenses. Until then, take care!

[outro music ends]