



SIM CANADA

433 Blvd de L'Île
Pincourt, Québec
Canada J7W 8Z6

The Cost of Doing Nothing: A Federal Investment Case for Restoring Public Health in Canada

Brief to the House of Commons Standing Committee on Finance

Pre-Budget Consultations in Advance of the 2026 Federal Budget

May 22, 2026



Executive Summary

The Decline of Public Health in Canada

Canada's public health system is eroding, and this erosion is measurable, particularly in infectious diseases prevention.

Provincial and territorial governments have reduced their public education initiatives due to budget constraints. There is a shortage of experienced, health professionals to work in rural and remote communities. Outbreaks of vaccine-preventable diseases are straining emergency services.

These are early-warning signals that the public health system Canadians rely on to keep them healthy is losing ground.

Public health is the quiet infrastructure that keeps Canadians out of hospital. When it works nothing happens, and the acute-care system is spared avoidable demand. In the years since the COVID-19 pandemic, however, that infrastructure has weakened. Nowhere is this more evident than in immunization. Coverage against once controlled diseases has slipped, disease surveillance gaps persist, eligibility for vaccination varies by province and territory, and the programs and workforce that deliver public health services, including education are under sustained fiscal strain. Disease prevention has never been more critical.

The federal government holds powerful levers to reverse this trend.

Through the Public Health Agency of Canada (PHAC), and the Canada Health Transfer, Ottawa sets national direction, funds public and professional education, supports disease surveillance, and provincial and territorial immunization programs.¹

Our Question to the Committee

We respectfully ask the Committee to put the following question to the Government of Canada:

“Given the documented erosion of Canada's public health capacity since the pandemic, what concrete, funded commitments will the Government make in the next federal budget to reverse this decline?”

In support of that question, we ask the Committee to seek specific answers on the following points:

- *Will the Government commit to purchasing vaccines to sufficiently stockpile against outbreaks, and restore and exceed pre-pandemic immunization coverage targets?*
- *Will the Government modernize disease surveillance tools? And update the national notifiable system to include new information and include currently non-notifiable diseases*

¹Public Health Agency of Canada. 2025–2030 Interim National Immunization Strategy.

<https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/2025-2030-interim-national-immunization-strategy.html>

like RSV?

- Will the Government commit to working with the provinces and territories to remove known barriers to vaccination services like referrals?
- Will the Government work with the provinces and territories to harmonize eligibility so access no longer depends on where a person lives?
- To strengthen disease prevention and to protect the most vulnerable Canadians, will the Government commit to multi-year funding to help reinstate provincial and territorial public health capacity in education through the Canada Health Transfer and other various funding mechanisms such as the Immunization Partnership Fund (IPF)?

About this Brief

This brief makes the case that restoring and strengthening public health using these levers is among the highest-return investments available to the Government of Canada by focusing on four pathogens that together drive a substantial share of Canada's seasonal acute-care burden and that are now, more than ever, preventable: influenza, respiratory syncytial virus (RSV), COVID-19, and pneumococcal disease.

Each has effective and available vaccines whose potential is being left unrealized by a lack of public and professional education, barriers to vaccination services including inconsistent eligibility criteria and the requirement of health care provider referrals, and uneven access to vaccine inventory. These diseases also disproportionately harm the same priority populations including people living with chronic diseases, older adults, infants and young children, and equity-denied communities such as rural and remote populations, and Indigenous communities.

About the Society for Intelligence Management (SIM)

The Society for Intelligence Management (SIM) is an independent association that promotes evidence-based knowledge translation, education and training, communication, and decision-making. Its mandate is to ensure that the flow of information is accurate, reliable, and contributes to informed decision-making in a rapidly evolving world. SIM represents millions of Canadians, and we advocate for the reform of public health systems through various consortia, coalitions and committees. To learn more about SIM, visit <https://intelsociety.org/>.

About the Flu, RSV and Pneumonia Awareness Consortia

The Flu, RSV and Pneumonia Awareness Consortia are collaborations of health advocates, including non-governmental organizations, dedicated to spreading evidence-based knowledge. Our goal is to drive meaningful change across Canada by investing in both individual and societal health literacy, encouraging critical thinking, and empowering people to make informed, independent decisions.

Our mission is to prevent respiratory diseases through proactive education, targeted outreach, and strong community support. We are committed to delivering accurate, unbiased information that helps individuals take charge of their health. To learn more about the consortia, visit fluawareness.ca, rsvawareness.ca and pneumoawareness.ca.



The Brief

The Issue

Public health plays a central role in infectious disease management and prevention. It uses various government infrastructure pathways and tools to ensure Canadians are safe and healthy. The most recognized tools to control infectious diseases include vaccines procurement, vaccination services, quarantine measures, and disease surveillance. However, these tools have sustained years of fiscal pressures that place the health of Canadians at risk.

In this brief, we address four pathogens that are endemic to Canada, and yet, many Canadians continue to suffer from illness due to reduced prevention efforts despite the most clinically and cost-effective tools at our disposal – vaccines.

Influenza

Influenza remains a significant and recurring threat to the health of Canadians and a major driver of seasonal acute-care utilization, disproportionately affecting adults aged 65 and older and children under five. Among older adults, influenza infection frequently precipitates functional decline; severe cases requiring intensive care unit (ICU) admission often result in permanent loss of independence and accelerated transition into long-term care, and outcomes associated with substantial and ongoing costs to the health system.² These pressures are amplified by population aging and persistent gaps in access to adult-specific influenza vaccines designed to address age-related declines in immune response.³

At the same time, children under five continue to demonstrate historically low influenza vaccination coverage, contributing to predictable surges in pediatric emergency-department use during respiratory-virus season and to productivity losses among parents and caregivers. A single pediatric influenza infection frequently results in five to seven days of parental or caregiver absenteeism, and children serve as primary vectors of transmission, carrying the virus into schools, households, and ultimately into higher-risk older-adult populations.

In older adults, greater disease severity, including cases requiring ICU admission can precipitate rapid health decline and hinder healthy ageing,⁴ with compounding complications that may result in loss of independence and increased need for assistance with daily living.⁵ Diversifying delivery

²Andrew MK, MacDonald S, Godin J, McElhaney JE, LeBlanc J, Hatchette TF, Bowie W, Katz K, McGeer A, Semret M, McNeil SA. Persistent Functional Decline Following Hospitalization with Influenza or Acute Respiratory Illness. *J Am Geriatr Soc.* 2021;69(3):696–703.

³Langer J, Welch VL, Moran MM, Cane A, Lopez SMC, Srivastava A, et al. High clinical burden of influenza disease in adults aged ≥65 years: Can we do better? A systematic literature review. *Adv Ther.* 2023;40(4):1601–27.

⁴Lees C, Godin J, McElhaney JE, McNeil SA, Loeb M, Hatchette TF, et al. Frailty hinders recovery from influenza and acute respiratory illness in older adults. *J Infect Dis.* 2020;222(3):428–37.

⁵Beyer WEP, McElhaney J, Smith DJ, Monto AS, Nguyen-Van-Tam JS, Osterhaus ADME. Cochrane re-arranged: support for policies to vaccinate elderly people against influenza. *Vaccine.* 2013;31(50):6030–3.

for children through school-based catch-up clinics and expanded pharmacy access, and by raising awareness of needle-free intranasal options addresses a major barrier, since pain and fear are leading deterrents to childhood vaccination.⁶

Respiratory Syncytial Virus (RSV)

RSV is the most common cause of bronchiolitis and pneumonia among infants and a serious, underrecognized threat to older adults. In Canada, approximately 2% of all infants are hospitalized with RSV in their first year of life. There is a higher burden of RSV hospital admissions in northern and remote settings compared to the rest of Canada. High rates of RSV hospitalization, particularly among those less than 1 year of age, have been observed among infants in the Yukon, Northwest Territories, and Nunavut as well as in Nunavik, the northernmost part of Quebec.⁷ Infant RSV hospitalization routinely requires supplemental oxygen and, in a meaningful share of cases, intensive care, while imposing significant out-of-pocket costs, lost work, and stress on caregivers. There is no treatment for RSV.

The burden in older adults is now well documented. Canada ranks among the countries with the highest RSV-related mortality among adults aged 65 and older.⁸ For the first time, this burden is broadly preventable. Health Canada approved two RSV vaccines for older adults in 2023 followed by a newer mRNA option, and NACI has issued guidance supporting their use, alongside maternal immunization and infant monoclonal-antibody products that protect newborns.⁹

Yet a critical gap undermines the response; RSV is not a nationally notifiable disease in Canada,¹⁰ leaving decision-makers without the consistent surveillance data needed to target programs, while provincial and territorial coverage of the new products remains uneven.

COVID-19

COVID-19 has not gone away. Caused by SARS-CoV-2, it now circulates year-round, with activity concentrated from late summer through early January; squarely overlapping the fall and winter

⁶Taddio A, Ilersich A, McMurtry CM, Bucci LM, MacDonald NE. Managing pain and fear: Playing your CARDS to improve the vaccination experience. *Can Commun Dis Rep.* 2021;47(1):87–91.

⁷Public Health Agency of Canada. Canadian Immunization Guide. Respiratory syncytial virus (RSV) vaccines. 2026. <https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/respiratory-syncytial-virus.html#a6.4>

⁸Abrams EM, Doyon-Plourde P, Davis P, Lee L, Rahal A, Brousseau N, Siu W, Killikelly A. Burden of disease of respiratory syncytial virus in older adults and adults considered at high risk of severe infection. *Can Commun Dis Rep.* 2025;51(1):26–34.

⁹National Advisory Committee on Immunization (NACI). Summary updated guidance on the use of RSV vaccines in older adults, including RSVPreF3 and mRNA-1345. Public Health Agency of Canada. 2024–2025. <https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-updated-guidance-respiratory-syncytial-virus-vaccines-older-adults-high-risk-severe-rsv-disease.html>

¹⁰Public Health Agency of Canada. Canadian Immunization Guide. Respiratory syncytial virus (RSV) vaccines. 2026. <https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/respiratory-syncytial-virus.html#a6.4>

respiratory season alongside influenza and RSV. The risk of severe illness, hospitalization, and death follows a steep age gradient and is highest in adults 80 and older. NACI continues to recommend vaccination for all adults 65 and older and for residents of long-term care and congregate settings, people with underlying medical conditions, pregnant individuals, members of First Nations, Inuit and Métis and other equity-denied communities, and health-care workers.¹¹

For a brief about the federal role in public health, COVID-19 illustrates the central problem most sharply. Beginning in the fall of 2025, the federal advance-purchase agreements that supplied COVID-19 vaccines throughout the pandemic ended, and responsibility for purchasing COVID-19 vaccines shifted to provinces and territories.¹² This download of cost without a corresponding, dedicated federal transfer is precisely the kind of quiet retrenchment that erodes equitable access. What a high-risk senior obtains at no charge in one province may carry a referral requirement, a wait, or an out-of-pocket cost in another.

Pneumococcal Disease

Invasive pneumococcal disease (IPD) is an acute, serious illness that manifests as bacteremia, meningitis, and pneumonia. It has been nationally notifiable in Canada since 2000. The highest burden again concentrated among children under five and adults aged 65 and older.¹³ The disease is frequently a sequel to respiratory infection such as influenza, RSV, and COVID-19, which can each open the door to secondary bacterial pneumonia, which is why the four pathogens in this brief must be addressed together rather than in isolation.

The severity is striking. Estimated mortality from invasive pneumococcal pneumonia in adults has remained near 20% for decades.¹⁴ Between 2019 and 2023, Canada's National Microbiology Laboratory characterized 14,563 invasive isolates in adults, 39% of them from adults aged 65 and older.¹⁵ Here, too, the tools exist. Following Health Canada's authorization of higher-valency conjugate vaccines, NACI now recommends including at least one of the conjugate vaccines in adult immunization programs, with a single dose for all adults 65 and older and for younger adults at increased risk.¹⁶ The barrier is uptake. The national target of 80% coverage among adults 65 and

¹¹National Advisory Committee on Immunization (NACI). Guidance on the use of COVID-19 vaccines for 2025 to summer 2026. 10 January 2025. <https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-guidance-covid-19-vaccines-2025-summer-2026.html>

¹²ibid.

¹³Public Health Agency of Canada. Canadian Immunization Guide. Pneumococcal vaccines. 2025. <https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-16-pneumococcal-vaccine.html>

¹⁴Sulis G, Maredia N, Wolfson C, Basta NE. Changes in pneumococcal vaccine coverage in the Canadian Longitudinal Study on Aging (CLSA): An analysis based on the 2018-2021 follow-up 2 survey. *PLoS One*. 2026 Jan 23;21(1):e0338213.

¹⁵Wong E, Baclic O, Salvadori MI, Hildebrand K, on behalf of the National Advisory Committee on Immunization (NACI). Summary of the National Advisory Committee on Immunization (NACI) Statement: Recommendations on the use of pneumococcal vaccines in adults, including Pneu-C-21. *Can Commun Dis Rep* 2025;51(10/11/12):375-80.

¹⁶National Advisory Committee on Immunization (NACI). Recommendations on the use of pneumococcal vaccines in adults, including PNEU-C-21. 2024. <https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization->



older by 2025 remains unmet, with only about 55% of older adults reporting that they have been vaccinated.¹⁷

The Fiscal Context

The financial impact of these four respiratory diseases is driven by acute-care resource utilization and by indirect productivity losses, such as parental or caregiver absenteeism. Costs are disproportionately concentrated among the oldest and youngest Canadians. These costs fall on the same populations that vaccination protects the most effectively, placing substantial budgetary pressure on the health systems the federal government helps fund. A recent study in *the Lancet* indicates that ***RSV hospitalizations, specifically, can cost the Canadian healthcare system an average of \$66 million annually, with infants under six months accounting for nearly half of those costs.***¹⁸

The single most expensive node in this chain is the ICU. ***The average daily cost of an ICU bed in Canada is \$3,592.***¹⁹ To illustrate the scale at the provincial level: during the current influenza season Ontario alone reported 762 influenza outbreaks and 7,463 hospital admissions across all age groups. In December 2025, during the peak, Ontario recorded 134 influenza ICU admissions in a single month.²⁰ Multiplied across all provinces and territories and across four respiratory pathogens, the avoidable demand on critical-care capacity, and its cost, is considerable. Every hospitalization and ICU admission prevented through immunization is a direct saving to the public purse and a unit of capacity freed for other priorities.

A Patchwork of Access: Eligibility, Referrals, and Inequity

Even where effective vaccines exist and are recommended, Canadians do not have equal access to them. Delivery has shifted decisively to pharmacies, which now administer most adult respiratory vaccinations and have expanded reach into communities. But the rules that govern pharmacy delivery (pharmacist scope of practice), and the eligibility criteria for publicly funded programs, are set province by province, and they are far from uniform.

In several jurisdictions, the people who would benefit most face the most friction. High-risk individuals may be required to obtain a physician referral or prescription before a pharmacist can

[statement-recommendations-use-pneumococcal-vaccines-adults-pneu-c-21.html](#)

¹⁷Maredia N, Laurie C, Ramsay T, MacDonald SE, McMillan J, Basta NE, Fadel SA, Andrew MK, Wilson K, Chyderiotis S, Elliott S, Bouzanis K, Barratt J, Sulis G. Assessing knowledge, attitudes, willingness, and barriers to Pneumococcal vaccination among Canadian older adults: a cross-sectional survey. *BMC Public Health*. 2026 Jan 8;26(1):472.

¹⁸ Vadlamudi N, Gomes K, Chow E et al. Healthcare costs and resource utilization for acute respiratory syncytial virus pediatric hospitalizations in Canada: a population-based study. *The Lancet Regional Health – Americas*. 2025; 51.

¹⁹ Canadian Institute for Health Information. *Care in Canadian ICUs*. Toronto: Canadian Institute for Health Information; 2016.

²⁰ Public Health Ontario (2026). Ontario Respiratory Virus Tool. <https://www.publichealthontario.ca/en/Data-and-Analysis/Infectious-Disease/Respiratory-Virus-Tool>

administer a publicly funded vaccine, and in some places, a prescription is required before they can access certain vaccines; adding an appointment, a wait, and a cost in time precisely for those least able to absorb it. Eligibility criteria for publicly funded programs also differ markedly across provinces and territories. The same older adult or immunocompromised patient may be fully covered in one jurisdiction and ineligible or required to pay out of pocket in another. The result is a postal-code lottery.

The Federal Opportunity

The most fiscally responsible path is prevention, delivered through a coordinated, product-to-population approach in which the right vaccine reaches the right population at the right time, without artificial barriers. The federal government can enable this through four complementary levers:

- **Public and professional education.** Restore public health to its traditional role as the trusted source of public and professional education. Sustained federal investment through vehicles such as federal/provincial/territorial working groups, and the Canada Health Transfer to fund regional public health education initiatives and support public health in its capacity to inform the public to rebuild both public health literacy and the capacity of health professionals to counsel patients and deliver vaccines.
- **Product-to-population alignment.** Support equitable national access to age-appropriate products. High-dose vaccine and needle-free intranasal options where indicated; RSV immunization for infants and older adults; COVID-19 vaccination for those at increased risk; and pneumococcal for adults 65 and older and at-risk groups, consistent with NACI guidance.
- **Access and equity.** Work with provinces and territories to harmonize eligibility for publicly funded respiratory vaccines and to remove unnecessary referral or prescription requirements, and direct dedicated resources to the populations that bear the heaviest burden such as northern, remote, and Indigenous communities, and lower-income older adults.
- **Surveillance and data.** Unlock federal, provincial and territorial surveillance data. For example, fund PHAC to make RSV nationally notifiable and to modernize pan-Canadian immunization registries and respiratory-virus surveillance, so programs can be targeted and evaluated based on real-time data.

Underlying all four levers is a single principle: public health must return to its traditional role as the trusted source of public and professional education. Vaccines do not protect populations if people do not know they are eligible, cannot easily find where to get them, or have lost confidence in them, and if the professionals who deliver and recommend them are not equipped and supported to advise. Rebuilding that educational foundation is the most durable investment the federal government can make.

The Evidence

High-efficacy influenza vaccines for older adults are critical clinical and fiscal tools, particularly in mitigating the age-related immune decline that reduces the effectiveness of standard-dose

vaccines.^{21,22,23} For children, intranasal influenza vaccines offer a needle-free option that can reduce injection-related distress, a barrier that has grown since the COVID-19 pandemic while remaining publicly available across provinces and territories, though awareness of the option is limited.^{24,25} Emerging evidence also positions influenza vaccination as a cardiovascular risk-reduction strategy, especially in older adults and those with pre-existing cardiovascular conditions.²⁶

Influenza infection can trigger or worsen cardiovascular events, including myocardial infarction and stroke through systemic inflammation and cardiovascular stress. Vaccination is associated with reduced risk of acute coronary events and all-cause mortality in adults 65 and older.^{27,28,29,30} This extends the value of influenza programs well beyond respiratory disease alone.

For RSV, COVID-19, and pneumococcal disease, the case is reinforced by NACI's own reviews, which found prioritization of older adults and those with chronic conditions to be cost-effective and equity-promoting. Taken together with the established cost-effectiveness of seasonal influenza immunization in older adults,³¹ the evidence points consistently in one direction - targeted respiratory immunization yields a measurable preventive return on investment.

²¹Johansen ND, Modin D, Pardo-Seco J, et al. Effectiveness of high-dose influenza vaccine against hospitalisations in older adults (FLUNITY-HD): an individual-level pooled analysis. *The Lancet*. 2025;406(10518):2425–2434.

²²Belongia EA, Levine MZ, Olaiya O, Gross FL, King JP, Flannery B, et al. Clinical trial to assess immunogenicity of high-dose, adjuvanted, and recombinant influenza vaccines against cell-grown A(H3N2) viruses in adults 65 to 74 years, 2017–2018. *Vaccine*. 2020;38(15):3121–8.

²³DiazGranados CA, Dunning AJ, Kimmel M, Kirby D, Treanor J, Collins A, et al. Efficacy of high-dose versus standard-dose influenza vaccine in older adults. *N Engl J Med*. 2014;371(7):635–45.

²⁴Mallory RM, Bandell A, Ambrose CS, Yu J. A systematic review and meta-analysis of the effectiveness of LAIV4 and IIV in children aged 6 months to 17 years during the 2016–2017 season. *Vaccine*. 38(18):3405–3410.

²⁵Stuurman AL, Enxing J, Gutiérrez AV, Gray CM, Sepúlveda-Pachón IT, Ubamadu E, Meeraus W. Real-world effectiveness of live attenuated influenza vaccines (LAIV) and inactivated influenza vaccines (IIV) in children from 2003 to 2023: a systematic literature review and network meta-analysis. *Expert Rev Vaccines*. 2025;24(1):703–725.

²⁶Johansen ND, Modin D, Pardo-Seco J, et al. Effectiveness of high-dose influenza vaccine against hospitalisations in older adults (FLUNITY-HD): an individual-level pooled analysis. *The Lancet*. 2025;406(10518):2425–2434.

²⁷Barbetta LMDS, Correia ETdO, Gismondi RAOC, Mesquita ET. Influenza vaccination as prevention therapy for stable coronary artery disease and acute coronary syndrome: a meta-analysis of randomized trials. *Am J Med*. 2023;136(5):466–75.

²⁸De Wals P, Desjardins M. Influenza vaccines may protect against cardiovascular diseases. *Can Commun Dis Rep*. 2023;49:10.

²⁹Clar C, Oseni Z, Flowers N, Keshtkar-Jahromi M, Rees K. Influenza vaccines for preventing cardiovascular disease. *Cochrane Database Syst Rev*. 2015;(5):CD005050.

³⁰Liu M, Lin W, Song T, Zhao H, Ma J, Zhao Y, Yu P, Yan Z. Influenza vaccination is associated with a decreased risk of atrial fibrillation: a systematic review and meta-analysis. *Front Cardiovasc Med*. 2022;9:970533.

³¹Loong D, Pham B, Amiri M, Saunders H, Mishra S, Radhakrishnan A, et al. Systematic review on the cost-effectiveness of seasonal influenza vaccines in older adults. *Value Health*. 2022;25:1439–58.

Conclusion

Respiratory immunization is a cost-effective public-health investment. Beyond mitigating immediate clinical risk, strategic immunization protects priority populations from a cascade of downstream complications — hospitalization, ICU admission, frailty, loss of independence, secondary pneumonia, and even cardiovascular events. By aligning vaccine product with population risk across influenza, RSV, COVID-19, and pneumococcal disease, Canada can realize a preventive return on investment that directly addresses major drivers of healthcare utilization.

Despite these benefits, coverage gaps persist, surveillance remains incomplete, and access is uneven — increasingly a matter of postal code rather than need. Addressing these gaps through stable federal funding, harmonized eligibility, stronger national coordination, and renewed investment will strengthen population resilience and free critical healthcare resources for Canada's broader priorities. The most durable of these investments is also the most traditional: restoring public health's role as the trusted source of public and professional education. The cost of doing nothing is not neutral — it is paid in avoidable hospitalizations, ICU days, lost productivity, and lives. The preventive dividend, by contrast, is real, it is measurable, and it is available now. We urge the Committee to seize it.