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Claire Morrison

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Mulroney Institute Advisor:
Dr. Anna Zuschlag

Prepared for the Brian Mulroney
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www.mulroneyinstitute.ca

4048A Mulroney Hall
St. Francis Xavier University
Antigonish, Nova Scotia
Canada
B2G 2W5

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Policy+ is an undergraduate peer-reviewed student journal published by the Brian Mulroney Institute of Government at St. Francis Xavier University.

The journal provides a venue for undergraduate publication covering a wide array of interdisciplinary topics surrounding public policy and governance at the local, provincial, federal, and international level. Editions come out annually, and submissions are accepted year-round.

The mission of *Policy+* is to highlight student academic excellence by publishing undergraduate academic work across an array of disciplines with a common grounding in public policy and governance.

Policy+ would like to congratulate the graduating members of the Editorial Board, Erin MacLellan, Sophie Godin, and Claire Morrison. We wish them all the best in their future studies. They rest easy knowing that *Policy+* is in good hands with the future editorial board.

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LETTER FROM THE EDITOR



Claire Morrison

STFX CLASS OF 2026

Over the last year, members of the editorial board have worked tirelessly to prepare the 2025 edition of *Policy+*. Now in its third year, the journal continues to bring together policy research on a wide range of topics, from addressing gaps in healthcare policy to grappling with the future of Canada's national security in the face of a second Trump administration, to the need for intersectional policymaking on the issue of domestic labour. The breadth of topics reflects not only the diversity of interests among undergraduate students but also the increasing number of real-world questions and issues facing policymakers today.

Dr Anna Zuschlag has been instrumental in the publication of this edition. Her guidance, mentorship, and advice were invaluable, and I would like to extend my sincerest thanks to her for her assistance, work, and support throughout this year as I learned the ropes of a leadership position within the journal. Thank you also to Rory Jakubec, the previous Editor of *Policy+*, who patiently answered my numerous questions and who set a strong example for me to follow.

Thank you as well to the Brian Mulroney Institute of Government for its support and for providing a venue through which undergraduate policy research can be spotlighted.

Finally, the success of this edition rests on the shoulders of the editorial board, who worked diligently with authors to deliver the highest quality of work. Editorial board members put in hours of work during their highly valued summer vacations to ensure high-quality, polished papers that display academic excellence. We, as a team, are proud to present the third edition of *Policy+* and look forward to the journal's continued growth and success in the years to come.

Sincerely,

Claire Morrison

Claire Morrison
Editor (2025–26), *Policy+*

Improving Access to and Education for Personal Protective Equipment Within Nova Scotia Healthcare

Ashlyn Bona, Maggie Broussard, Ben Tehrani, and Jorja Verge

ABSTRACT

Following the COVID-19 pandemic, it is evident that there is an insufficient supply of Personal Protective Equipment (PPE) and a lack of promotional education materials for individuals in Nova Scotia. These barriers put healthcare workers, patients, and visitors at substantial risk for infectious disease transmission. New public policy is needed to improve access to and create educational materials for PPE. This policy brief outlines the steps necessary for overcoming these barriers. Partners needed to guide and support policy development including Non-Government Organizations, impacted healthcare institutions, and public health agencies. Recommendations include policies for developing universal educational materials, implementing educational programs in clinics and hospitals, and creating new funding opportunities to enhance accessibility to and quantity of PPE.

INTRODUCTION

Within the healthcare setting, communicable diseases, an illness that can pass from person to person, are inevitable workplace exposures.¹ Infectious diseases may spread to staff, other patients, or family members (and the extended community by association). This puts a significant strain on the healthcare system by increasing the number of people who require medical attention and reducing the staffing capacity needed to treat patients. A crucial component in reducing the spread of infection is having enough of and correctly using personal protective equipment (PPE). However, some healthcare clinics lack sufficient funding for PPE. Furthermore, in Nova Scotia, there are currently no universal educational materials for proper PPE usage for visitors and patients. This policy brief aims to address these two issues.

¹ Peter Edemekong and Ben Huang, *Epidemiology of Prevention* (National Library of Medicine, 2022), <https://www.ncbi.nlm.nih.gov/books/NBK470303/>.

PURPOSE

The purpose of this policy brief is to develop awareness regarding the lack of universal educational materials for proper PPE usage and the lack of funding for PPE for some clinics and healthcare facilities. Ensuring access to and education regarding PPE will significantly improve community health by reducing the prevalence of sick individuals in the community and reducing staffing shortages due to illnesses within the Nova Scotia healthcare system.

BACKGROUND

Consistent access to PPE was a major concern for many private clinics during the COVID-19 pandemic.² A vital component of PPE access is the funding necessary to purchase these materials. During the pandemic, many private practitioners had additional government funding for PPE supplies. However, as the risk of the pandemic decreased and fewer people were contracting COVID-19, these supplies were taken away.³ Lack of funding is a critical issue in ensuring consistent access to PPE for clinics.

In addition, there is a need for training on safe and correct usage and disposal of PPE supplies. Improved training is vital for protecting non-health professionals who may only use PPE when visiting clinics or sick individuals. Insufficient training and supply of PPE increases the risk of exposure within healthcare facilities for staff and patients, thus leading to an increased spread of infectious diseases in hospitals and clinics. A recent article states that “poor compliance with personal protective behaviours, improper use of PPE, and reuse of PPE were associated with an increased risk infection among frontline healthcare workers during the COVID-19 pandemic.”⁴ Furthermore, prior to the COVID-19 pandemic, various healthcare professionals inconsistently used PPE or did not fully recognize its importance for preventing disease transmission, despite the training that occurs within educational facilities.⁵ Having improper knowledge on appropriate PPE usage can cause harm and potentially lead to infections being spread to communities from healthcare facilities. Improving education for proper PPE usage and increasing funding for

² Jennifer Coto et al., “The Impact of COVID-19 on Allied Health Professionals,” *PLOS ONE* 15, no. 10 (2020), <https://doi.org/10.1371/journal.pone.0241328>.

³ “Personal Protective Equipment Supply Extended for Health Care Practitioners,” Nova Scotia College of Nursing, <https://www.nscn.ca/explore-nscn/news-and-media/news/2021/personal-protective-equipment-supply-extended-health-care-practitioners>.

⁴ Jisa George et al., “Factors Influencing Compliance with Personal Protective Equipment (PPE) Use Among Healthcare Workers,” *Cureus* 15, no. 2 (2023), <https://doi.org/10.7759/cureus.35269>.

⁵ Samantha Shwe et al., “Personal Protective Equipment: Attitudes and Behaviors Among Nurses at a Single University Medical Center,” *Cureus* 13, no. 12 (2021), <https://doi.org/10.7759/cureus.20265>.

purchasing PPE for all healthcare facilities in Nova Scotia requires a coordinated approach and engagement from multiple sectors outside the healthcare system.

SECTORS

Non-Governmental Organizations

Non-Governmental Organizations (NGOs) crucially contribute to public health safety by providing recommendations for the use of PPE and making sure that PPE is accessible to necessary personnel. NGOs play a significant role in identifying epidemiological trends such as hotspots and disease outbreaks. Likewise, NGOs provide insight into strategies that help slow the spread of diseases. During times such as the COVID-19 global pandemic, local responses by NGOs and social workers became more important than ever to support medical and public health services.⁶ The National Collaborating Centre for Infectious Diseases, the Canadian Public Health Association, and the Nova Scotia Government can provide support for coordination of PPE across the healthcare system in Nova Scotia. NGOs' efforts to prevent disease, increase access to PPE and advocate for certain policies emphasize the need for assistance.

Provincial Government

Provincial government grants are a vital sector for improving access to PPE. Healthcare facilities incorporated within this policy brief include hospitals, private clinics, medical offices, and so forth. PPE funding is required within healthcare facilities to provide and maintain the safety of workers and patients in all health-related environments. General PPE includes hand, body, respiratory, and eye protection, along with footwear and headwear. Smaller clinics, including dental offices and private healthcare clinics, do not have access to the same PPE resources that hospitals and larger facilities possess. This occurs as a result of non-standard workplace PPE requirements in healthcare because of varying exposure risks. The government grant, the Emergency Services Provider Fund, ensures PPE is accessible to all healthcare facilities in Nova Scotia. The grant requires clinics to apply and be accepted to receive PPE. However, "organizations can only receive funding once every two years."⁷ By improving the consistency of funds, it would increase the ability to cover the cost of PPE accessibility in all healthcare facilities.

⁶ Oiyuyu Jiang, "What Small NGOs Can Deliver: A Case Study of a Canadian Community-Based Project Making Fabric Scrub Caps for Healthcare Workers During the COVID-19 Pandemic," *International Social Work* 63, no. 6 (2020): 851–856, <https://doi.org/10.1177/0020872820959374>.

⁷ "Apply for Funding to Buy Equipment That's Used Directly in Response to a Fire or Emergency: Emergency Services Provider Fund," Government of Nova Scotia, <https://beta.novascotia.ca/apply-funding-buy-equipment-thats-used-directly-response-fire-or-emergency-emergency-services-provider-fund>.

These investment opportunities would include ensuring yearly training sessions and consistently updating equipment for worker and patient safety within Nova Scotia healthcare.

Public health, the health of an entire population with the support of governmental bodies, plays a vital role in the healthcare system and governmental responsibilities within the province of Nova Scotia. Government health services use regulation to promote healthy options within the sector, with the goal of improving support systems available for patients. During the COVID-19 pandemic, public health was instrumental in spreading accurate information to the public regarding COVID-19 symptoms, procedures and vaccine effectiveness.⁸ A key aim for public health is reducing potential public health risks, such as communicable diseases. Moreover, this branch of government is responsible for educating the public on potential health threats and spreading awareness through media campaigns and educational programs. Finally, public health helps to advise and advocate for better health policies.⁹ This sector is essential for achieving these goals, as its responsibilities (such as public education on health) directly influence the designated target areas within the province (such as promoting education regarding proper PPE usage). Public health could help develop universal educational materials for the proper wearing of PPE, a pivotal step toward making PPE usage a protective factor against transmission of communicable disease. Likewise, public health will be essential for communicating provincial mandates or guidelines around existing PPE usage. Lastly, public health can help advise changes in legislation and recommend new policies to increase PPE accessibility for all healthcare institutions in the province and enforce these new policies once they are in effect.

Healthcare Institutions

Healthcare institutions are a crucial sector when striving to reduce the number of exposures to communicable diseases within the healthcare system in Nova Scotia. Healthcare institutions such as hospitals and clinics are the front-line areas in which communicable diseases are spread between patients and healthcare professionals, and are therefore the last form of protection against the spread of disease. PPE is designed to protect healthcare providers and their patients from the spread of hospital-acquired communicable diseases. Healthcare institutions are crucial resources to ensure proper PPE usage as they translate information regarding proper PPE usage into practice. Healthcare facilities determine what works and does not work specific to their facilities and are responsible for distributing PPE and its accessibility. Implementing guidelines and designated information specific to their facilities regarding where to find PPE, how to use

⁸ "Coronavirus (COVID)," Nova Scotia Health, <https://www.nshealth.ca/coronavirus>.

⁹ "Department of Health and Wellness," Government of Nova Scotia, <https://beta.novascotia.ca/government/health-and-wellness>.

PPE, how to store PPE, and proper disposal of PPE are a few of the many ways healthcare institutions contribute to the prevention of the spread of communicable diseases.¹⁰

DISCUSSION

PPE is essential for reducing the spread of disease among healthcare professionals, patients, and their families. However, it is important to note that PPE is only useful when used properly; thus, mandatory training and education on proper use are essential. It is also important to note how crucial proper PPE usage is, as it helps to prevent the spread of diseases and infections in healthcare settings where it is prevalent.

However, there are many barriers when it comes to ensuring that PPE is used as intended, including a lack of training & educational material and a lack of access due to limited funding. Overcoming these barriers requires an intersectoral approach. NGOs are needed to help promote the use of PPE, identify disease hotspots, and provide recommendations for PPE use. Provincial government grants can ensure that there is adequate funding for small medical clinics or private clinics (where there is currently a lack of funding for PPE). Healthcare institutions are at the frontline, where communicable diseases are spread, and thus, it is crucial to ensure that PPE is

To ensure that PPE is implemented effectively, government grants, healthcare facilities, public health, and NGOs must successfully

accessible and is properly used and disposed of to reduce the risk of communicable diseases. Public health aids in marketing and building awareness regarding the lack of PPE and educates the public on proper usage.

If PPE funding is improved and universal educational materials are created, healthcare environments become safer for both healthcare professionals and the public due to a reduced spread of communicable diseases. To ensure that PPE is implemented effectively, government grants, healthcare facilities, public health, and NGOs must successfully collaborate. Strengthening the consistent and sustainable supply and appropriate use of PPE throughout the healthcare system will improve adaptability in the case of future communicable disease outbreaks. Figure 1.1 represents the logical steps taken to provide available funding for PPE.

¹⁰ Logan Smith, "What to Know About Personal Protective Equipment (PPE)," *WebMD*, July 25, 2024, <https://www.webmd.com/a-to-z-guides/cm/what-to-know-about-personal-protective-equipment-ppe>.

GOAL Improve the use and knowledge of PPE to reduce transmission and prevalence of communicable diseases

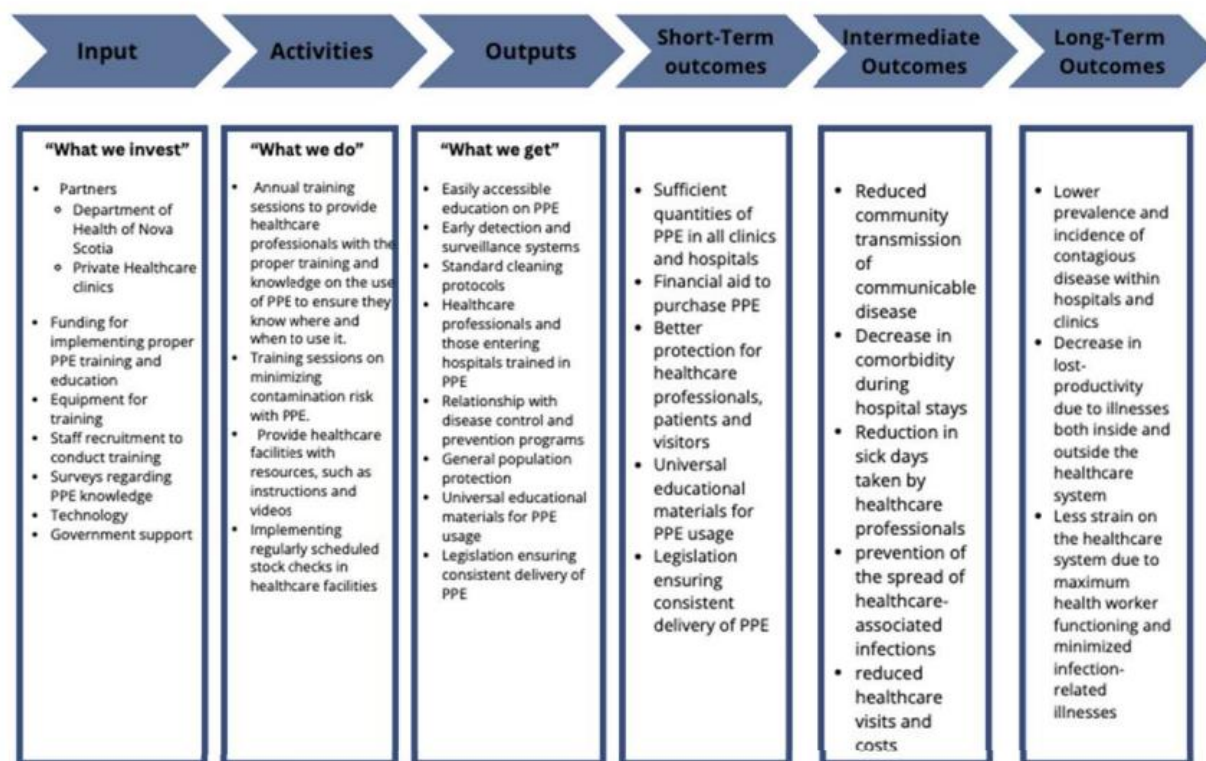


Figure 1.1: Logic Model: Improving Access to and Education for Personal Protective Equipment Within the Healthcare System in Nova Scotia. Author Created, 2025.

RECOMMENDATIONS

To improve the use and knowledge of PPE to reduce transmission and prevalence of communicable diseases, this brief recommends the following actions:

1. Mandate training for accurate PPE usage for all healthcare staff;
2. Create universal educational materials on proper PPE usage for all healthcare facilities;
3. Ensure that healthcare facilities maintain a continuous and adequate supply of PPE, such as masks, gloves, gowns, and face shields by keeping a record of when supplies become low and restocking resources as needed;
4. Implement educational programs for patients and visitors, such as pamphlets, posters, educational sessions and so on. Ensuring that patients and visitors understand the importance of PPE and that they are using and disposing of it properly;

5. Form connections with non-governmental organizations to help promote the use of PPE, identify hotspots of disease, and provide recommendations for PPE usage;
6. Apply for government grants for adequate funding for small medical clinics or private clinics; and
7. Partner with the provincial government when implementing PPE mandates and funding in healthcare facilities such as hospitals and clinics.

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ABOUT THE AUTHORS

Ashlyn Bona, Maggie Broussard, Ben Tehrani, and Jorja Verge are in their fourth and final year of the Bachelor of Arts and Science in Health program, with an expected graduation date of May 2026. Ashlyn and Ben are both pursuing a concentration in Biomedical Sciences, with Ben also completing the program with Honours.



The Colonial Weight of Care

José Miguel Nunes da Silva

ABSTRACT

This paper examines how domestic work in Brazil and Canada continues to be shaped by enduring colonial and patriarchal structures, despite divergent legal frameworks. Drawing on the concepts of coloniality of power, gender, and knowledge, the study explores how domestic labour, performed predominantly by racialized and migrant women, remains devalued, feminized, and socially invisible. In Brazil, despite the ratification of the International Labour Organization’s Convention No. 189 and constitutional labour protections, widespread informality and cultural normalization of servitude persist. In contrast, Canada has not ratified the Convention and instead regulates domestic work through immigration-based programs that legally bind workers to precarious conditions. Through a comparative analysis of emblematic case studies this research reveals how colonial logics of labour extraction endure across both contexts. The study argues that achieving decent work for domestic workers requires more than legal reform: it demands decolonial and intersectional policymaking that centres the lived experiences of those who carry the colonial weight of care.

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INTRODUCTION

Domestic work has roots in systems where certain bodies¹ were assigned roles of servitude under colonial rule. The legacies of colonial slavery, Indigenous exploitation, and racial-gender hierarchies continue to influence who performs domestic work and how it is valued. As Gutiérrez-Rodríguez² states: “the social significance of domestic work is defined through the historical legacy of colonialism, slavery, indentured labor, serfdom, and the contemporary organization of a heteronormative social order.”³ Its ongoing devaluation, through low wages, informality, and weak legal protections, reflects colonial ideologies that deem certain types of labour and workers

¹ Black, Indigenous, racialized, and female.

² Encarnación Gutiérrez-Rodríguez, “Domestic Work—Affective Labor: On Feminization and the Coloniality of Labor,” *Women’s Studies International Forum* 46 (2014): 45–53.

³ This research is situated within the context of social and economic relations shaped by power structures that date back to the colonial period.

less deserving of rights and recognition. This dynamic is what legal scholar Adelle Blackett terms the “asymmetrical, unequal, and largely invisible law of the household workplace.”⁴ Blackett argues that this “unjust law” is a global legacy of subordination and servitude, shaping the common-sense ways in which the domestic work relationship is understood and regulated, often outside of formal state law.

In Brazil, paid domestic work is the occupation of millions of people, predominantly women.⁵ According to data from the National Household Sample Survey, in 2023, more than 6 million people were engaged in paid domestic work in Brazil, 91.1 percent of whom were women.⁶ The reality of these workers is marked by several challenges and adverse conditions. Domestic work is often characterized by long hours, low wages, and widespread informality.⁷ Due to the significant proportion of informal employment in the domestic sector, most of these workers lack labour and social security protections.⁸ Moreover, the social recognition of domestic work remains insufficient. For instance, domestic workers are rarely included in mainstream labour union debates, and many still refer to their labour as ‘help’ rather than employment – language that erases their professional identity and reinforces informal, subordinate roles.⁹

Conversely, domestic work in Canada, according to Shaw, is primarily performed by migrant workers predominantly from the Philippines, with women forming the majority.¹⁰ Here, the parallels with Brazil begin to emerge. While Brazil’s domestic labour force is mostly composed of internal workers, meaning Brazilians who migrate from poorer regions to wealthier urban centres for employment,¹¹ Shaw highlights that domestic work in Canada is highly racialized, characterized by low wages and precarious working conditions, where worker exploitation is a

⁴ Adelle Blackett, *Everyday Transgressions: Domestic Workers’ Transnational Challenge to International Labor Law* (ILR Press, 2019), 11.

⁵ Nathália Patrício Leão, “Trabalho doméstico e cuidado: Articulações entre responsabilidades familiares e trabalho pelas trabalhadoras domésticas de Palmas/TO” (Master’s diss., Universidade Federal do Tocantins, 2022); Instituto Brasileiro de Geografia e Estatística (IBGE), *Estatísticas de gênero: Indicadores sociais das mulheres no Brasil, Estudo e Pesquisa Informações Demográficas e Socioeconômicas*, no. 38 (Rio de Janeiro: IBGE, 2018).

⁶ Instituto Brasileiro de Geografia e Estatística (IBGE), *Pesquisa Nacional por Amostra de Domicílios Contínua: Resultados 2023* (Rio de Janeiro: IBGE, 2023).

⁷ Leão, *Trabalho doméstico e cuidado*.

⁸ Joaze Bernardino-Costa, ed., *Saberes subalternos e decolonialidade: Os sindicatos das trabalhadoras domésticas do Brasil* (Editora Universidade de Brasília, 2015).

⁹ Leão, *Trabalho doméstico e cuidado*.

¹⁰ Jennifer E. Shaw, “Tender Labor: Transnational Young People and Continuums of Familial Care,” *Anthropology of Work Review* 41, no. 1 (2020): 14–23.

¹¹ Leão, *Trabalho doméstico e cuidado*.

constant reality. This migratory phenomenon does not occur in isolation but is directly linked to the lack of well-paid employment opportunities in these women's home countries, which compels them to seek economic alternatives abroad. Additionally, the promise of obtaining permanent residency in Canada serves as an incentive, leading many to accept adverse conditions in the hope of securing a more stable future for themselves and their families.¹²

As previously noted, since domestic work is predominantly performed by women in both Brazil and Canada, this study will use the term *domestic workers* to refer to this category, with a specific emphasis on the Brazilian term *trabalhadoras domésticas*. In Portuguese, nouns carry gender, and *trabalhadoras domésticas* is the feminine form commonly used to describe women in this occupation, a linguistic reflection of the deeply gendered nature of domestic labor in Brazil. This terminological choice aims to give visibility to the category, avoiding gender-neutral language that could obscure the structural inequalities faced by these professionals. Furthermore, by adopting this term, the study seeks to highlight not only the centrality of women in this sector but also the necessity of recognizing their rights and valuing domestic work as an essential activity for maintaining the capitalist system in both Brazil and Canada.

Whether through internal structures of postcolonial inequality in Brazil or through transnational migration regimes in Canada, domestic work is systematically devalued and feminized. In both settings, the labour of racialized women is rendered invisible while serving as a foundational pillar for economic and social reproduction. Drawing on the theory of the coloniality of power, gender, and knowledge, this paper argues that domestic work today cannot be fully understood without tracing the historical continuities of colonial domination, capitalist accumulation, and patriarchal subordination. To achieve this, the paper is structured as follows: the next section introduces the key theoretical concepts that ground the research. Following this, case studies of domestic workers in both countries that inform the analysis are presented and examined in detail. Finally, the conclusion offers critical reflections and policy recommendations aimed at strengthening protections for *trabalhadoras domésticas* and advancing decent domestic work in both Brazil and Canada.

DOMESTIC WORK IN THE SHADOW OF COLONIALISM

This study examines the activities classified by Glenn as reproductive labour, which includes cleaning, childcare, eldercare, caregiving for people with special needs, home security, cooking,

¹² Geraldine Pratt, *Families Apart: Migrant Mothers and the Conflicts of Labor and Love* (University of Minnesota Press, 2012); Ethel Tungohan, *Care Activism: Migrant Domestic Workers, Movement-Building, and Communities of Care* (University of Illinois Press, 2023).

and gardening.¹³ As she states: “Domestics were employed to clean house, launder and iron clothes, scrub floors, and care for infants and children.”¹⁴ According to her studies, when analyzing different population compositions in regions of the United States, such as Mexican, African American, and Japanese communities, it was observed that these groups, within what she defines as the racial division of reproductive labour, were legally segregated from white people and excluded from fundamental rights and guarantees accessed by ‘full citizens’. This racial dualism was reflected “in the legal, political, and economic systems.”¹⁵

The racial division of reproductive labour identified by Glenn in the United States finds parallels

Domestic work, far from being a private or apolitical activity, is embedded in global structures of exploitation that reflect and perpetuate the colonial and capitalist ordering of labour.

in both Brazil and Canada, where racial and migratory hierarchies similarly shape who performs domestic work and under what conditions. Capitalism plays a central role in sustaining and reproducing these hierarchies by structurally positioning racialized and marginalized women, such as Black women in Brazil and migrant women from the Global South in Canada, as the primary providers of

undervalued reproductive labour. Thus, domestic work, far from being a private or apolitical activity, is embedded in global structures of exploitation that reflect and perpetuate the colonial and capitalist ordering of labour.

Regarding the maintenance of the capitalist system, it is crucial to initially understand the dynamic between the absence of freedom and exploitation within this system through a Marxist lens. Marx conceives the lack of freedom as the alienation of workers from their own labour, resulting from specific socio-economic systems of exploitation.¹⁶ He defines exploitation as the extraction of value from one individual for the benefit of another, not only for personal gain, but also to sustain the wealth, operations, and social position of the capitalist, their business, or even their family structure. Moreover, Marx argues that exploitation is not exclusive to capitalism and thus is not limited to profit generation;¹⁷ rather, it represents a structural mechanism that

¹³ Evelyn Nakano Glenn, “From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor,” *Signs* 18, no. 1 (1992): 1–43; Evelyn Nakano Glenn, *Forced to Care: Coercion and Caregiving in America* (Harvard University Press, 2010).

¹⁴ Glenn, “From Servitude to Service Work,” 7.

¹⁵ Glenn, “From Servitude to Service Work,” 8.

¹⁶ Rhacel Salazar Parreñas, *Unfree: Migrant Domestic Work in Arab States* (Stanford University Press, 2021).

¹⁷ The driving force of capitalism.

transcends different socio-economic formations such as slavery-based economies, and colonial systems, where labour was also extracted through unequal power relations.¹⁸

With this elucidation, Federici's assertion becomes evident: "capital rules and develops through the wage, that is, that the foundation of capitalist society was the wage laborer and his or her direct exploitation."¹⁹ However, Marx's definition alone is insufficient. Since globalization and neoliberalism allow capitalism to take control of labour and natural resources, Federici asserts that capitalism over-exploits women.²⁰ She argues that Marx's analysis of capitalism is blind to the significance of reproductive labour performed by women in the process of capital accumulation. Ignoring this factor limits the understanding of how exploitation within capitalism can expand through the creation of divisions within the working class, "starting with the relation between women and men."²¹ This perspective allows for an understanding that *trabalhadoras domésticas* are embedded within socio-economic systems of exploitation that result in their alienation and the perpetuation of historical inequalities.

This historical inequality is not merely a byproduct of capitalism but deeply rooted in colonial systems of domination. Starting from Federici's perspective that "work in a capitalist system is exploitation and there is no pleasure, pride or creativity in being exploited,"²² domestic work emerges as an essential activity that carries deep historical and cultural marks, stemming from the colonization process to which these countries were subjected and characterized by exploitation. More than that, as Schuller shows, nineteenth-century scientific discourse used notions of sensibility and sentiment to reinforce patriarchy by assigning emotional and moral traits differently to white men and women: white men were seen as rational and fit for public life, while white women were portrayed as overly emotional and suited for domestic and caregiving roles.²³

Schuller also argues that nineteenth-century scientific discourse constructed racial hierarchies in which white bodies were viewed as emotionally and morally superior, while Black bodies were deemed coarse and unfeeling, thus, biologically destined for servitude.²⁴ These notions served

¹⁸ Karl Marx, *Das Kapital: A Critique of Political Economy* (Henry Regnery, 1959).

¹⁹ Silvia Federici, *Revolution at Point Zero: Housework, Reproduction, and Feminist Struggle* (PM Press, 2012), 40.

²⁰ Federici, *Revolution at Point Zero*, 105, 111.

²¹ Federici, *Revolution at Point Zero*, 112.

²² Federici, *Revolution at Point Zero*, 76.

²³ Kyla Schuller, "Taxonomies of Feeling: The Epistemology of Sentimentalism in Late-Nineteenth-Century Racial and Sexual Science," *American Quarterly* 64, no. 2 (2012): 277–299.

²⁴ Schuller, "Taxonomies of Feeling."

as ideological justifications for the exploitation of racialized labour under colonial regimes, particularly the assignment of caregiving and domestic roles to women of colour. By denying Black and Indigenous women access to the sentimental and moral frameworks afforded to white women, colonial ideology positioned them outside the idealized private sphere and instead embedded them in roles of subservience and hard labour. This exclusion from emotional refinement and femininity did not disappear with the end of formal colonization: it became foundational to the ongoing racial and gendered division of labour under capitalism. Blackett emphasizes that the history of domestic work is “particularly punctuated by the global institution that is the centuries-long transatlantic slave trade” and encompasses the colonial encounter

Domestic work serves as a continuity link between colonial society and the present, revealing the persistence of a social ethic that perpetuates the devaluation of domestic labour and those who perform it

across continents.²⁵ As pointed out by Carneiro, domestic work serves as a continuity link between colonial society and the present, revealing the persistence of a social ethic that perpetuates the devaluation of domestic labour and those who perform it.²⁶

In this sense, the exploitation of domestic work cannot be analyzed solely through the lens of capitalism but must also be understood

in light of the colonial structures that have shaped and continue to influence labour relations. This brings forth the concept of the coloniality of power, introduced by Quijano, which serves as an analytical tool to describe the persistence of domination and exploitation patterns established during the European colonization of the Americas.²⁷ Quijano argues that even after the formal end of colonization, the power structures and control mechanisms implemented by the colonizers continue to exert a profound and lasting influence on postcolonial societies. These structures are not confined to historical events but permeate contemporary dynamics, shaping social, political, and economic relations in significant ways.

Thus, in considering the coloniality of power, it is essential to understand how the power relations established during colonization continue to shape contemporary social dynamics, reinforcing structural hierarchies and injustices.²⁸ Analyzing these colonial structures allows for

²⁵ Blackett, *Everyday Transgressions*, 11.

²⁶ Sueli Carneiro, “Presentation,” in *Saberes subalternos e decolonialidade: Os sindicatos das trabalhadoras domésticas do Brasil*, ed. Joaze Bernardino-Costa (Editora Universidade de Brasília, 2015), 7–10.

²⁷ Aníbal Quijano, “Colonialidade do poder, eurocentrismo e América Latina,” in *A colonialidade do saber: Eurocentrismo e ciências sociais – Perspectivas latino-americanas*, ed. Edgardo Lander (CLACSO, 2005), 107–130.

²⁸ Bernardino-Costa, *Saberes subalternos e decolonialidade*.

a deeper comprehension of existing inequalities and highlights the necessity of dismantling these forms of domination to foster more just, equal, and inclusive societies. As a response to the recognition of the coloniality of power, Quijano conceptualizes decoloniality as an intellectual and political project aimed at dismantling the power and knowledge structures established by European colonialism, which continue to influence contemporary societies.²⁹

Since coloniality did not end with the formal conclusion of colonialism but persists through racial, cultural, economic, and epistemological hierarchies that sustain the domination and exploitation of non-Western populations, decoloniality involves the critique and rejection of these hierarchies. It promotes the recognition and revitalization of the knowledge, identities, and practices of historically colonized peoples. This movement seeks not only the deconstruction but also the de-structuring of colonial forms of knowledge and power that still permeate contemporary societies. Mignolo, through the concept of the coloniality of knowledge, falls in line with Smith who emphasizes that decoloniality requires an epistemic disobedience, which consists of rejecting the norms and knowledge imposed by colonialism.³⁰ This disobedience is not limited to questioning existing power structures but also actively challenges narratives and paradigms that perpetuate domination and marginalization. Following the same decolonial perspective, Lugones employs the concept of the coloniality of gender.³¹ She focuses on the decolonization of gender relations, demonstrating how coloniality profoundly influenced gender perceptions and practices. Lugones highlights the need to dismantle colonial gender constructions that perpetuate hierarchies and oppression, advocating for forms of resistance and transformation that acknowledge the diversity and complexity of gender experiences.³²

In this context, understanding the relationship between power, knowledge, and gender within coloniality becomes fundamental to comprehending how *trabalhadoras domésticas*, especially racialized women, are relegated to positions of subordination within contemporary labour dynamics in both countries. By articulating capitalist exploitation with persistent colonial structures, it becomes clear that the precarization of domestic work is not merely a reflection of capitalism's contradictions but also a continuation of historical systems of domination and social stratification. Precarity, in this sense, refers not only to informal or unauthorized employment but to a broader structural condition marked by persistent vulnerability and exclusion from stable, valued labour. As Parreñas explains, care workers "are still likely to confront economic

²⁹ Aníbal Quijano, *Colonialidade do poder, eurocentrismo e América Latina*.

³⁰ Walter Mignolo, *La idea de América Latina: La herida colonial y la opción decolonial* (Gedisa Editorial, 2007); Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples*, 2nd ed. (Zed Books, 2012).

³¹ María Lugones, "Rumo a um feminismo descolonial," *Revista Estudos Feministas* 22, no. 3 (2014): 935–952.

³² María Lugones, "Rumo a um feminismo descolonial."

precarity, as they face an unstable labor market where they are limited to low-wage employment as unskilled and contingent workers, or alternatively, face difficulty in identifying a sustainable business.”³³

Given this reality, these challenges, rooted in historical and social prejudices,³⁴ devalue domestic work and the rights of the women who perform it. With this theoretical framework, this study aims to make a significant contribution to the field of decoloniality and labour relations, emphasizing the intersection between domestic work and coloniality in its three manifestations: power, knowledge, and gender. In doing so, this study seeks to shed light on the perpetuation of colonial practices and ideologies in contemporary times in both Brazil and Canada. Despite economic and geographic differences, as well as differences in how domestic work is structured in each country, both share characteristics of unfreedom and exploitation that bring them closer together.

STORIES THAT CANNOT ALLOW US TO LIE

To critically examine how coloniality continues to structure domestic labour, it is essential to foreground specific cases that reveal the lived realities behind these systemic patterns. In the Brazilian context, this becomes evident through the following story:

Madalena Gordiano³⁵

Madalena Gordiano (Figure 1.1) was just eight years old when she knocked on the door of a household in search of food. A white woman, a schoolteacher, invited the young Black girl inside and offered to adopt her. Her biological mother, caring for a large family that included Madalena’s twin sister and seven other siblings, agreed. However, the promised adoption and education never materialized. Instead, Madalena became a domestic servant for the family, entering a regime of unpaid labour that lasted for over four decades. Throughout this period, she was never formally employed, received no wages, was granted no days off or vacation, and remained entirely excluded from formal education. Her days were filled with housework within a wealthy household located in an apartment building in the state of Minas Gerais.³⁶

³³ Parreñas, *Unfree*, 136.

³⁴ Colonial in nature.

³⁵ Naiara Galarraga Gortázar, “Madalena, escrava desde os oito anos, expõe caso extremo de racismo no Brasil do século XXI,” *El País Brasil*, January 14, 2021.

³⁶ As Glenn (1992) pointed out.

According to federal labour prosecutor, she lived under conditions that met legal definition of contemporary slavery.³⁷ Her room was a small, windowless space, she owned just three T-shirts and had no mobile phone or television. For over 38 years, her existence remained invisible, normalized within the private space of domestic life. One of the most disturbing aspects of Madalena's case was the imposition of a coerced marriage in her twenties to a 78-year-old relative of the family, who received a military pension due to his service in World War II. After his death, Madalena became the legal beneficiary of the pension, which amounted to over 8,000 BRL per month. Yet, despite this formal entitlement, she continued to live in poverty and precarity, receiving only scraps while her employers retained control over the bulk of the funds.³⁸

Her eventual rescue, in 2020, was only made possible through the intervention of a neighbour who became suspicious of her condition. Forbidden from speaking with other residents,



Madalena had resorted to slipping handwritten notes beneath their doors, pleading for money to purchase soap and basic hygiene items. Her handwriting was shaky, and her ability to express herself severely limited after years of social and emotional deprivation. When authorities intervened, they found a 46-year-old woman with short hair, visibly malnourished and psychologically traumatized.

Figure 1.1 (left): Madalena Gordiano after being rescued from conditions analogous to slavery. Source: Fantástico, Globoplay.

Other stories like that, such as those of other care workers like Dona Maria and Elisa, illustrate how domestic servitude operates through deeply informal, socially naturalized structures that

³⁷ Isolated, dependent, and systematically deprived of autonomy and dignity.

³⁸ Parreñas, *Unfree*.

trace back to Brazil's history of slavery and racial hierarchy.³⁹ In each instance, domestic work was disguised as familial care, loyalty, or moral obligation, obscuring its exploitative nature and shielding it from state oversight.⁴⁰ These cases reflect a cultural and structural informality wherein the absence of contracts, salaries, or rest is not treated as illegal but normalized through interpersonal relationships and historicized narratives of servitude.

Juana Tejada⁴¹

Born and raised in the rural province of Abra in northern Philippines, Juana Tejada (Figure 1.2) came from a large farming family, she was the fifth of nine children. Although she held a teaching degree, the limited economic opportunities in her home country compelled her to seek better-paying employment abroad. In 1995, she began working as a domestic helper in Hong Kong. After eight years in overseas contract work, she briefly returned to the Philippines before migrating to Canada in 2003 under the Live-in Caregiver Program (LCP). Upon arriving in Alberta, Juana began working as a nanny for two sets of twins. Like many Filipina care workers in Canada, she sent regular remittances back home to support her parents, husband, and siblings.

The LCP allowed foreign domestic workers to apply for permanent residency after completing 24 months of employment. After fulfilling this requirement, Juana submitted her application and was granted an open work permit. However, as part of the process, she was required to undergo a second medical exam, in addition to the one she passed to first enter the country. In 2006, Juana's application for permanent residency was denied after the medical exam revealed she had a severe form of cancer. She was deemed inadmissible and immediately lost access to provincial health insurance. She was given 60 days to appeal the decision, during which she moved to Toronto. Without public health coverage and unable to afford immediate care, Juana postponed cancer treatment for months while continuing to work as a caregiver to cover her medical expenses. Her situation exposed a troubling contradiction: the Canadian state relied on her labour to sustain its care economy but swiftly revoked her right to remain once she was no longer deemed 'productive'.

³⁹ Fausto Macedo, "'O argumento do afeto é muito usado', diz procurador após resgate de Maria, 84, de trabalho escravo," *Estadão*, February 28, 2024; Irene Rizzini and Cláudia Fonseca, *As meninas e o universo do trabalho doméstico no Brasil: Aspectos históricos, culturais e tendências atuais* (CIESPI, 2002).

⁴⁰ Leão, *Trabalho doméstico e cuidado*.

⁴¹ Ysh Cabana, "Juana Tejada," *The Canadian Encyclopedia*, September 8, 2021.

Juana Tejada’s case ignited national media attention and mobilized widespread advocacy from human rights organizations, culminating in the formation of the Justice for Juana Tejada Coalition. Her activism transformed her into a powerful symbol of migrant resistance, and her struggle led to a landmark policy change in 2010 with the passage of the “Juana Tejada Law,” which removed the requirement for a second medical exam for live-in caregivers applying for permanent residency in Canada. This case, and many others such as Gelyn Dasoc-Hilot and Vesmindia Cara, expose a system in which domestic labour is formally legalized yet structurally precarious, sustained through state-regulated immigration pathways such as the Live-in Caregiver Program.⁴² In this context, exploitation is not informal but institutionalized: the legal architecture itself generates vulnerability by binding immigration status to employment,



mandating live-in arrangements, and imposing barriers to permanent residency and access to justice. These mechanisms create a framework where migrant *trabalhadoras domésticas* are legally recognized yet socially marginalized, reinforcing patterns of racialized and gendered labour exploitation under the guise of regulated employment.

Figure 1.2 (left): Juana Tejada at home in Canada during her battle for permanent residency, after being denied due to a cancer diagnosis despite fulfilling all requirements under the Live-in Caregiver Program.

Source: *Toronto Star*.

This persistence of precarious and exploitative conditions in domestic work occurs despite the existence of international institutions dedicated to protecting *trabalhadoras domésticas*, such as International Labour Organization (ILO) Convention No. 189, which establishes guidelines to ensure decent working conditions in the sector.⁴³ In Brazil, its ratification was incorporated through Constitutional Amendment No. 72, marking a significant milestone in the fight for

⁴² CBC News, “Côte Saint-Luc Woman Ordered to Pay \$41K in Damages to Live-in Nanny,” *CBC News*, May 21, 2018; Michele Brunoro, “‘I Was So Shocked’: Filipino Caregiver Says She Faced Labour Exploitation in B.C.,” *CTV News*, January 17, 2025.

⁴³ ILO, *Convention No. 189 Concerning Decent Work for Domestic Workers* (International Labour Organization, 2011).

domestic workers' rights in the country.⁴⁴ This legislation introduced important advances, including the guarantee of labour rights such as a 44-hour work week, overtime pay, night shift premiums, mandatory *Fundo de Garantia do Tempo de Serviço* contributions,⁴⁵ and unemployment benefits, among others. However, despite these achievements, the effective implementation of these rights still faces numerous challenges. The precarization of domestic work persists due to some employers' resistance to complying with the legislation, as well as a lack of proper oversight and the absence of effective mechanisms to ensure labour rights enforcement, resulting in ongoing vulnerability and informality for *trabalhadoras domésticas*.

In Canada, the convention has not been ratified, reflecting the continued precarization and vulnerability these workers face. According to the Canadian Labour Congress a significant number of *trabalhadoras domésticas* are migrant and racialized women without legal status who encounter barriers to decent work and labour protections due to their immigration status and systemic racism.⁴⁶ Massie, Minh, and Shaw demonstrate that the Canadian federal government's caregiver pilot programs have failed to meet their objectives of providing permanent residency to migrant care workers, while simultaneously announcing a new program despite an already extensive backlog.⁴⁷ Furthermore, they highlight that "Caribbean and Asian women have largely been denied this recognition and security, entering Canada temporarily to perform work deemed 'low-skilled' and 'low-waged'."⁴⁸

CONCLUSION: WHAT DOES IT MEAN THAT BRAZIL HAS RATIFIED ILO CONVENTION 189 AND CANADA HAS NOT?

In light of the exploitation faced by domestic workers, it is essential to consider the significance of a country's decision to ratify, or not ratify, ILO Convention No. 189. This ratification is not merely a symbolic gesture: it represents a formal commitment to upholding international labour standards that guarantee decent work, social protection, and fundamental rights for *trabalhadoras domésticas*. The act of ratifying, or choosing not to ratify, serves as a powerful

⁴⁴ Brasil, *Emenda Constitucional nº 72, de 2 de abril de 2013: Altera a Constituição Federal para assegurar aos empregados domésticos direitos iguais aos dos demais trabalhadores urbanos e rurais*, *Diário Oficial da União*, April 3, 2013; Domestic Workers' Rights Amendment.

⁴⁵ Brazil's mandatory Severance Indemnity Fund for Employees.

⁴⁶ Canadian Labour Congress, "Human Rights Day: Canada Must Ratify C-189 to Protect Vulnerable Domestic Workers," 2021, .

⁴⁷ Bagon, Cenen et al., "A Decade of Migrant Care Worker Programs. Vancouver," *Canadian Centre for Policy Alternatives*, September 25, 2024, <https://www.policyalternatives.ca/news-research/a-decade-of-migrant-care-worker-programs/>.

⁴⁸ Bagon et al., "A Decade of Migrant Care Worker Programs. Vancouver."

indicator of a state's political will to confront and dismantle the colonial and patriarchal foundations that continue to structure domestic work in contemporary societies.

However, it is important to recognize that ratification of international conventions alone does not guarantee transformation. While Brazil has ratified ILO Convention 189, informality and the normalization of servitude among *trabalhadoras domésticas* persist due to weak enforcement and deep-rooted cultural norms. In contrast, Canada's refusal to ratify the Convention highlights a policy approach that maintains migrant care workers in legally precarious conditions, reinforcing their invisibility and limiting recognition of domestic labour as essential work. In both contexts, the gap between legal frameworks and lived realities underscores the need for structural and societal transformation beyond formal commitments.

Addressing these injustices requires more than incremental legal reform; it necessitates a profound reconfiguration of the structural and cultural foundations through which societies understand and value care, labour, and the racialized, feminized bodies that have historically been assigned to perform them. This is not merely a question of labour law or immigration policy, but of confronting the colonial legacies and patriarchal ideologies that continue to shape social hierarchies and economic relations in both Brazil and Canada. These legacies manifest in the persistent undervaluation of domestic work, the normalization of informality and exploitation, and the systemic exclusion of *trabalhadoras domésticas*, many of whom are Black, Indigenous, or migrant women, from full citizenship and labour protections.

This study therefore calls for a renewed and sustained commitment to decolonial and intersectional policymaking, approaches that go beyond surface-level diversity and inclusion frameworks to actively center the voices and lived experiences of *trabalhadoras domésticas*. Such frameworks must seek to dismantle the historical, racial, gendered, and class-based inequalities embedded in national labour regimes. The objective is not only to achieve formal equality through legal recognition, but to realize transformative justice: a structural reimagining of labour relations, social protection systems, and the social value accorded to reproductive labour. Only through such a radical reorientation can Brazil and Canada begin to undo the colonial weight of care and move toward societies where care work is no longer invisibilized, but recognized, protected, and dignified.

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ABOUT THE AUTHOR



José Miguel Nunes da Silva is a final-year Bachelor of Laws student at the Federal University of Tocantins, Brazil. A 2025 Emerging Leaders in the Americas Program scholar at Thompson Rivers University, he has also been recognized as a Selected Researcher for the Brazil Conference at Harvard & MIT. His research integrates public governance with decolonial theory and international labour law, focusing on how legal and policy frameworks can address the systemic precarity affecting migrant workers and other socially vulnerable communities.

Crisis in the Queue: Addressing Emergency Room Wait Times in Nova Scotia and New Brunswick

Sam Chapman, Amy Maynard, Isabella Regenvanu, and Stephanie Walker

ABSTRACT

Emergency room (ER) wait times in Nova Scotia (NS) and New Brunswick (NB) are among the longest in Canada, producing delayed care, preventable deaths, and declining public trust. This report analyzes the structural causes of the crisis, including healthcare worker shortages, insufficient long-term care capacity, low physician and nurse wages, and the absence of adequate primary care access. Despite recent initiatives, such as virtual care platforms, wait time portals, and retention bonuses, systemic issues persist. Three policy options are assessed: expansion of long-term care facilities, public education on virtual care, and a transition to activity-based funding (ABF). Using the criteria of cost feasibility, effectiveness, and speed of implementation, ABF is identified as the most viable solution. While requiring a moderate implementation timeline, ABF incentivizes efficiency and has demonstrated success in reducing wait times elsewhere. The paper concludes that ABF provides the strongest pathway toward reducing ER wait times in NB and NS.

EXECUTIVE SUMMARY

This paper highlights the critical issue of excessive emergency room (ER) wait times in Nova Scotia (NS) and New Brunswick (NB), which are among the worst in Canada. Long wait times, overcrowding, and healthcare worker shortages have contributed to a worsening crisis, exacerbated by an aging population and insufficient long-term care facilities. As a result, patients experience delayed care, which is a key factor in worsened health outcomes, unnecessary deaths, and a loss of trust in the healthcare system.

Situations contributing to long ER wait times include a shortage of beds, especially for patients needing long-term care, and a shortage of family physicians, forcing many individuals to visit ERs for non-emergent issues. The low wages in NS and NB push healthcare physicians and nurses away from coming to these provinces, further contributing to this problem. Furthermore,

reduced emergency department hours, particularly in rural areas, increases the strain on nearby hospitals, worsening their wait times.

Several efforts have been made to address these challenges, including the implementation of Waiting Room Care Providers (WRCPs) in NS, virtual care platforms in both provinces, and ER wait time portals to provide transparency. Despite these initiatives, as well as the retention bonuses to alleviate staff shortages, the lack of sufficient healthcare staff remains a barrier.

The consequences of inaction require immediate attention. Prolonged wait times worsen patient conditions, cause preventable deaths, and impact public trust. Immediate intervention is necessary to reduce ER wait times and ensure timely, effective medical care for the residents of NS and NB.

The first policy option to address wait times in emergency departments is a five-year action plan for long-term care facilities. Building more long-term care facilities will reduce wait times by moving the critical and long-term care patients that take up hospital beds for extended periods to alternate care facilities, thus opening more hospital beds for incoming patients in the ER.

The second option is to expand knowledge on virtual care. This policy option includes sending physical letters to residents of NS and NB to inform the public about virtual care and its accessibility. This will give the public an alternative to turn to instead of going to the ER.

The third option is implementing a transition to activity-based funding (ABF). ABF provides increased funding to hospitals for each patient they treat. This approach encourages hospitals to hire more staff, therefore relieving some strain on the provinces' current nurses and doctors. This option will encourage a quicker flow of patients — the more efficient the patients are seen and treated within the hospital, the more funding the hospitals will receive. ABF has been proven to reduce wait times in other provinces and countries.

This problem is putting people's lives at risk, therefore efficiency and effectiveness are vital when considering the options. Upon conducting an analysis evaluating the criteria deemed most important, and the tradeoffs of the options, this paper recommends policy option three; activity-based funding. ABF is proven to be effective in reducing wait times in comparable areas, so it will likely be effective in NB and NS. Implementation can be done within a year, and as hospitals become comfortable with this transition, ER wait times will be reduced.

INTRODUCTION

Nova Scotia and New Brunswick have the worst emergency room wait times in all of Canada causing mistrust, worsened conditions, and overworked staff.¹ This problem is recognized by the provincial governments but has failed to improve despite several previous efforts. As this paper will discuss, it becomes increasingly evident how pressing a crisis this is.

In 2022, a man in a New Brunswick emergency room passed away while waiting for healthcare.² He waited a consequential seven hours before seeing a doctor, and at that point, it was too late. Unfortunately, this case is among many others across Nova Scotia and New Brunswick in which unnecessary deaths are occurring due to extended ER wait times.³ In response to the death in 2022, the New Brunswick Nurses Union stressed that staff shortages in hospitals are undoubtedly unsafe and must be addressed.⁴

New Brunswick's wait times are among the longest in Canada, nearly doubling the national average in 2023.⁵ This statistic poses a health risk concerning the right to access healthcare. Extended wait times can not only lead to worsened symptoms, permanent disability, and death, but they can deter individuals from seeking medical care altogether.⁶ Therefore, ER wait times

¹ Alex Whalen, "New Brunswick Health-Care Wait Times among Longest in Canada," *Fraser Institute*, December 16, 2020, <https://www.fraserinstitute.org/commentary/new-brunswick-health-care-wait-times-among-longest-canada>; "Emergency Department Wait Times," Nova Scotia Health, February 8, 2025, <https://www.nshealth.ca/emergency-care/emergency-department-wait-times>.

² Bobbi-Jean MacKinnon, "Family of Man Who Died Waiting for Care at Fredericton ER Sues Horizon, 2 Nurses," *CBC News*, August 23, 2024, <https://www.cbc.ca/news/canada/new-brunswick/darrell-mesheau-lawsuit-fredericton-chalmers-er-patient-died-family-horizon-nurses-1.7301283>.

³ Nicola Seguin, "'The System is Obviously Broken,' says N.S. Man Whose Wife Died in ER" *CBC News*, January 9, 2023, <https://www.cbc.ca/news/canada/nova-scotia/system-broken-woman-dies-emergency-room-1.6707596>; The Canadian Press. "N.S. Emergency Department Deaths Hit Six-Year High, Doctors Point to 'Bed-Blocking,'" *Global News*, July 10, 2024, <https://globalnews.ca/news/10614233/bed-blocking-nova-scotia-hospitals-advanced-disease/#:~:text=Nova%20Scotia's%20health%20authority%20says,with%20558%20the%20year%20before>.

⁴ "Statement: Poor Planning, Not Individual Nurses, Is Responsible for Emergency Room Death," New Brunswick Nurses Union, <https://nbnu.ca/statement-poor-planning-not-individual-nurses-is-responsible-for-emergency-room-death/>.

⁵ Alex Whalen, "Health-Care Wait Times in New Brunswick Nearly Double National Average," *Fraser Institute*, March 18, 2024, <https://www.fraserinstitute.org/commentary/health-care-wait-times-new-brunswick-nearly-double-national-average>.

⁶ "The Risks Associated with Long ER Wait Times," *Physicians Premier*, August 23, 2024, <https://mdpremier.com/the-risks-associated-with-long-er-wait-times/#:~:text=Extended%20waiting%20times%20can%20adversely,permanent%20disability%2C%20or%20even%20death>.

must be decreased to ease the strain on healthcare workers, reduce preventable health complications, and provide effective medical care to patients in a timely manner. By exploring solutions to decrease ER wait times, the quality of care in the NB and NS can improve to better meet the needs of communities across the provinces.

CONTEXT AND BACKGROUND

Emergency room wait times across NS and NB are rising with growing constraints on already stretched medical resources.⁷ Since the COVID-19 pandemic, ER wait times have increased, and healthcare practitioners (HCPs) have been presented with new factors, such as utilizing personal time that was not used during the pandemic and recovering from burnout.⁸

There are various adverse effects of long ER wait times, including loss of confidence in the healthcare system, morbidity and even death.⁹ Many factors contribute to longer ER wait times, including short staffing, overcrowding, and lack of medical resources.¹⁰ No particular population is more susceptible to shorter wait times; the factors with the most significant influence on wait times are the time of presentation and triage priority.¹¹ It should also be noted that prolonged ER wait times significantly impact healthcare professionals, causing burnout, high workforce turnover, low retention, and lack of recruitment in the medical profession, which further extends ER wait times.¹² An environment where patients are waiting hours for care and healthcare workers are working overtime does not foster an atmosphere with high-quality care.

⁷ Frances Willick, "N.S. Emergency Departments 'Pushed to the Limit,' New Report Shows," *CBC News*, December 21, 2022, <https://www.cbc.ca/news/canada/nova-scotia/emergency-department-accountability-report-1.6693696>.

⁸ Vernon Ramesar, "Nova Scotia Health Warns of Longer Emergency Room Wait Times This Summer," *CBC News*, July 16, 2021, <https://www.cbc.ca/news/canada/nova-scotia/emergency-room-wait-times-nova-scotia-delays-summer-patient-volume-1.6106265>; Whalen, "New Brunswick Wait Times."

⁹ Jenipher Kayuni et al., "Exploring Delay Points at the Emergency Department," *Canadian Journal of Emergency Nursing* 47, no. 1 (2024), <https://doi.org/10.29173/cjen158>.

¹⁰ New Brunswick Healthcare Professionals, "The 2024 Pre-Budget Health Stakeholder Forum Report," March 12, 2024, <https://www.nbms.nb.ca/wp-content/uploads/2024/03/Health-Stakeholder-Forum-Report-Final.pdf>, 6.

¹¹ Goodacre and Webster, "Who Waits Longest in the Emergency Department and Who Leaves Without Being Seen?" *Emergency Medicine Journal* 22, no. 2 (2005), <https://doi.org/10.1136/emj.2003.007690>.

¹² "Insight: Why are Patients Spending 22 Hours in the Emergency Room Waiting for a Hospital Bed?" *Canadian Medical Association*, January 19, 2024, <https://www.cma.ca/latest-stories/insight-why-are-patients-spending-22-hours-emergency-room-waiting-hospital-bed>.

The lack of beds and physicians in hospitals significantly impacts ER wait times.¹³ There is an overflow of seniors taking up long-term care (LTC) beds in hospitals, which is a necessary space that drastically slows the inflow of patients.¹⁴ Many of these seniors are eligible to be placed in long-term care facilities but are on waitlists or cannot afford to get in.¹⁵ Infrastructure has not kept up with the rising elderly population, contributing drastically to the surplus of patients in long-term care facilities which overflow and start relying on LTC beds in hospitals.¹⁶ Not only is the elderly population occupying a large portion of hospitals, but currently, 35 percent of beds in Horizon Health hospitals are taken up by alternate levels of care patients (ALC).¹⁷ Even more concerning, in November of 2024, there were 931 people in NB waiting for a bed in a nursing home—436 of whom waited in the hospital.¹⁸ The backlog at long-term care facilities is a root cause of overcrowding in the NB and NS ERs. Additionally, NS has seen a 35 percent drop in the number of emergency department hours.¹⁹ This percentage is mainly from rural areas of the province. These closures and reduced hours are due to staffing shortages and the inability to meet the required number of clinicians to ensure safe operations. In the span of one year from April 1, 2023, to the end of March 2024, a hospital in Shelburne was closed for 4,832 hours, which is the equivalent of 201 days.²⁰ Similar statistics were found in a hospital in Digby. Not only is this dangerous for residents of these areas, but it also causes the hospitals nearby to see higher volumes of patients, causing those ERs to face more severe wait times.

¹³ CMA, “Insight.”

¹⁴ Ro-Ting Lin et al., “Long Working Hours and Burnout in Health Care Workers: Non-Linear Dose-Response Relationship and the Effect Mediated by Sleeping Hours—a Cross-Sectional Study,” *Journal of Occupational Health* 63, no. 1 (2021), <https://doi.org/10.1002/1348-9585.12228>.

¹⁵ “Seniors’ Advocate Calls for Urgent Action in Long-Term Care Report,” Government of New Brunswick, March 13, 2024, https://www2.gnb.ca/content/gnb/en/news/news_release.2024.03.0116.html.

¹⁶ “A Portrait of Canada’s Growing Population Aged 85 and Older from the 2021 Census,” Statistics Canada, 2022. www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021004/98-200-x2021004-eng.cfm.

¹⁷ “Horizon Says Hospital Beds Occupied by ALC Patients Up Almost 10%,” New Brunswick Health Council, January 8, 2024, <https://nbhc.ca/health-in-the-news/horizon-says-hospital-beds-occupied-alc-patients-almost-10>; ALC refers to patients in hospital beds who are waiting to receive proper care because their current care needs does not match their needs.

¹⁸ “Horizon Says Hospital Beds Occupied by ALC Patients Up Almost 10%.”

¹⁹ Lyndsay Armstrong, “Nova Scotia Sees 35 Percent Drop in ER Closures, But Some Rural Hospitals Struggle,” *Global News*, January 8, 2025, <https://globalnews.ca/news/10948801/ns-report-drop-er-closures/>.

²⁰ Armstrong, “Nova Scotia Sees 35 Percent Drop in ER Closures.”

New Brunswick and Nova Scotia have the lowest wages for nurses and doctors in the country.²¹ This influences new nursing and medical school graduates to be more inclined to practice in Central or Western Canada than in Eastern Canada.²² This discrepancy overworks the healthcare professionals who remain in NB and NS. Hospital staff in NB and NS work millions of overtime

Long ER wait times are not just an annoying part of free healthcare; they increase suffering and decrease quality of life.

hours yearly, causing them to be persistently burnt out and tired.²³

Long ER wait times are not just an annoying part of free healthcare; they increase suffering and decrease quality of life. In several instances, this gap between healthcare and

patients has led to death.²⁴ The NB and NS healthcare crisis requires a multi-level governance approach. These provinces need coordination and collaboration from the national, regional, and local levels. This approach must drive an allocation of resources towards building a stronger healthcare system that provides every citizen with the resources they need.

An additional problem that disproportionately affects NB and NS is the extremely low number of family physicians.²⁵ Statistically, 1.19 per 10,000 physicians left their practices in NB and NS, compared to 0.17 per 10,000 in the rest of the country.²⁶ When people do not have a family doctor to visit for minor problems, they tend to go to the emergency room for simple concerns

²¹ "Registered Nurse Jobs (with Salaries) in Canada - 2025 Look," Employee Benefits Source, January 7, 2025, <https://ebsource.ca/registered-nurse-jobs-in-canada/>.

²² Employee Benefits Source, "Registered Nurse Jobs (with Salaries) in Canada - 2025 Look"; Willick, "N.S. Emergency Departments 'Pushed to the Limit,' New Report Shows."

²³ Benjamin Shingler and Graeme Bruce, "These Charts Show Nurses Are Doing More OT than Ever. They Say It's Driving Many from the Profession," *CBC News*, August 10, 2022, <https://www.cbc.ca/news/canada/nurses-canada-overtime-pandemic-burnout-1.6545963>.

²⁴ KarlaRenic, "'Shock, Sadness, Anger': Another N.S. Woman Dies after 7-Hour ER Wait, Family Says," *Global News*, January 12, 2023, <https://globalnews.ca/news/9405547/shock-sadness-anger-another-n-s-woman-dies-after-7-hour-er-wait-family-says/>.

²⁵ "Balancing the Needs of Canadians and Our Health Workforce," Canadian Institute for Health Information, October 24, 2024, <https://www.cihi.ca/en/taking-the-pulse-measuring-shared-priorities-for-canadian-health-care-2024/health-workforce-and-surgeries/balancing-the-needs-of-canadians-and-our-health>.

²⁶ Canadian Institute for Health Information, "Balancing the Needs of Canadians and Our Health Workforce."

such as common bacterial and viral infections, sports injuries, and stomach pain.²⁷ These types of hospital visits are one of several driving factors of the healthcare crisis.

SIGNIFICANCE OF THE PROBLEM

Various policies have been employed in the past to address long ER wait times. Some have targeted waiting rooms directly, such as implementing waiting room care providers (WRCP), reducing barriers to primary healthcare providers, and remuneration incentives for nurses. In contrast, others have focused on improving information transparency with the public, as seen through the enactment of estimated ER wait times portals. Many policies aiming to decrease patient volume in ERs have highlighted the lack of available hospital beds as a key cause of overcrowding.²⁸

1) Waiting Room Care Providers

The implementation of waiting room care providers is an initiative originating in Nova Scotia. It is designed to alleviate stress on ER personnel, complete necessary tests more efficiently, and improve patient sentiment during extended waiting periods. Waiting room care providers are experienced nurses who take vitals, initiate tests, and monitor patients in the ER before a physician sees them.²⁹ WRCPs are separate from triage nurses and act as liaisons between patients and physicians in the ER itself. WRCPs are present in all NS regional emergency departments. According to NS healthcare professionals, this initiative has reduced ER wait times since its enactment.³⁰ While not referred to explicitly as WRCPs, NB hospitals provide an identical

²⁷ "Primary and Virtual Care Access: Emergency Department Visits for Primary Care Conditions," Canadian Institute for Health Information, December 5, 2024, <https://www.cihi.ca/en/primary-and-virtual-care-access-emergency-department-visits-for-primary-care-conditions>.

²⁸ "Overcrowding and Site Overcapacity," Nova Scotia Health, November 30, 2023, https://policy.nshealth.ca/Site_Published/nsha/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=106269.

²⁹ "Overcrowding and Site Overcapacity."

³⁰ "Waiting Room Care Providers Enhancing Patient Experience and Reducing Wait Times in Emergency Departments," Nova Scotia Health, August 23, 2024, <https://www.nshealth.ca/news-and-notice/waiting-room-care-providers-enhancing-patient-experience-and-reducing-wait-times>.

service, adding staff to ERs to ensure quality of care.³¹ These dedicated waiting room staff have been implemented in hospitals in Fredericton, Miramichi, Moncton, Saint John and Waterville.³²

2) Virtual Care Platforms

Nova Scotia and New Brunswick have developed plans to reduce stress on ERs, reduce barriers to primary care clinics, and alleviate the need for specific individuals to seek care in ERs. NS has developed an emergency care improvement plan that employs multiple new methods of accessing primary care. These methods include virtual urgent care, mobile primary care, pharmacy and walk-in clinics, and the YourHealthNS app.³³ Similarly, NB has developed strategies to improve access to primary care options under the Stabilizing Health Care: An Urgent Call to Action plan.³⁴ These strategies are outlined under the NB Primary Care Networks model, which includes virtual, telephone, and in-person access to primary health care providers. Patients seeking care can access the platform's virtual option, allowing them to receive treatment without leaving their homes. This convenience reduces congestion and improves timely care for patients.

3) ER Wait Time Portals

Wait time portals were developed to identify ER wait time lengths in each Maritime province. These portals have been implemented to help patients determine which ER best suits their needs and is most appropriate for them. Wait time calculations are made using past data, including the number of arrivals, the average severity of patients, and the number of physicians.³⁵ Since their implementation, these portals have remained active in NS and NB.³⁶ Wait time portals can be especially helpful if patients have non-urgent needs and are situated relatively equidistant between two hospitals.

³¹ "Pilot Adds Staff Members to N.B. Ed Waiting Rooms to Ensure Safety, Quality of Care," New Brunswick Health Council, August 2, 2022, <https://nbhc.ca/health-in-the-news/pilot-adds-staff-members-nb-ed-waiting-rooms-ensure-safety-quality-care>.

³² "New Program – Extra Helping Hands Help Keep Everyone Safe in Our Emergency Departments," Horizon Health Network, July 29, 2022, <https://horizonnb.ca/horizon-stories/new-program-extra-helping-hands-help-keep-everyone-safe-in-our-emergency-departments/>.

³³ "Emergency Care Plan," Action for Health, <https://actionforhealth.novascotia.ca/emergency-care-plan>.

³⁴ "Stabilizing health care: An urgent call to action," Government of New Brunswick, 2022, <https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/Stabilizing-health-care.pdf>, 7.

³⁵ Nova Scotia Health, "Emergency Department Wait Times."

³⁶ Nova Scotia Health, "Emergency Department Wait Times"; "Estimated Emergency Department Wait Times," Horizon Health Network, September 25, 2024, <https://horizonnb.ca/services/emergency-department/estimated-emergency-department-wait-times/>.

4) Efforts to Address HPC Short Staffing

In recognition of the shortage of nurses in NB, the provincial government issued \$10,000 retention bonuses for all nurses in NB, including registered nurses, licensed practical nurses, and managers and supervisors working with NB regional health authorities.³⁷ These payments were issued in December 2023 and totalled an investment of \$83 million.³⁸ Similarly, an identical, one-time retention payment of \$10,000 was made by the NS government to qualifying nurses in March 2024.³⁹ This payment was offered with an additional remuneration of \$10,000 if qualifying nurses sign commitment contracts for an additional two-year period.⁴⁰ These payments were made to acknowledge the strain current HCPs undergo due to short staffing and to ensure that the nursing workforce shortage does not accelerate. According to NS Health in 2023, they were focused on collaboration between all levels of care, encouraging a “Health Home” model, which can have positive impacts, however it is not enough, and it has not been effectively implemented yet.⁴¹

Emergency room wait times are not an isolated problem; it has been an issue for decades but has seen a concerning rise since the COVID-19 pandemic in 2019.⁴² The issue has been growing at extreme rates ever since, and it does not seem to be slowing down. From 2020 until 2024, hospital beds occupied by ALC patients have increased by nearly 10 percent.⁴³

Despite several efforts from the government — such as making virtual care accessible — there has been little effective progress in decreasing wait times.⁴⁴ Healthcare has been a priority for the provincial government’s for the past couple of years, with the premier's office in Nova Scotia in 2022 stating that “[their] number one priority is healthcare.”⁴⁵

³⁷ “Nurse Retention Payments to be Delivered in the Coming Weeks,” Government of New Brunswick, December 3, 2023,

https://www2.gnb.ca/content/gnb/en/departments/health/news/news_release.2024.12.0485.html#:~:text=The%20government%20committed%20to%20delivering,%2C%E2%80%9D%20said%20Premier%20Susan%20Holt.

³⁸ Government of New Brunswick, “Nurse Retention Payments to be Delivered in the Coming Weeks.”

³⁹ “Retention Bonuses, Incentives for Nurses, Healthcare Workers,” Government of Nova Scotia, March 20, 2023, <https://news.novascotia.ca/en/2023/03/20/retention-bonuses-incentives-nurses-healthcare-workers>.

⁴⁰ “Retention Bonuses, Incentives for Nurses, Healthcare Workers.”

⁴¹ Nova Scotia Health, “Strengthening the Primary Health Care System in Nova Scotia,” April 2017, <https://www.nshealth.ca/sites/default/files/documents/Strengthening%20Primary%20Healthcare.pdf>

⁴² Ramesar, “Nova Scotia Health Warns of Longer Emergency Room Wait Times This Summer.”

⁴³ “Horizon says Hospital Beds Occupied by ALC Patients up almost 10%.”

⁴⁴ “VirtualCareNS,” Nova Scotia Health, <https://www.nshealth.ca/clinics-programs-and-services/virtualcarens>.

⁴⁵ Government of Nova Scotia, “Statement on First Year in Government,” August 17, 2022,

1) Assessment of WRCP

Waiting room care providers, for instance, have been shown to reduce wait times. Dr. Valerie Ross explains the impact of the care providers: “it allows the triage nurses to work more effectively because once patients are triaged, there's another provider who can look after them while they're waiting to be seen.”⁴⁶ The issue with this policy is that given the already low number of nurses, waiting room care providers are simply not feasible due to the lack of staff. For care providers to be more effective, improvements have to be made to staffing efforts.

2) Assessment of Virtual Care Platforms

Virtual healthcare platforms allow the general public to access quality healthcare from the comfort of their homes, thereby alleviating stress on ERs and decreasing wait times. These virtual platforms have had a noticeable effect on ER congestion since their implementation. Dr. Serge Mellanson, Horizon NB’s Director of Emergency Management, has insisted that implementing virtual care as an option has reduced ER doctor workload by 20 percent.⁴⁷ There have been drawbacks to this care plan, however, critics of the platform have noted that the technologies do not offer the same quality of care and threaten the integrity of the healthcare system.⁴⁸ In NS, virtual care platforms have successfully reduced congestion in ERs. Specifically, Virtual Urgent Care NS has assisted 55 percent of individuals who would have otherwise gone to the ER for urgent care.⁴⁹ As for primary care, Virtual Primary Care NS has assisted 60 percent of individuals who would have pursued care at an ER.⁵⁰ Finally, the YourHealthNS app has been effective for citizens seeking access to health records and lab results. The app has redirected 15 percent of people who would have otherwise sought care at an ER.⁵¹

<https://news.novascotia.ca/en/2022/08/17/statement-first-year-government>.

⁴⁶ Nova Scotia Health, “Waiting Room Care Providers Enhancing Patient Experience and Reducing Wait Times in Emergency Departments.”

⁴⁷ Bobbi-Jean Mackinnon, “N.B. Medical Society Calls for End of Virtual ER Pilot at 2 Hospitals, Warns of Closures,” *CBC News*, February 11, 2025, <https://www.cbc.ca/news/canada/new-brunswick/virtual-er-sussex-charlotte-county-teladoc-new-brunswick-medical-society-horizon-1.7451498#:~:text=Last%20week%2C%20Dr.%20Serge%20Melanson,doctors%20by%20%20per%20cent>.

⁴⁸ “N.B. Medical Society Calls for End of Virtual ER Pilot at 2 Hospitals, Warns of Closures”

⁴⁹ Action for Health, “Emergency Care Plan.”

⁵⁰ Action for Health, “Emergency Care Plan.”

⁵¹ Action for Health, “Emergency Care Plan.”

3) Assessment of ER Wait Time Portals

ER wait time portals are an effective resource as they consistently post accurate wait times that are easily accessible to the public. This tool provides access to information which allows individuals with non-life-threatening emergencies to make informed decisions on which care facility best suits their needs.⁵² Importantly, data has shown that 70 percent of the people waiting in ER rooms receive their health care in the estimated time given by this digital tool.⁵³ This statistic suggests that the majority of people interacting with the portals can rely on this resource for an accurate wait estimate.

The issue with wait time portals is that many people in NB and NS will not have the accessibility or ease to pick between going to two different hospitals. Given the limited number of hospitals in NB and NS, especially in rural areas, many people do not have the option to choose between hospitals.⁵⁴ Many people are stuck with the hospital closest to them. Portals allow people to have an idea about the time they will spend waiting but it does not increase care options of everyone.

4) Assessment of Addressing HPC Short Staffing

The Government of New Brunswick issued over 9,950 retention bonuses to nurses in December 2024.⁵⁵ Although the New Brunswick Nurses Union signed this agreement, the Canadian Union of Public Employees did not.⁵⁶ Furthermore, many rural nurses are deemed ineligible for these incentives.⁵⁷ Over 1200 nurses in New Brunswick were denied the \$10,000 bonus, which undermines their value.⁵⁸ Thus, only the nurses represented by the New Brunswick Nurses Union received this bonus. Due to its recent implementation, accurately assessing its effectiveness is not possible. However, since not all nurses were eligible for this bonus, it is clear that it could be improved to better address the issue of short staffing.

⁵² Nova Scotia Health, "Emergency Department Wait Times."

⁵³ Nova Scotia Health, "Emergency Department Wait Times."

⁵⁴ "Number of Hospitals in Canada by Province," Statista, <https://www.statista.com/statistics/440923/total-number-of-hospital-establishments-in-canada-by-province/>.

⁵⁵ Government of New Brunswick, "Nurse Retention Payments to be Delivered in the Coming Weeks."

⁵⁶ Government of New Brunswick, "Nurse retention payments to be delivered in the coming Weeks."

⁵⁷ Legislative Assembly of New Brunswick, "Oral Questions," December 10, 2024, https://www.legnb.ca/content/house_business/61/1/qp_transcripts/2024-12-10%20EN.pdf.

⁵⁸ Legislative Assembly of New Brunswick, "Oral Questions."

The Government of Nova Scotia has similarly implemented a \$10,000 bonus to full-time registered nurses across the province.⁵⁹ This incentive would extend to nurses who left NS and returned to work for a minimum of two years.⁶⁰ Because this new incentive has only recently been put into place, its impacts on short staffing remain to be investigated further.

As the issue of emergency room wait times remains, increasingly alarming consequences for hospital staff and patients persist. Lengthy emergency wait times have been shown to lead patients to leave before receiving the health care that they sought out in the first place.⁶¹ Leaving the ER prior to seeing a doctor can lead to worsening symptoms or death, and in most cases, these patients are forced to return to the ER.⁶² It should be noted that a study in Alberta revealed that Indigenous populations within Canada are more likely to leave the ER without seen by a provider.⁶³ As the population in NS and NB continue to age, and as the population increases, ER wait times will progressively worsen.⁶⁴ Additionally, NS's increasingly high rates of cancer and diabetes are worsening the issue due to their elevated need for care in hospitals.⁶⁵

Along with people leaving the ER without being seen, wait times in general cause worsening conditions and declining health due to ineffective triage.⁶⁶ Worsening conditions for patients are leading to unnecessary deaths that could have been dealt with and potentially avoided if they were assessed efficiently.⁶⁷

⁵⁹ Government of Nova Scotia, "Retention Bonuses, Incentives for Nurses, Healthcare Workers."

⁶⁰ Government of Nova Scotia, "Retention Bonuses, Incentives for Nurses, Healthcare Workers."

⁶¹ Gregor Lindner and Bertram K. Woitok, "Emergency Department Overcrowding," *Wiener klinische Wochenschrift* 133, (2020), <https://doi.org/10.1007/s00508-019-01596-7>.

⁶² Lindner and Woitok, "Emergency Department Overcrowding," 231.

⁶³ Patrick McLane et al., "Leaving Emergency Departments Without Completing Treatment among First Nations and Non-First Nations Patients in Alberta: A Mixed-Methods Study," *Canadian Medical Association Journal* 196, no. 15 (2024), <https://doi.org/10.1503/cmaj.231019>.

⁶⁴ G. George et al., "Effect of Population Ageing on Emergency Department Speed and Efficiency: A Historical Perspective From a District General Hospital in the UK," *Emergency Medicine Journal* 23, no. 5 (2006):379-383, <https://doi.org/10.1136/emj.2005.029793>; Public Health Agency of Canada, "Aging and Chronic Diseases: A Profile of Canadian Seniors," *Government of Canada*, July 14, 2022, <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/aging-chronic-diseases-profile-canadian-seniors-report.html#>.

⁶⁵ "Why There Are Wait Times," Government of Nova Scotia, <https://waittimes.novascotia.ca/why-there-are-wait-times>.

⁶⁶ Yuzeng Shen and Lin Hui Lee, "Improving the Wait Time to Consultation at the Emergency Department," *BMJ Open Quality* 7 (2018), <https://doi.org/10.1136/bmjopen-2017-000131>.

⁶⁷ MacKinnon, "Family of Man Who Died Waiting for Care at Fredericton ER Sues Horizon, 2 Nurses."

Long ER wait times can worsen experiences with healthcare. Extended ER wait times may lead people to believe that their personal health issues are not essential and not a priority, thus creating a distrust of the healthcare system. Scholars Shen and Hui Lee state that “explanatory information of waiting time duration and the caring attitude of the staff is important for patient satisfaction,” pointing to how it is essential for trust to be a part of health care.⁶⁸ Many scenarios can cause distrust within the ER waiting rooms, but they all often result in individuals avoiding healthcare and postponing care they need. There are many consequences of distrust, but understanding that people must trust the healthcare system is vital as it allows staff to do their jobs to their fullest capacity.⁶⁹

Long wait times can also impact patient outcomes by disincentivizing patients to seek care they need in the first place. Hundreds of residents of New Brunswick claim to not go to the hospital even when they think it necessary because they do not want to wait in an emergency room for hours on end.⁷⁰ It is quite impossible to determine precisely how many people have died due to the extended wait times in NB and NS because, according to Harrison Flemming, about 50 percent of Canadians avoid venturing to the hospital under the assumption that they will not receive timely treatment.⁷¹ Regardless of a precise estimate of the number of deaths the healthcare crisis has led to, it has unarguably caused preventable worsened conditions for a large percentage of patients. The public is concerned for their safety and the consequences that come from this crisis.⁷² People are their own assessors for how extreme a problem is, and to have nowhere to go for immediate help is a huge concern for cases like these.⁷³

Healthcare policy issues have persisted in NB and NS for years. As discussed, the current extended wait times in the NB and NS healthcare systems pose health risks by postponing healthcare, thus

⁶⁸ Yuzeng Shen and Lin Hui Lee, “Improving the Wait Time to Consultation at the Emergency Department”

⁶⁹ Derek Griffith et al., “Using Mistrust, Distrust, and Low Trust Precisely in Medical Care and Medical Research Advances Health Equity,” *American Journal of Preventive Medicine* 60, no. 3 (2021):442-445, <https://doi.org/10.1016/j.amepre.2020.08.019>.

⁷⁰ Dom Lucyk, “Incomplete Data Shows Patients Continue to Die on Waitlists in New Brunswick,” *SecondStreet.Org*, November 26, 2024, <https://secondstreet.org/2024/11/26/incomplete-data-shows-patients-continue-to-die-on-waitlists-in-new-brunswick/>.

⁷¹ Harrison Fleming, “Another Poll Shows Canadians Want Health Care Reform,” *SecondStreet.Org*, 2024, <https://secondstreet.org/wp-content/uploads/2024/11/Policy-Brief-Another-Poll-Shows-Canadians-Want-Health-Reform-final.pdf>, 1.

⁷² Mitchell Bailey and Nathalie Sturgeon, “Growing Concerns over ER Capacity in N.B. and How It’s ‘Busting at the Seams,’” *Global News*, January 3, 2024, <https://globalnews.ca/news/10201642/emergency-departments-in-new-brunswick-growing-concerns/>.

⁷³ Bailey and Sturgeon, “Growing Concerns over ER Capacity in N.B. and How It’s ‘Busting at the Seams.’”

increasing the severity of symptoms and risk of death.⁷⁴ The lack of staff has caused nurses and physicians to be overworked. Notwithstanding these statistics, over the past ten years, little has been done to effectively address the understaffing issues.⁷⁵ As a result, wait times continue to prevail, and the quality of care remains poor. The disconnect between administrators and policymakers fuels continued backups throughout the healthcare system in long-term care

Considering the consequences of inaction, the strain on healthcare workers, and the precarity of worsening symptoms, it is imperative that measures are taken to reduce ER

facilities, hospital beds, and ER rooms. Understanding the scope of the issue allows the root causes of extended wait times to be addressed directly. Considering the consequences of inaction, the strain on healthcare workers, and the precarity of worsening symptoms, it is imperative that measures are taken to reduce ER wait times.

Nova Scotia has several healthcare gaps for policies that are already in place. Family practices and physicians continue to grow, but the population is growing much faster, and the percentage of people looking for a doctor has increased.⁷⁶ The policies that are in place aim to bridge these gaps, but they have not been successful yet.

PROBLEM STATEMENT

Intervention is necessary and will require new budgets and approaches. Departmental silos and barriers within the system are evidently faulty and insufficient.⁷⁷ Canada has a considerable budget for healthcare and therefore, healthcare optimization is necessary.

Wait times in emergency rooms have been an ongoing issue for quite some time, reaching a peak during COVID-19.⁷⁸ Despite Canada's healthcare budget, there are severe shortages within the system, which has led to avoidable deaths, resulting in mistrust from the public. The wait times

⁷⁴ Physicians Premier, "The Risks Associated with Long ER Wait Times."

⁷⁵ "Supply and Distribution," Canadian Institute for Health Information, February 29, 2024, <https://www.cihi.ca/en/the-state-of-the-health-workforce-in-canada-2022/supply-and-distribution>.

⁷⁶ "Current State Assessment of the Primary Health Care System in Nova Scotia," Nova Scotia Health, June 2022, <https://www.nshealth.ca/sites/default/files/documents/Current%20State%20Assessment%20of%20the%20Primary%20Health%20Care%20System%20in%20Nova%20Scotia%202020-2021.pdf>.

⁷⁷ "The 2024 Pre-Budget Health Stakeholder Forum Report," New Brunswick Healthcare Professionals.

⁷⁸ Ramesar, "Nova Scotia Health Warns of Longer Emergency Room Wait Times This Summer"; Whalen, "New Brunswick Health-Care Wait Times Among Longest in Canada."

continue to increase despite mitigation efforts from the government. This problem warrants government attention. This crisis puts residents in NS and NB at a disadvantage and risk. The provincial governments must act immediately to reduce the wait times and manage emergency departments more efficiently. Therefore, how can the provincial health authorities of NS and NB address deficiencies in healthcare institutions to immediately reduce the average wait times in emergency rooms?

POLICY OPTIONS

Option 1: Five-Year Action Plan for Long Term Care Facilities

This policy focuses on taking a long-term approach over the span of five years focusing on the strain long-term-care patients place on the ER. This five-year action plan has the goal of building two long-term care facilities per year over the span of five years resulting in 10 new long-term care facilities. This would mean that both Nova Scotia and New Brunswick would have five new long-term care facilities after the five years.

This policy aims to tackle the issue of long ER wait times as many people who are going to the ER for medical help are people who are in need of long-term care. Through focusing on long-term care facilities, this will make the ER less busy as people who really need timely medical assistance will be a priority. This policy assesses a core issue that is leading to long ER wait times by addressing the issue of limited long-term care facilities.

Option 2: Expanding Education for Virtual Care

Virtual care has been on the rise in popularity in both the provinces of NS and NB as people without family doctors are able to access health care without having to go to the ER to do so, freeing up wait times. Many people are unaware of the use of virtual care, presenting a policy gap. This option looks at educating the public on virtual care and its uses. In NS, residents with primary care providers can have two free virtual care visits per year.⁷⁹ New Brunswick has eVisitNB which allows those with a New Brunswick Medicare card free online visits.⁸⁰ The issue

⁷⁹ "Accessing Virtual Care for Attached Patients," Nova Scotia Health, <https://www.nshealth.ca/accessing-virtual-care-attached-patients#:~:text=Nova%20Scotians%20who%20have%20a,the%20Province%20of%20Nova%20Scotia>.

⁸⁰ "Frequently Asked Questions," eVisitNB, <https://www.evisitnb.ca/faqs#:~:text=Do%20I%20have%20to%20pay,a%20New%20Brunswick%20Medicare%20card>.

with virtual care is that many people are unaware that this is an option for health care.⁸¹ Educating the public about the available programs and how to access virtual care is a policy option that will reduce ER visits for minor health issues able to be addressed virtually, hence tackling the issue of long ER wait times.

Education about virtual care will be conducted through an open letter sent by email and physical letters sent by traditional mail and will include information about how to access and use virtual care. Informing the public about free, virtual care will motivate people to utilize this service more. This would aid them in understanding that they do not need to go to the ER to receive medical attention for certain health concerns. In New Brunswick, the Patient Voices Network revealed that most participants found virtual care effective and useful; “for many individuals, not having to wait in an emergency room makes primary care more accessible. Consequently, virtual care is sometimes the most appropriate option, particularly when it comes to reasonable wait times.”⁸²

Option 3: Transition to Activity-Based Funding

Activity-based funding has been utilized in the province of Québec and in the country of Australia. Through ABF, hospitals obtain more funding based on the number of patients they receive and treat.⁸³ This policy incentivizes hospitals to treat patients more efficiently in order to receive more funding. ABF can also encourage hospitals to hire more staff to work on treating a higher volume of patients more efficiently.⁸⁴ This policy option has been effective as the UBC Center for Health Services and Policy Research states that research has shown that ER wait times have been reduced due to AFB.⁸⁵

⁸¹ “Citizen Brief - Virtual Access to Primary Care,” Patient Voices Network, <https://nbhc.ca/sites/default/files/publications-attachments/NBHC-Citizen%20Brief%20on%20virtual%20access%20to%20primary%20care.pdf>, 16.

⁸² “Citizen Brief - Virtual Access to Primary Care,” Patient Voices Network, 15.

⁸³ “Activity Based Funding,” Independent Health and Aged Care Pricing Authority, March 21, 2024, <https://www.ihacpa.gov.au/health-care/pricing/national-efficient-price-determination/activity-based-funding>.

⁸⁴ “The Why, the What and the How of Activity-Based Funding in Canada: A Resource for Health System Funders and Hospital Managers,” Canadian Institute for Health Information, <https://www.cihi.ca/en/activity-based-funding>.

⁸⁵ J. Sutherland and N. Repin, “Activity-Based Funding (ABF); Hospital Funding Models for Canadian Provinces,” *UBC Center for Health Services and Policy Research*, March 2014, <https://healthcarefunding2.sites.olt.ubc.ca/files/2014/03/White-Paper-ABF.pdf>, 2.

ANALYSIS FRAMEWORK

To effectively recommend the best course of action for the Provinces of Nova Scotia and New Brunswick, it is necessary to develop criteria for evaluation. *Figure 1.1* describes the three criteria that each policy option is assessed on. Each criterion is measured on a three-point scale of *Low, Medium or High* (as described in Figure 1.1)

Figure 1.1: Establishing Policy Criteria				
Criterion	Measure	Low	Medium	High
Cost Feasibility: Minimizing costs for the provincial governments of NS and NB.	Costs to administer policy option compared to projected yearly healthcare budget in NS and NB.	Costs to administer policy option are significantly higher than projected healthcare spending.	Costs to administer policy option are considerably higher than projected healthcare spending.	Costs to administer policy option are the same or lower than projected healthcare spending.
Effectiveness: Providing NS and NB residents with reasonable ER wait times.	Decrease in average ER wait times in hospitals across NB and NS.	Average ER wait times are slightly reduced on average (by 0-45 minutes).	Average ER wait times are moderately reduced on average (by 46-90 minutes).	Average ER wait times are reduced significantly on average (91+ minutes).
Speed of Implementation: Effectuating a decrease in ER wait times in NB and NS in a reasonably quick time frame.	Timeliness of full implementation of option.	Policy option can be fully implemented in 4+ years.	Policy option can be fully implemented within two to three years.	Policy option can be easily implemented within a year.

These criteria (cost feasibility, effectiveness, and speed of implementation) were chosen to evaluate the alternatives because they provide an important foresight analysis of each options' potential strengths and weaknesses.

The first criterion, cost feasibility, is vital in the consideration of ER wait times in NS and NB. The current 2025–2026 projected fiscal deficit in New Brunswick is \$549 million, and it is \$897.5 million in Nova Scotia.⁸⁶ Although NB highlights a need for investment in healthcare, it is necessary to carefully evaluate cost feasibility to ensure the implementation of a strong option that effectively addresses the issue of ER wait times.⁸⁷ Considering the current state of the

⁸⁶ Government of New Brunswick, "2025-2026 Budget Highlights," December 10, 2024, [https://www.gnb.ca/en/gov/budget.html#:~:text=Economic%20and%20fiscal%20conditions,2025%2D26%20is%20\\$549%20million](https://www.gnb.ca/en/gov/budget.html#:~:text=Economic%20and%20fiscal%20conditions,2025%2D26%20is%20$549%20million); Government of Nova Scotia, "Nova Scotia Budget 2025-2026," February 18, 2025, <https://www.novascotia.ca/finance/statistics/news.asp?id=20741#:~:text=The%20Province%20of%20Nova%20Scotia,contingency%20allowance%20for%20economic%20uncertainty>.

⁸⁷ Government of New Brunswick, "2025-2026 Budget Highlights."

governments' budgets, costliness of a policy option should weigh heavily on its overall favourability.

Secondly, the effectiveness criterion is unquestionably needed in this analysis. Long ER wait times in NB and NS is a significant issue that affects all persons in these areas.⁸⁸ Ensuring that the policy option will be effective is, in essence, the main objective of any policy. Therefore, it is logical to establish effectiveness as the overarching criterion for this paper's policy options.

Finally, the criterion speed of implementation is undoubtedly a priority. As expressed before, this issue is growing and becoming increasingly dangerous for all actors involved.⁸⁹ Attacking this problem with speed is not only a priority, but it is necessary for the health and safety of all persons living in NB and NS.

ANALYSIS OF OPTIONS

The following section will assess the three policy options proposed in this paper using the criteria previously outlined (Figure 1.1). See Figure 1.2 to discern the findings of this paper.

Figure 1.2: Analytical Matrix

Criteria	Cost Feasibility	Effectiveness	Speed of Implementation
Scoring Definitions	Low: Costs to administer policy options are significantly higher than projected budget. Medium: Costs to administer policy option are considerably higher than projected budget. High: Costs to administer policy option are the same or lower than projected budget.	Low: Average ER wait times are slightly reduced (by 0-45 minutes). Medium: Average ER wait times are moderately reduced (by 46-90 minutes). High: Average ER wait times are reduced significantly (by 91+ minutes).	Low: Policy option can be fully implemented in 4+ years. Medium: Policy option can be fully implemented within two to three years. High: Policy option can be easily implemented within a year.
Policy 1 <i>Five-year LTC expansion plan</i>	Low: Exceptionally costly option, although costs may be slightly offset in the long-term. ⁹⁰	Medium: Would relieve pressure in ERs by removing long-term patients from hospital beds, but the demand for LTC facilities will continue to grow with the population. Increasing beds may only maintain wait times rather than significantly decrease them.	Low: 5 years. The scaled approach limits how quickly the project can be completed.

⁸⁸ "Horizon Says Hospital Beds Occupied By ALC Patients Up Almost 10%"; Willick, "N.S. Emergency Departments 'Pushed to the Limit,' New Report Shows."

⁸⁹ Ro-Ting Lin et al., "Long Working Hours."

⁹⁰ Robyn Gibbard, "Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada," *The Conference Board of Canada*, November 2017, [https://www.cma.ca/sites/default/files/2018-11/9228_Meeting the Demand for Long-Term Care Beds_RPT.pdf](https://www.cma.ca/sites/default/files/2018-11/9228_Meeting%20the%20Demand%20for%20Long-Term%20Care%20Beds_RPT.pdf), 6.

Policy 2 <i>Virtual primary care education</i>	Medium-High: Estimated \$834,564.06 to send a letter to each household in NS and NB. ⁹¹	Low: Has potential to decrease inflow of patients to ERs, but would require individuals to read, understand, and take action from the information. Effectiveness to be seen in the long term.	High: 2-8 months. Letters can be sent in a timely manner, delays may occur with funding approval or postal strikes.
Policy 3 <i>Activity-based funding</i>	Medium: Costly upfront implementation but depending on how much patient cases vary (low-cost patients outweigh high-cost patients), this option could yield similar (or cheaper) results than the current system. ⁹²	Medium: Depends on the number and variation of patients. Creates an incentive for administrators to work quickly and efficiently.	Medium-High: 24-36 months. Similar provincial transitions took roughly 3 years. ⁹³

RECOMMENDATION

In addressing the question of how the provincial governments of Nova Scotia and New Brunswick

This wicked problem cannot be completely resolved with one approach, nor will it ever truly be ‘fixed’, but there are several new political approaches and implementations that can help mitigate the issue.

can reduce emergency room wait times, all three options would reduce ER wait times in emergency departments across NS and NB. However, through a thorough analysis of the selected criteria, this paper found that option 3, activity-based funding, is the strongest option to address this pressing issue (see Figure 1.2).

Extended emergency room wait times in these provinces are multi-faceted issues with many deep and systemic causes. This wicked problem cannot be completely resolved with one approach, nor will it ever truly be ‘fixed’, but there are several new political approaches and implementations that can help mitigate the issue. This issue

⁹¹ Estimate based on the number of households in Nova Scotia (842,994) multiplied by the cost of postage per letter (\$.99); “Estimates of the number of census families on July 1st,” Statistics Canada, November 7, 2025, <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710006101>; “Canada Post proposes new postage rates for 2024,” Canada Post, February 9, 2024, <https://www.canadapost-postescanada.ca/cpc/en/our-company/news-and-media/corporate-news/news-release/2024-02-09-canada-post-proposes-new-postage-rates-for-2024>.

⁹² Karen Palmer, Danielle Martin, and Gordon Guyatt, “Prelude to a systematic review of activity-based funding of hospitals: potential effects on cost, quality, access, efficiency, and equity,” *Open Medicine* 7, no. 4 (2013), <https://pmc.ncbi.nlm.nih.gov/articles/PMC4161500/>.

⁹³ Jason Sutherland, Guiping Liu, Trafford Clump, and Michael Law, “Paying for Volume: British Columbia’s Experiment with Funding Hospitals Based on Activity,” *Health Policy* 120, no. 11 (2016), <https://doi.org/10.1016/j.healthpol.2016.09.010>.

is connected to other problems and is socially complex. In this situation, there are no ‘right’ or ‘wrong’ options; there are only ‘better’ or ‘worse’ options. Considering the nature of this problem and the risk it poses to people’s health and well-being, effectiveness is the most valued criterion.

Thus, this paper recommends option 3: a transition into activity-based funding. ABF has been effective in other parts of the world, and in one Canadian province as well, showing further support towards the efficacy of this option. ABF is not the quickest solution to implement, but its long-term sustainability outweighs this slight delay. This policy option will functionally reduce wait times by changing the nature of hospitals across the provinces. An incrementalist approach is the best way to address this wicked problem. Although this option does not completely solve the problem, it is a big step in the right direction. It benefits not only patients in NB and NS, but also healthcare providers—supporting their needs and well-being as frontline administrators.

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ABOUT THE AUTHORS



Sam Chapman is a third-year honours Public Policy and Governance Student at St. Francis Xavier University in Nova Scotia, Canada. Sam was recently awarded the J. Armand Bombardier Internship Award. Sam has a strong passion for contract and estate law and plans on pursuing these interests following undergraduate studies.



Amy Maynard is a third-year Applied Forensic Psychology major, with a minor in Public Policy and Governance at St. Francis Xavier University in Nova Scotia, Canada. She is the recipient of the Joyce Foundation Bursary for Public Policy and Governance for the past three years. Amy has an interest in law, government, politics, and criminology, and is planning on furthering her education in one or multiple of those areas after graduation.



Stephanie Walker is a third-year Applied Forensic Psychology (AFP) student with a minor in Public Policy and Governance at St. Francis Xavier University in Nova Scotia. She is the Junior Class Representative for the AFP program and is involved in numerous societies on campus. Stephanie wants to pursue the field of Clinical Psychology and/or Policy after she completes her undergraduate degree.



Isabella Regenvanu is a third-year undergraduate student pursuing a degree in English with a minor in Public Policy and Governance at St. Francis Xavier University in Nova Scotia, Canada. She is a recipient of the Right Honourable Brian Mulroney Scholarship for the past three years, awarded for academic achievement, leadership and community service. Isabella is interested in pursuing teaching in the future and hopes to improve access to education for marginalized learners.

Finding Security in America's Shadow

Vitoria Wortman

ABSTRACT

Canadian foreign policy is paradoxical: on the one hand, Canada's foreign policy has a relatively insignificant impact on world politics, but on the other hand, Canada's foreign policy is crucial to Canada's domestic politics. This unique phenomenon is the direct outcome of Canada's unique geopolitical situation. Canada's sole neighbour is the United States, the most powerful nation in the world, from which it cannot defend itself militarily. Thus, since the emergence of the United States as a global superpower at the beginning of the Cold War, Canadian foreign policy prioritized building Canada's special relationship with the US. Massie's theory of Canadian strategic cultures explains this foreign policy approach in part by identifying three Canadian strategic cultures: continental soft-bandwagoning, defensive internationalism, and soft-balancing Atlanticism. However, I argue that continental soft-bandwagoning is Canada's sole strategic culture; internationalism and Atlanticism are a result of the pressures exerted on Canadian foreign policy by Canada's unique nationalism, shaped by Franco-Canadian and Loyalism, not a reflection of Canadian strategic thinking. When this framework is applied to Canada's involvement in the Russo-Ukraine war, Canada's involvement benefits Canada, provided the US continues to support Ukraine by increasing Canadian security, protecting the Canadian economy, and facilitating Canada's special relationship with the US.

Canadian foreign policy is paradoxical: on the one hand, Canada's foreign policy has a relatively insignificant impact on world politics, but on the other hand, Canada's foreign policy is crucial to Canada's domestic politics. This unique phenomenon is the direct outcome of Canada's unique geopolitical situation. Canada has but one neighbour, the most powerful nation in the world, from which it would be completely unable to defend itself militarily: the United States (US). Thus, since the beginning of the Cold War, when the US emerged as one of the two global superpowers, Canadian foreign policy prioritized building Canada's special relationship with the US in a soft-bandwagoning continentalism approach. This was reinforced by the US emerging as the sole global hegemony following the collapse of the Soviet Union. The predominance of soft bandwagoning continentalism approach to Canadian foreign policy, as opposed to the foreign policy approaches of internationalism or Atlanticism, is exemplified by economic continentalism, including the Canada Free Trade Agreement, later expanded to United States-Mexico-Canada Agreement, pioneered by Prime Minister Brian Mulroney in the 1980s, and by Canada's unique position in multilateral organizations such as the North Atlantic Treaty Organization (NATO).

Understood through this framework, borrowed from Justin Massie's classical realist-constructivist framework of foreign policy, Canada's involvement in the Russo-Ukrainian War, including the \$442 million in aid it has committed to Ukraine and the sanctions it has imposed on Russia, is an extension of its continentalism policy.¹ Canadian involvement in Ukraine, despite the negative economic ramifications, benefits Canada as a middle power bordering the US, provided the US continues to support Ukraine. This support increases Canadian security, protects the Canadian economy, and facilitates Canada's special relationship with the US.

Canadian foreign policy has long been characterized by the tension between nationalism and continentalism, a Canadian international relations theory emphasizing closer ties (including trade links, political ties, and security agreements) with the US. In the early stages of the Dominion, anti-American sentiments were often weaponized by the Conservatives to win federal elections, such as in 1891, when Conservative Sir John A. Macdonald wrapped himself in the Union Jack and accused the Liberals of treason for their 'unrestricted reciprocity' policy, winning the election; or in 1911, when Liberal Sir Wilfrid Laurier's government promoted the signing of a free-trade agreement with the United States and lost to the Conservatives.² Core beliefs of Canadian continentalism traditionally included opposition to policies that prevent foreign investment, strong advocacy for tariff reduction, unrestricted continental free trade, strong hostility to nationalism, and a push for Canadian-American cultural integration. In other words, continentalism was not just economics – it was a rejection of Canadianism in favour of Americanism.³

However, the bonds forged between the US and Canada during the Second World War, along with the Cold War's pressures on Canadian foreign policy, mutated Canadian continentalism. In 1940, during the Second World War, Canada and the United States established the Permanent Joint Board on Defence at Ogdensburg, New York, their first major military treaty.⁴ Canada furthered its relationship with the US in the post-war era. In 1949, under External Affairs minister Lester B. Pearson, Canada played a key role in the creation of NATO, a multilateral security pact between Canada, the United States, and other key Western European nations, originally meant to counteract the Soviet threat in Europe. Canada pushed for political, economic, and cultural

¹ Government of Canada, "Canada-Ukraine Relations," *Global Affairs Canada*, September 9, 2024, <https://www.international.gc.ca/country-pays/ukraine/relations.aspx?lang=eng>.

² Stephen Clarkson, "Continentalism," *The Canadian Encyclopedia*, 2013, <https://www.thecanadianencyclopedia.ca/en/article/continentalism>.

³ Clarkson, "Continentalism."

⁴ Norman Hillmer, "Permanent Joint Board on Defence," *The Canadian Encyclopedia*, December 16, 2013, <https://thecanadianencyclopedia.ca/en/article/permanent-joint-board-on-defence>.

bonds between the NATO members, among which the US holds a distinguished place, and participated fully in NATO activities, including stationing troops in Europe during the Cold War.⁵ NATO was unique – it was Canada’s first peacetime military alliance, born out of fear of the Union of Soviet Socialist Republics, frustration with the shortcomings of the United Nations (UN), and hope that the pact would prevent an American retreat into isolationism or a resort to unilateralism. More importantly, for Canada, it had an American focus.⁶

Conservatives, who had been previously opposed to continentalism, began pushing for greater economic and security cooperation between Canada and the US. Progressive Conservative Prime Minister Brian Mulroney’s cabinet pushed for unrestricted American investment in Canada, “furthering the continental military planning for space-age weaponry.”⁷ Under his government, Canada adopted its first free-trade agreement with the US in 1988, “intended to create a North American energy market, to abolish all tariffs and to accelerate the expansion of US capital throughout the Canadian services industry.”⁸ Mulroney reconciled nationalism under continentalism in “confident continentalism”, where Canada could benefit from free trade with the US while maintaining its economic and political freedom, or in other words, while remaining Canada.⁹ Following Mulroney’s re-election in 1988, it was clear that continentalism had won and continues to define Canadian policy considerations today.¹⁰

Justin Massie, a former doctoral candidate at Queen’s University and now professor at the Université du Québec à Montréal, explains the theoretical underpinnings of Canadian continentalism and its practical implications.¹¹ Massie notes that Canada’s foreign policy approach, shaped by its imperatives to “[maintain] unity at home, especially between the two founding nations; and [to live] distinct from but in harmony with the world’s most powerful and dynamic nation—the USA”, cannot be explained by neo-realism, which focuses entirely on the material and structural constraints of the international system on state behaviour.¹² In this

⁵ NATO, “Canada and NATO – 1949,” *NATO*, n.d., https://www.nato.int/cps/en/natohq/declassified_161511.htm.

⁶ Hillmer, “NATO: Canada’s First Peacetime Military Alliance,” *The Canadian Encyclopedia*, March 4, 2015, <https://thecanadianencyclopedia.ca/en/article/nato-when-canada-really-mattered-feature>.

⁷ Clarkson, “Continentalism.”

⁸ Clarkson, “Continentalism.”

⁹ Christopher John Pennington, “The Continentalist Movement in the Politics of Canada and the United States, 1887–1894,” *University of Toronto Scholar*, 2007.

¹⁰ Norman Hillmer and Andrew McIntosh, “Brian Mulroney,” *The Canadian Encyclopedia*, April 22, 2013. <https://www.thecanadianencyclopedia.ca/en/article/brian-mulroney>.

¹¹ UQAM, “Justin Massie,” <https://professeurs.uqam.ca/professeur/massie.justin/>.

¹² Justin Massie, “Making Sense of Canada’s ‘Irrational’ International Security Policy: A Tale of Three Strategic Cultures,” *International Journal* 64, no. 3 (2009): 625–645. <https://www.jstor.org/stable/40542193>.

approach to international relations (IR), pioneered by Kenneth Waltz and further developed by John Mearsheimer, states are assumed to be unitary actors, interested in their self-preservation in an anarchical self-help system, who pursue either external balancing (creating alliances) or internal balancing (developing their military capabilities).¹³ Under Waltz's understanding of IR, Canada's decision to bandwagon with the United States, the most powerful country in the world, is irrational, as Waltz theorizes that "because power is a means, not an end, states prefer to join the weaker of two coalitions" and tend to balance against stronger states.¹⁴

Massie reconciles classical realism and constructivism to provide a realist theoretical framework for understanding Canadian foreign policy. He defines classical realism according to classical realist Hans Morgenthau, who asserts that it is the state's national interest (material and non-material, including "the political and cultural context within which foreign policy is formulated") that best explains its strategic behaviour.¹⁵ Using this understanding of IR as his foundation, Massie examines Canadian foreign policy based on constructivist principles, i.e. on how identity, norms, and culture impact international relations. Massie focuses on the constructivist

I argue that internationalism and Atlanticism are not true Canadian strategic cultures – foreign policy decisions that favour these approaches are a result of domestic Canadian politics.

conception of strategic culture, which comprises the state's external (national role conception and relations with other states on a spectrum) and internal identities (regime type, territory, etc.).¹⁶ He identifies three Canadian strategic cultures: continental soft-bandwagoning, defensive internationalism, and soft-balancing Atlanticism.¹⁷ However, I argue that internationalism and Atlanticism are not true Canadian strategic cultures –

foreign policy decisions that favour these approaches are a result of domestic Canadian politics, namely the influence of Canadian nationalism, not a reflection of Canadian strategic thinking.

Canada finds itself in a unique position not only because of its geopolitical situation but also because of its brand of nationalism. Historically, Canada is seen as having two founding nations – the British and the French – largely ignoring the pre-existing Indigenous populations and

¹³ Kenneth Waltz, *Theory of International Politics* (Waveland Press, 2010), 116-126.

¹⁴ Waltz, *Theory of International Politics*, 126.

¹⁵ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," 627.

¹⁶ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," 630.

¹⁷ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," 627.

communities.¹⁸ As a result, it has traditionally focused on building bridges between these two linguistic and cultural communities through institutional accommodations of Quebec and navigating Canada's complex relationship with, first, the British Empire, then the United States, with caution, so as not to exclude French Canada.¹⁹ Canada's relationship with the United States is further complicated by the influence of Loyalists in English Canada. Loyalists, American colonists who supported the British during the American Revolutionary War, and migrated to British North America, following their defeat, deeply influenced English Canada's culture and attitudes toward the US. "The Loyalists found themselves hating America, but loving and envying it as well", an attitude that has persisted among Canadians.²⁰ As Canada adopted a continentalist approach to its foreign policy, the danger of alienating its French-Canadian population, as well as its temperamental English-Canadian population, was mitigated by using multi-lateral and international institutions to facilitate Canada's strengthened political relationship with the United States.

Internationalism, as a foreign policy approach, refers to a commitment to engagement in conflict and involvement in global organizations.²¹ In the Canadian context, it is tied to Canada's view of itself as a good world citizen with liberal international values and as a middle power.²² It is a mutated form of nationalism, as it is deeply tied to Canadian self-perception and supposed Canadian values, which emphasize order and the rule of law over freedom. The internationalist approach speaks directly to Loyalist tendencies. In the post-Cold War period, Canada has found itself increasingly neglecting this approach in favour of soft-bandwagoning continentalism. Canada was forced to choose between the UN and NATO military operations, and it chose NATO. Canada, following 9/11, elected to join the US in its invasion of Afghanistan despite little international incentive to do so, spending both Canadian blood and treasure. Its international aid to Ukraine follows a similar pattern.²³ The UN, which Canada played a historically significant role in with former Prime Minister Lester B. Pearson's invention of modern peacekeeping missions, has not and will not approve of sanctions or any collection action against Russia, given Russia and

¹⁸ Tyler Dawson, "One, Two or Three Founders: How Canada's Historical Memory is Changing," *National Post*, July 1, 2022, <https://nationalpost.com/news/canada/one-two-or-three-founders-how-canadas-historical-memory-is-changing>.

¹⁹ Roger Gibbins, "The New Face of Canadian Nationalism," p. ix. Institute of Intergovernmental Relations, Queen's University, 1995.

²⁰ David V. J. Bell, "The Loyalist Tradition in Canada," *Journal of Canadian Studies* 5, no. 2 (1970): 22-33, <https://doi.org/10.3138/jcs.5.2.22>.

²¹ Ettinger, "Explaining Canada's Unsurprising Response to Russia's Invasion of Ukraine, 2022–2023."

²² Massie, "Making Sense of Canada's 'Irrational' International Security Policy," 637.

²³ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," 639.

China's permanent positions on the UN Security Council. These two world powers support Russia's illegal invasion of Ukraine and prevent the UN from taking any decisive action against Russia.²⁴ However, Canada has decided to join the American-led NATO initiative to sanction Russia and provide military aid to Ukraine, which is explained by their commitment to soft-bandwagoning continentalism over internationalism. This is logical when internationalism is viewed as a transitory phase by which softbandwagoning continentalism was made palatable to Canadians.

Atlanticism, which refers to Canada's multilateral orientation toward the North Atlantic region, is likewise a facilitator for soft-bandwagoning continentalism.²⁵ France's participation in NATO enables Canada to act in lockstep with the US (which undisputedly leads NATO) without angering French Canada.²⁶ Massie explains that "Quebeckers' skepticism toward militarism was notably translated into Canada's insistence on establishing more than a military alliance (i.e., moral) and France's participation in the alliance was deemed essential, not only because of historical ties amongst francophones across the Atlantic, but also because France's presence would help create a 'countervailing force' to Washington and London."²⁷ NATO aid to Ukraine is the most recent example of this; however, other examples include Canada's participation in the US led 1999 unauthorized NATO bombing of Yugoslavia.²⁸

Canada's decision not to participate in the 2003 war in Iraq, led by the United States in the aftermath of 9/11, complicates this assertion. Prime Minister Jean Chrétien refused to publicly support the war, citing a lack of a UN Security Council resolution approving the operation.²⁹ However, Massie argues that Prime Minister Chrétien left the door open on what UN approval could look like and that if France had chosen to participate in the war, Canada would have joined. This decision was driven by national constraints on Canadian foreign policy, namely the need to maintain French Canadian political support for the Liberals.³⁰ This supports the claim that

²⁴ Tony Wesolowsky, "Where Are the Blue Helmets? Why the UN Can't Keep the Peace in Ukraine," *RadioFreeEurope*, March 17, 2022, <https://www.rferl.org/a/russia-invades-ukraine-un-peacekeeping/31758188.html>.

²⁵ Ettinger, A. 2023, "Explaining Canada's Unsurprising Response to Russia's Invasion of Ukraine, 2022–2023."

²⁶ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," p. 640-41.

²⁷ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," p. 640-41.

²⁸ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," p. 641; Andrew Glass, "NATO Begins Bombing Serbia, March 24, 1999," *POLITICO*, March 24, 2019, <https://www.politico.com/story/2019/03/24/this-day-in-politics-march-24-1231269>.

²⁹ John Boileau, "Canada and the Iraq War," *The Canadian Encyclopedia*, December 20, 2023, <https://www.thecanadianencyclopedia.ca/en/article/canada-and-the-iraq-war>.

³⁰ Massie, "Making Sense of Canada's 'Irrational' International Security Policy," p. 641.

Atlanticism is not a true Canadian strategic culture; it is a nationalist-driven adaptation of Canadian soft-bandwagoning continentalism.

If soft-bandwagoning continentalism is the only true Canadian strategic culture, how has it served Canada? Soft-bandwagoning continentalism, where Canada aligns itself with the US through political and economic cooperation, reaping the benefits of free-riding off the US while maintaining the independence to refuse US demands without severe economic or political consequences, has ostensibly benefited Canada and will continue to do so. Even as the Arctic is melting and Canada faces the prospect of becoming neighbours with Russia, Canadians do not stay awake worrying about military invasion even as Canada consistently fails to meet their 2 percent NATO spending commitment. In 2021–22, Canada spent 1.36 percent of its GDP on its military, less than three-quarters of its NATO spending commitment.³¹ Nevertheless, its security remains guaranteed by its political and economic integration with the US, which spent 3.45 percent of its GDP on military spending in 2022 and makes up almost half of the worldwide military expenditure.³² The US spent \$997 billion USD in 2024 on its military.³³ This is a great benefit to Canada as it alleviates the economic burden of building up the Canadian military.

The Canadian economy is also heavily reliant on the American economy. 76.88 percent of all Canadian exports go to the US. The current Trump White House has imposed unprecedented tariffs on Canada: a 35 percent ‘fentanyl’ duty; 50 percent sectoral tariffs on steel and aluminum; a 50 percent tariff on some copper products; and a 25 percent tariff on the non-USMCA parts of the auto sector. These tariffs are, in part, driven by Trump’s love for tariffs and are not yet a fixture of American foreign policy.³⁴ However, it is worth noting that non-continentalist Canadian foreign policy, pursued by Prime Minister Mark Carney, has exacerbated the effects of these tariffs. For example, Carney’s public support for Palestinian statehood led Trump to threaten to

³¹ National Defence, “Government of Canada,” 2022, <https://www.canada.ca/en/department-national-defence/corporate/reports-publications/proactive-disclosure/afgh-9-may-2022/nato.html>.

³² Trading Economics, n.d., “United States - Military Expenditure (% of GDP) 2024 Data 2025 Forecast 1960–2022 Historical.”

³³ Xiao Liang, Nan Tian, Diego Lopes Da Silva, Lorenzo Scarazzato, Zubaida Karim and Jade Guiberteau Ricard, “Trends In World Military Expenditure, 2024,” *SIPRI*, April 2025, https://www.sipri.org/sites/default/files/2025-04/2504_fs_milex_2024.pdf.

³⁴ James Moore, “James Moore: Trump tariffs are here to stay. Here’s what Canada should do.” *CTV News*, August 12, 2025, <https://www.ctvnews.ca/world/trumps-tariffs/article/james-moore-a-reaction-plan-to-the-trump-tariffs/>.

back out of trade talks.³⁵ This means that the most effective Canadian approach remains soft-bandwagoning continentalism – drawing itself closer to the United States but retaining its independence by not becoming completely reliant on the US. This includes investing in its military and developing free-trade agreements with other nations, while recognizing the geographic

Through soft-continentalism, Canada signals to the US that it does not pose a threat to their national security, thus Canadians are protected from military invasion by the world's most powerful country.

conditions that led Canada to develop such strong economic ties with the US in the first place.

Most importantly, through soft-continentalism, Canada signals to the US that it does not pose a threat to their national security, thus Canadians are protected from military invasion by the world's most powerful

country. Since the beginning of the Cold War, Canada has bandwagoned with the US on matters concerning the Soviet Union, now Russia, to signal to the US that “it is not a direct or indirect threat to US national security.”³⁶ In doing so, it has bound its fate alongside the US. This comes with costs. In a world where non-Western countries have grown weary of American interventionism, close alignment with the US has cost Canada its ability to project soft power abroad, especially in the Global South.³⁷ Imposing sanctions based on American foreign policy interests also has costs for the Canadian economy. In response to the war in Ukraine, Canada followed suit and imposed sanctions on Russia, which devalued the Canadian dollar from \$78.63 to \$77.93 USD, as Canada imported \$500 million worth of oil from Russia before the outbreak of war, subsequently raising gas prices.³⁸ Nevertheless, none of these costs are outweighed by the immense benefit of close relations with the US. Canada's military and humanitarian aid, including the \$442 million spent on Ukraine, is nowhere near comparable to the \$81.9 billion it would have

³⁵ Charlie Buckley, “‘Hard For Us to Make a Trade Deal’: Trump on Canada Recognizing a Palestinian State,” *CTV NEWS*, July 31, 2025, <https://www.ctvnews.ca/politics/article/hard-for-us-to-make-a-trade-deal-trump-on-canada-recognizing-a-palestinian-state/>.

³⁶ Massie, “Making Sense of Canada's ‘Irrational’ International Security Policy,” p. 632.

³⁷ Alexander Hill, “What Happened to Canada's Foreign Policy?” *Canadian Dimension*, January 23, 2023, <https://canadiandimension.com/articles/view/what-happened-to-canadas-foreign-policy>.

³⁸ Ruth Endam Mbah and Divine Forcha Wasum, “Russian-Ukraine 2022 War: A Review of the Economic Impact of the Russian-Ukraine Crisis on the USA, UK, Canada, and Europe,” *Advances in Social Sciences Research Journal* 9, no. 3 (2022): 149, <https://doi.org/10.14738/assrj.93.12005>.

to spend to meet the 2 percent NATO military spending goal, which would still be inadequate to protect Canada from any real threats, most notably the US.³⁹

And if the United States pulls its support from Ukraine? From a foreign policy perspective, the answer is obvious. All the economic and political incentives for Canada to continue providing humanitarian and military aid to Ukraine disappear, so from a strictly realist perspective, Canada should also pull its support from Ukraine. This remains true even if it strains Canada's relationship with European allies. Canada has limited security interests in Europe, and the armies and economies of the other NATO members are not sufficiently developed to incentivize Canada to choose Europe over the US. They are also much farther away, making it more expensive to trade with them and reducing their incentives to protect Canada. However, from a classical realist-constructivist perspective, the domestic impact of this decision would outweigh its benefits.

Canadian foreign policy in Ukraine captures the essence of post-Second World War Canadian foreign policy – balancing on a tight rope, stuck between its interests abroad and its duties at home. Canada, despite its frustrations about being seen as America's Little Brother and its nationalistic tendencies, should recognize the value of its relationship with the United States, the global hegemon, for the good of its economy, its security from other countries, and its security from the United States itself. As hard as it is to live in America's shadow, it is far harder to live in its contempt.

³⁹ Government of Canada, 2024, "Government of Canada."; Al Mallees, N. 2024, "The Federal Government Would Have to Double Military Spending to Meet NATO Target."

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ABOUT THE AUTHOR



Moran Vitoria Wortman is a 2025 graduate from St. Francis Xavier University, where she earned her Bachelor of Arts with Honours in Political Science with a Concentration in International Relations with a Subsidiary in Economics with First Class Honours. There, she won the Dr. John B. Stewart Scholarship for Political Science for the highest cumulative grade in Political Science courses and overall ability in, and aptitude for, the study of politics. She is interested in foreign policy and security studies, with a particular interest in the Israeli-Arab conflict.



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