Written Submission for the Pre-Budget Consultations in Advance of the 2026 Federal Budget

Children's Healthcare Canada | Santé des enfants Canada

Pediatric Chairs of Canada
Directeurs de pédiatrie du Canada

Recommendations

Children's Healthcare Canada and the Pediatric Chairs of Canada recommend four federal actions in Budget 2026 to improve health outcomes for Canada's eight million children and youth:

1. Build strong, Canadian children's healthcare systems through an investment of $10 billion over ten years, targeting infrastructure renewal, a national funding framework that recognizes the complexity involved in the delivery of children's healthcare, and a pan-Canadian pediatric workforce plan.
2. Reshape and expand federal commitment to $5 billion over ten years for child and youth mental health, supporting integration of care across hospital, community, and school-based services from birth.
3. Prioritize child and youth health-focused research with an investment of $33 million to support CIHR-funded research and sustained child health data collection through the Canadian Health Survey on Children and Youth (CHSCY).
4. Strengthen funding for Jordan's Principle, the Inuit Child First Initiative, and reform the Non-Insured Health Benefits (NIHB) program, so Indigenous children can access care without harmful delays.

A National Imperative for Children's Health

Children living in Canada face significant barriers accessing timely, equitable, high-quality healthcare services. Surging wait times for time-sensitive, essential services, a mental health crisis, outdated capital and digital infrastructure, and widening inequities all contribute to worsening health outcomes for children and youth in Canada. UNICEF's Report Card 19 (2025) ranked Canada 24th of 36 high-income countries with respect to children's physical health and 33rd of 36 on a metric of adolescent suicide—despite boasting a top ten economy. Countries that consistently outperform Canada on children's health and well-being prioritize children in national policy, invest sustainably, and hold leadership accountable for outcomes.

Recommendation 1: Right-Size Children's Healthcare Systems

Healthcare systems serving children and youth are structurally undersized and under-capitalized to meet the needs of a growing and increasingly medically complex population—and the gap is widening. Without sufficient capacity, kids are waiting too long for care that should be available closer to home. Delivered through bilateral agreements, capital investments would transform the delivery of healthcare to meet the unique needs of children and youth. While we welcome the Health Infrastructure Fund announced in Budget 2025, Deloitte's *Thrive: The Economic Case for Investing in Children's Health* report (2025) demonstrates how investment in children's healthcare systems specifically strengthens our economy, in the short and long term.

At the core of right-sizing is the highly specialized healthcare workforce serving children which is neither adequately prioritized nor appropriately resourced within current funding models. Children's healthcare delivery services are uniquely resource-intensive, yet the workforce—including physicians, nurses, and allied health professionals—that sustains them is shrinking.

One troubling example is the training pipeline crisis: with fewer medical students choosing pediatrics, the next generation of specialized care is already at risk. The recent national pediatric residency match (CaRMS) left a historic 21 of 150 positions unfilled after the first round—more than double the year before (a previous "record"). CaRMS also reported 66 subspecialty pediatrics positions went unmatched nationally.

Three drivers are compounding the workforce crisis:

- **Required specialized training:** Children are not little adults. The healthcare providers who care for children are highly specialized (even within their professions, e.g. pediatric rheumatologists, child psychiatrists, or neonatal nurse practitioners), requiring additional training compared to those caring for adults. In fact, the required length of training for physicians pursuing subspecialty positions in pediatrics has recently (2024) been extended by one year.

- **Compensation:** Children's healthcare professionals are routinely paid less than their adult counterparts. This is especially true of pediatric subspecialists (e.g., pediatric neurologists, pediatric cardiologists, pediatric oncologists). Rising costs of training (medical schools or otherwise) incentivize trainees toward better-compensated specialties.
- **Licensing and immigration barriers:** federal immigration delays, alongside interprovincial licensing friction, are slowing recruitment of rare subspecialists, often for roles where no qualified Canadian candidates are available.

CHC and PCC recommend two integrated actions:

- **Invest $10 billion over ten years in children's healthcare infrastructure,** delivered through bilateral agreements with provinces and territories that include dedicated action plans, performance targets, and public reporting. This would advance right-sizing of children's hospitals, and community-based healthcare delivery organizations (community hospitals, children's rehabilitation, mental health, palliative care, respite care, etc); modernize purpose built child-specific facilities for surgical, imaging, rehabilitation, and complex care; and digital, data, and virtual care infrastructure that reduces long-term costs and Canada's dependency on US-based technology.
- **Create a pan-Canadian pediatric health human resources plan**, with an urgent focus on subspecialty pediatricians —addressing compensation disparities, pediatric trainee debt relief, interprovincial licensing barriers, and federal immigration pathways for highly trained subspecialists.

Recommendation 2: Invest $5 Billion to Bolster Mental Health Services for Children from Birth Through Adolescence

Children's Healthcare Canada members report unprecedented demand for children's mental health services across the continuum of care, spanning early childhood through adolescence. According to the World Health Organization, investing in mental health from the earliest years delivers a 4:1 economic return; preventing long-term impacts on education, employment, and chronic disease. The Youth Mental Health Fund, introduced in Budget 2024 at $500 million over five years, was a welcome first step. However, its scope and scale fall short of meeting the current need, and it excludes programs that support infants and young children.

- According to CIHI's 2025 report, 20% of hospitalizations among children and youth are related to mental health disorders.
- 1 in 4 youth report poor mental health.
- Suicide is the second-leading cause of death among youth aged 10–19 in Canada.
- Over 50% of children and youth with mental health needs face long waits or difficulty accessing services.

Interventions before age 12 offer the greatest return in costs avoided. Canada has no pan-Canadian infant and early childhood mental health framework. A lack of integrated

models that bridge hospital, community, and school-based services across the developmental continuum leave families navigating disconnected and underfunded systems, acting as de facto care coordinators.

CHC and PCC recommend $5 billion over ten years to reshape and expand federal investment in children's mental health, with clear directives to:

- Extend the funding mandate to include infants, children, and families with dedicated streams for infant and early childhood mental health.
- Catalyze integrated models across hospital, community, and school-based services, with a focus on prevention, timely access, and continuity of care.
- Prioritize early intervention and family-centred approaches, including perinatal and early parenting supports.

Recommendation 3: Invest $33 Million in Child and Youth Health Research

Canada chronically underinvests in children's health research, and the consequences are becoming impossible to ignore—we understand too little about the current state of children's health, we are unprepared for emerging threats, and children's health outcomes are worsening.

For more than two decades, the CIHR Institute of Human Development, Child and Youth Health (IHDCYH) has received no increase to its base budget—a prolonged freeze that has quietly limited Canada's capacity to support the next generation of child health researchers. Today, its early career researcher competition funds a maximum of 13 grants totalling less than $2 million annually, with success rates between just 7 and 14 percent. In practical terms, that means the vast majority of qualified researchers who could be advancing our understanding of children's health are turned away—not for lack of talent, but for lack of investment.

Canada has a remarkable opportunity to lead globally in precision child health and advanced therapeutics. Realizing this vision requires sustained federal investment in translational research infrastructure, data platforms, and pediatric clinical trial capacity—while ensuring discoveries are rapidly and equitably translated into care so that innovation reaches every child, not only those near academic centres.

We recommend the following three actions:

- **Embed a lifespan inclusion policy within the Capstone research organization's mandate before its design is finalized**: a policy that would ensure children and underrepresented populations are systematically included in all federally funded research from the outset.
- **Invest $25 million annually for a dedicated children's health research initiative**: ring-fenced funding that ensures investments in child and youth health cannot be redirected to other research priorities within CIHR. This would

represent the first meaningful federal investment in children's health research infrastructure in over two decades.

- **$8 million to sustain the Canadian Health Survey on Children and Youth (CHSCY) across its next two waves**: Canada cannot make evidence-based child health policy without current, disaggregated national data. Sustained investment could also support efforts to expand CHSCY's reach to include children living on First Nations reserves and other Indigenous settlements—populations currently excluded from the survey, creating significant gaps in Indigenous children's health data. Under the Capstone research organization, administrative efficiencies should flow back into institute-level programming—including IHDCYH—rather than being absorbed centrally.

Recommendation 4: Strengthen funding for Jordan's Principle, the Inuit Child First Initiative, and Non-Insured Health Benefits

Jordan's Principle and the Inuit Child First Initiative were established to ensure that First Nations and Inuit children receive the services, supports, and products they need without jurisdictional delay. Recent funding reductions are eroding that promise at exactly the moment demand is rising. The federal government is directly responsible for programs that determine whether Indigenous children can reach, access, and benefit from health care. Restructuration and reductions to Jordan's Principle funding and to Indigenous Services Canada, combined with chronic operational dysfunction at the Non-Insured Health Benefits (NIHB) program, are producing escalating harm to children and families, particularly in northern regions.

The Spring Economic Update 2026 commits $794 million to NIHB in 2026-27. While it is welcome investment, it ignores calls for long-term investment and reform to address challenges that continue to affect timely access for Indigenous children and families. Front-line teams report the following consequences of NIHB failures, repeatedly and across regions:

- **Missed appointments and treatment delays:** Teams wait multiple days for simple approvals as they struggle to reach NIHB staff. Transportation is not arranged in time, appointments are missed, and rescheduling delays treatment by weeks or months compromising health outcomes.
- **Pediatric sedation disruption:** Coordinating sedation teams, anesthesiology, and diagnostic imaging for pediatric tests is complex, and NIHB-related cancellations are now so frequent that some anesthesiologists—already in short supply—are refusing to provide pediatric sedation services. Families are left choosing between further delay and proceeding without sedation, which is not in the best interest of the child.
- **Hospital beds held because no hotel has been arranged:** Out-of-town pediatric patients remain admitted, at system cost and at the expense of other children waiting for beds, because NIHB cannot arrange accommodations on time.

- **Erosion of Indigenous-led medical transportation:** An Indigenous organization providing medical transportation recently cut its program, citing inadequate NIHB funding and burdensome reporting. NIHB now relies on local taxis that cannot coordinate same-day follow-up testing, adding days of hotel costs and keeping families away from their communities far longer than clinically required.

We recommend the federal government:

- **Increase Jordan's Principle funding** to meet demand and honour the federal commitment to First Nations children.
- **Increase funding for the Inuit Child First Initiative** on the same terms, or updated terms set by territorial organization advocates.
- **Fund operational reform of NIHB**, including adequate staffing, published response-time standards, transportation rule flexibility for coordinated testing, and sustained funding for Indigenous-led medical transportation, that considers culturally-relevant and trauma informed processes (i.e. accompanying family member to be with patient who is medically transported).

About Us

Children's Healthcare Canada is a national association serving healthcare delivery organizations that care for children and youth, advocating to accelerate excellence and innovation in health systems serving children, youth, and their families across the continuum of care. Our members deliver health services to millions of children and youth across Canada, including all sixteen children's hospitals, community hospitals, rehabilitation hospitals, home and respite care agencies, children's treatment centres, and regional health authorities.

Pediatric Chairs of Canada is comprised of the University Department Heads of Pediatrics within Canada's seventeen medical schools. PCC provides national leadership to strengthen the future of pediatrics, advancing education, workforce planning and research in support of excellent care for children and youth.