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TABLE OF CONTENTS

POLICY BACKGROUND

The objectives of the Canada Health Act of 1984 were to guarantee universality, comprehensiveness, equal access, public administration, and portability, which have benefited Canadians for many years (Gordon, Mintz, and Chen 1998). In other words, Canada's sought to base healthcare access on need rather than the ability to pay, making it free at the point of care for medical and hospital services (Martin et al. 2018). Universal healthcare (UHC) does not imply that healthcare is cost-free but rather that people are shielded against "catastrophic health expenditure," which is defined as spending more than 30% of their family income on health (Akinola and Dimitrova 2019).

There have been numerous discussions about the effectiveness of Canada's UHC. In recent years, those discussions have become more heated as opponents claim that privatization will address several problems associated with universal health care, including long wait times for elective surgical procedures, crowded emergency rooms, hospital closures, reduced access to some services, and a lack of primary care providers (Lee, Rowe, and Mahl 2021; Forbes and Tsang n.d.).

However, several studies have asserted that privatization is not the answer to improving the shortfalls in the current health system, rather a coordinated approach that addresses the social determinants of health while reducing inequities and improving health outcomes for marginalized groups and the population as a whole (Lee, Rowe, and Mahl 2021; Martin et al. 2018). Despite the supporting evidence that public healthcare creates greater equity in access to healthcare, Ontario appears to be moving full speed ahead towards a two-tiered healthcare system, thereby reducing the value of equity and universality.

While some provinces have been taking baby steps towards privatization, Ontario has been making legislative changes and cementing a gradual shift away from a monopolistic public system. For example, the provincial government recently passed laws to enhance the role of the private sector in COVID-19 testing and immunization and the remaining aspects of home care (Farisco 2022). The provincial government should address the factors heightening the call for privatization (Forbes and Tsang n.d.).

More than 90% of Canadians think that having universal healthcare is a significant source of national pride (The Canadian Press 2012). However, universal healthcare is frequently cited as being subjected to financial constraints and beset by inefficiency, primarily because it is funded by taxes and only offers a small number of services (doctors and hospitals), leaving other crucial aspects of healthcare (dental care, prescription medications, and allied health services) vulnerable to patchy public or private coverage (Lee, Rowe, and Mahl 2021).

The main health policy concerns brought about by these constraints are inequitable access to services outside the "basic public basket," lengthy wait times for some elective healthcare services, and persistently poor health outcomes, particularly for Indigenous communities, all of which strengthen the case for privatization (Martin et al. 2018). This momentum for privatization is also coupled with an aging population, the rising cost of healthcare, and the increased availability of new technologies (Forbes and Tsang n.d.). This explains why Ontario is rapidly heading to a second tier because it cannot keep up with the rise in demand. However, copays make it difficult for the poor, elderly, and other marginalized groups to access care (Lee, Rowe, and Mahl 2021).

The cry for privatization in Ontario should not come as a surprise as critics of universal healthcare have been calling for it for decades but have become louder recently, particularly during the Covid-19 outbreak, which worsened the healthcare system. This clamour has led to several health reforms, ranging from budget cuts to hospital closures and mergers (Armstrong and Armstrong, 2022). For instance, in 1996, the Ontario provincial government ordered the Health Services Restructuring Commission (HSRC) to revamp the healthcare systems, leading to several hospital closures and mergers.

As a result, women were forced to travel to another province or the United States for healthcare, specifically for breast cancer screening, in search of neonatal beds (Armstrong and Armstrong, 2022). In other words, these shifts in cost and care constitute privatization (Armstrong and Armstrong, 2022).

Today is no different. The healthcare system in Ontario is still being reorganized, moving more toward a private model. For example, to facilitate more pediatric procedures and cancer screenings, the Ontario Health Ministry stated in February of this year that it would permit private clinics to run private hospitals, which have been banned since 1973. It is worth noting that such a turn would weaken the moral standards by which Canadian healthcare is provided, "corporatizing" healthcare in a manner akin to that of the United States, leading to "access issues, costly bureaucracy, and subpar care" (Gordon, Mintz, and Chen 1998).

Several countries have adopted a two-tiered system consisting of private/public access to healthcare but have struggled to achieve efficiency and reduce costs. For example, the lack of funding in the public sector and the growing demands of the people in India led the government to encourage the privatization of healthcare (Kaloti 2021).

However, privatization did not resolve this problem; on the contrary, it made it worse, with 80% of doctors in the metropolitan areas providing care to only 25% of the country's population, resulting in expanded usage of diagnostic testing, antibiotic prescriptions, and unnecessary surgical procedures (Kaloti 2021). Likewise, in Brazil, the increased privatization of reproductive services has increased the number of abortions, incorrect oral contraceptive use, and sterilizations, all of which are associated with an increased risk of mortality, particularly in younger women (Kaloti 2021).

In addition, a study that conducted a systematic review comparing public and private healthcare systems in low and middle-income countries found that while both systems lack accountability and transparency, the private sector typically serviced higher socioeconomic groups and appeared to be less efficient because of higher drug costs, unfavourable incentives for pointless testing and treatment, higher risks of complications, and lax regulation; whereas public healthcare systems tended to be less patient-focused and lacked access to supplies (Basu et al. 2012). According to (Lee, Rowe, and Mahl 2021), there is a negative correlation between increasing levels of private financing and the universality, equity, accessibility, and quality of care in healthcare systems. This suggests that a more effective public healthcare system in Ontario is the key to achieving better health outcomes and bridging the inequity and efficiency gaps.

RECOMMENDATIONS

In response to Ontario's privatized healthcare policy environment threatening the public's wellbeing, we endorse the preservation and expansion of universal healthcare in Ontario. Although there is no easy solution to the current system, we believe the provincial government could maintain the national pride of universal healthcare by incorporating the following recommendations:

Reducing wait times

Intuitively, the simplest solution to reducing delays in healthcare access is by increasing the supply of healthcare professionals. This can be accomplished by improving enrolment diversity in medical schools (Komaromy 1996), promoting medicine as a discipline of study while improving the affordability of medical school (Cooke, Irby, and O'Brien 2010), and expanding hiring programs to attract foreign healthcare professionals (Clark, Stewart, and Clark 2006). Yet, this solution might not be appropriate across all jurisdictions, nor necessary if other measures are considered.

What governments seeking to reduce wait times should begin with is a comprehensive analysis of the bottlenecks obstructing healthcare service delivery (Almomani and AlSarheed 2016). Having identified health system inefficiencies, implementing targeted solutions should become a priority.

Upon performing this analysis, governments may find that improving patient education presents a cost-effective strategy to alleviate healthcare delays. By supplying accessible educational materials to patients that focus on illness prevention, governments may succeed in alleviating the onset of more dire health complications in patients (Adams 2010).

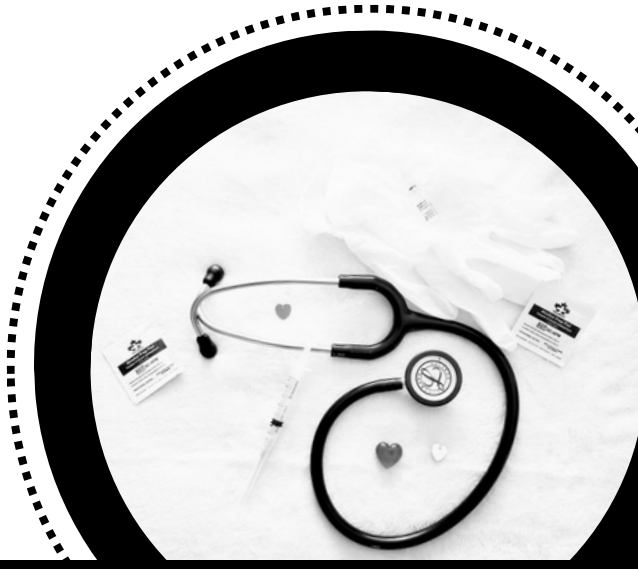
By adopting this approach, governments should not simply rely on education as a conclusive remedy to improving healthcare efficiency. Instead, they can find success with this strategy by adopting additional measures such as expanding telemedicine. By facilitating access to medical professionals, barriers such as locomotion, distance, and the geographic availability of healthcare experts cease to complicate patients' healthcare access (Annaswamy, Verduzco-Gutierrez, and Frieden 2020).

Consequently, the number of healthcare facilities available and the rate at which practitioners can respond to patients increases (Hjelm 2016). Of course, access to telemedicine can be a challenge to individuals as the availability of personal electronic devices and internet connectivity varies by household. Therefore, while this solution is not a definitive answer to reducing wait times, it remains a viable option.

Finally, supporting a turn towards more expansive telemedicine, but also effective as a standalone measure, governments can reduce healthcare delays by expanding the role of primary care providers.

Addressing the social determinants of health

Responding to the socio-economic factors which impact one's health begins by rectifying the causes that contribute to disparate health outcomes – i.e. poverty, deficient education access, barriers to employment, and inadequate housing. Improving collaboration between healthcare and adjoining social sectors, such as education and housing, stands to improve policy innovation and health outcomes across institutions (World Health Organization 2010). Bettering health equity would also contribute to reducing health disparities. To improve the healthcare outcomes of equity deserving groups, governments can expand access to primary care, increase the healthcare services that receive government subsidies, and implement community-based health clinics (Alder, Glymour, and Fielding 2016).



Expand the scope and availability of interprofessional and nurse-led care models

Given the important role that nurses play in our healthcare system, not simply as auxiliary staff but as essential, frontline healthcare workers (Kemppainen, Tossavainen, Turunen 2013), nurses should be allowed to play a more significant role in providing care. To accomplish this, governments should establish a regulatory landscape that expands the role of nurses in supplying care (Schmüdderich 2022). Governments should also support the training of healthcare staff to adopt a nurse-led care model and assist recruiting efforts to increase the capacity for this model.

With a clear framework and support system in place, governments should launch pilot projects to evaluate the efficacy of nurse-led models and innovate upon their design. If effective, governments should mediate partnerships between healthcare staff across hospitals and primary care clinics to increase the availability of healthcare professionals in supporting this model.

Lastly, to incentivize the adoption of this model, governments should supply financial incentives in the form of reimbursements and grants so that institutions complying with nurse-led care may reduce their operational expenses (Schmüdderich 2022).

CONCLUSION

While the Ontario government seems to be leaning towards privatization, Canada's labour movement is by and large against policies that seek to establish a private system coexisting with Canada's Medicare. The Canadian Office and Professional Employees Union (COPE) which is affiliated with the Canadian Labour Congress (CLC) argues on its website that privatization in Canada is not a new process, and has instead been pursued through incremental policies which have resulted in "a 70%:30% public-private split of healthcare expenditures" where before "virtually all Canadian medical care existed in the public sphere" (Farisco 2022).

They draw attention as well to alleged plans by the Ford government to privatize "18,000 long-term care beds over the next thirty (30) years" (Farisco 2022), and note that "of the eight hundred (800) Independent Health Facilities that primarily provide diagnostic services such as x-rays, ultrasounds and sleeping studies.... 98% of them are for profit corporations" (Farisco 2022).

These arguments raise urgency to claims that the question of Ontario's healthcare eventually falling to the dismembering scythe of privatization is not quite as far off as we would like to think, but instead is slowly being worked towards. One could maintain that labour unions have their own political agenda and conjuring imagined bogeys and crises helps advance this agenda. However, the labour movement is ultimately responsible to its working class members in order to maintain credibility, and is checked by its membership.

The Ford government's recent shifts on long term care are best understood against the context of the Covid-19 pandemic which saw Canada's long-term care crumple and residents be disproportionately impacted by infections and death (Sinha 2021). Ontario's auditor general found that Ontario's "long-term care sector and the ministry that oversees it were not 'prepared or equipped' to handle the litany of issues brought on by the COVID-19 pandemic" (Carter 2021).

The report released by the auditor general found three core issues to have contributed to the unpreparedness of Ontario's LTC sector: (i) the government not following expert advice made by panels and commissions it had established following other outbreaks like SARS, (ii) the government ignoring repeated concerns raised for 'over a decade' about systemic weaknesses in the sector, and (iii) the lack of integration of healthcare institutions into the larger healthcare sector (Office of the Auditor General of Ontario 2021).

It could be argued therefore that the very crisis that the government is attempting to address via increased privatization is one that has been manufactured over the preceding decade by the government's inaction and poor policy choices, rather than due to natural weaknesses within Canada's Medicare. It is worth noting that Ontario has 627 long-term care homes of which "16% are publicly owned, 57% are owned by private for-profit organizations and 27% are owned by private not-for-profit organizations" (Canadian Institute for Health Information 2021).

While the auditor general's report does not address how this mix in ownership complicates the integration challenges they have identified, the suggestion that increasing the share of privately owned options will increase efficiency seems to be more of an austerity/neoliberal ideological argument than one rooted in evidence-based research.

A report by the Ontario Health Coalition (OHC) published in November 2021, bolsters COPE's warnings regarding the privatization of long-term care (LTC). It noted that multiple academic studies have concluded that "for-profit long-term care is worse than public and non-profit long-term care across a whole range of measures and outcomes" (Ontario Health Coalition 2021). Despite this, the report claims that the Ford government will be allocating the majority of new LTC beds, being built in the wake of Covid-19's devastation, to for-profit providers. At the time of publication, the OHC, found that of the 30,436 beds covered in new licenses issued, 16,304 were for-profit, compared to 10,990 non-profit allocated beds and 2,918 public-allocated beds. The report goes further to list the top-10 all-for-profit chains that have garnered the most allocated licenses. The first of these chains, Extendicare, is also reported to 'have more than double the pandemic death rate of public (municipal) homes'. Long-term care has thus become the lone canary in the coal mine with regard to privatization.

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