The People's Healthcare Service (PHS) Canada Needs

I. The Present Situation

Canadians are proud of their publicly funded healthcare system and support is overwhelmingly. Over the past six decades, it has become and remained an immutable Canadian value. Despite this, our federal and provincial governments have underfunded healthcare in relation to need in recent decades and allowed, and at times even fostered, the creeping privatisation of the system. Private corporations have wound their way into the healthcare apparatus ever more deeply and widely, parasitically feeding off it and, inevitably, weakening it.

As Prime Minister, Brian Mulroney reduced social program funding by 25 percent while Jean Chrétien's government reduced it by another 40 percent in 1995, though his finance minister, Paul Martin temporarily halted that trend as prime minister with the 2003 Health Accord. Stephen Harper went further, imposing stringent constraints on healthcare funding transfers to a level well below the growing needs in healthcare services, limiting growth to 3.5%. Although elected on a platform of addressing decades of neglect of healthcare, Justin Trudeau has largely failed to reverse these measures and their harmful effects. Throughout these decades, health funding has generally lagged behind the growth in health needs attributable to population growth, the ever more complex medical needs of an ageing population, and medical science advances that expand available treatments.

In the 1990s, Ontario Premier Mike Harris launched the corrosive privatisation of the long-term care system that has caused so many unwarranted deaths during the COVID-19 pandemic. Many provinces followed his lead. For this assault on our collective well-being, Harris was rewarded with a leading and lucrative executive role in the private sector that continues to encroach on public seniors' care. Quebec and Alberta have instituted private health services delivery of medical procedures such as hip and knee operations and of diagnostic tests previously provided in public hospitals. In drafting Bill 30 (legislation to expand private surgeries) in mid 2020, the Alberta government announced that it is including a process to accelerate the approvals of private clinics carrying out surgeries.

As the list of these privatisations grows, the question of their conformity to the Canadian Health Act (CHA) has come to the forefront. The September 10, 2020, British Columbia Supreme Court decision deemed the setting up of private health clinics illegal, a ruling that could have repercussions for private clinics across the country if upheld on the appeal already announced.

The privatisation drive has been accompanied by relentless centralisation and regional health authorities in seven provinces and territories (Ontario - 2019, Quebec - 2015, Alberta - 2008, Nova Scotia - 2015, Saskatchewan - 2017, Prince Edward Island - 2005 and Northwest Territories - 2016) have been abolished. Centralization makes healthcare services insufficiently responsive to local communities and the results, when they are home to historically under-serviced and marginalised groups with special needs, have been particularly dire. If all this were not bad enough, our health system has never included a wide range of essential medical services like dental care, eye care or prescription drugs, except for minor, partial exceptions involving elderly and disabled people and through it has been publicly funded, it was never entirely publicly owned and controlled.

The privatisation and centralisation processes and practices amount to the slow burner dismantling of our public health system by parasitically draining health professionals, specialised medical equipment and scarce funds out of the public system for the benefit of customers of private healthcare, usually the well-do-do and very rich. This leaves most ordinary Canadians restricted to care from a deprived public system. This two-tier healthcare approach degrades the principle of universality of care, leaves the public healthcare system understaffed and underresourced and poses great obstacles to Canadians 'wellness, including long wait times for treatment and the high, often exorbitant, cost of drugs.

The COVID-19 pandemic has shone a clear light on the cracks, indeed the chasms, in underfunded and corporatized healthcare across Canada. The system was unprepared for the pandemic, despite warnings from scientists and the rising spate of zoonotic viruses that have infected humans. It has generated thousands of avoidable deaths in Canada, particularly in long-term care homes, inflicting immeasurable suffering among COVID survivors, their families and their communities.

If Canada had had a robust, full spectrum, adequately staffed healthcare system when the pandemic began, we would not have faced the draconian social and economic shutdowns of the present intensity, breadth and regularity. The collateral damage and suffering that they generated – such as massive job losses and business closures, social and mental suffering and the sudden, sharp increases in the numbers of excluded and homeless Canadians and the postponement of many scheduled procedures and treatments in the healthcare system – could have been substantially mitigated. We could have reopened our economies, our education systems and our social interaction sooner and with more confidence.

We would not be witnessing bereaved and aggrieved victims' families taking legal action to obtain redress for their losses and suffering via class action suits that will take years to resolve and will not bring back their loved ones. Meanwhile, even as they claim to care for their citizens' health, some provincial governments are pouncing on the fog of COVID-19 (war) via the Omnibus Bill route to limit or block citizens' constitutional right to initiate legal action against private health services providers for often wilful errors and omissions regarding their duty of care.

The unfolding tragedy of long-term care homes amid the pandemic is a damning indictment of our healthcare system. For years now, we have been witnessing numerous outbreaks of preventable deaths-by-influenza in long-term care homes. The opioid crisis is another. Clearly, for our political leaders and their corporate backers, the elderly, the disabled, Indigenous peoples, black communities, racialized communities, women, 2SLGBTQIA+ and others are lower priorities than are corporate profits.

Our leaders must take responsibility for these preventable deaths and the needless pain caused by their underfunding and insidious privatisation, and act on the findings of numerous weighty studies and coroners' findings. Private healthcare providers of long-term care, for instance, extract public health dollars from public long-term care facilities in order to turn a profit on the backs of our most vulnerable citizens and their impoverished healthcare givers. They delayed the reporting of acute COVID-19 cases to the health authorities even as a staggering number of lives were being lost under their watch.

A better way is possible.

II. Our Approach: The Defining Principles

The Green Party under Dimitri's leadership commits itself to redressing these and related inadequacies of Canada's existing healthcare system and to expanding it into a universal, comprehensive, public and publicly funded, decentralised, free-at-the-point-of-use **People's Healthcare Service (PHS)**. It will include dentistry, pharmacare, eldercare, mental healthcare, vision care and hearing care. Healthcare in Canada falls largely under provincial jurisdiction while also being governed by the provisions of the Canada Health Act, with its five criteria (Public Administration, Comprehensiveness, Universality, Portability and Accessibility) and the two conditions (Information and Recognition). Mindful of this, the Green Party under Dimitri's leadership will realise this vision through a combination of energetic initiative on all matters falling under federal jurisdiction and leadership, partnership and incentivisation on all matters falling under provincial jurisdiction.

The People's Healthcare Service will be an equitable quality healthcare service that grants the inalienable human right of all in Canada, including Canadian citizens, landed immigrants, refugees, migrant workers, irregular immigrants and homeless persons, to relevant, effective and efficient healthcare. The Peoples' Healthcare Service (PHS) will be anchored in nine indivisible principles:

1. The People's Healthcare Service will be universal, giving all residents of Canada access to timely, high quality and adequate healthcare.

2. The PHS will be publicly owned and operated, reversing the private and corporate incursion and the resulting service reduction.

3. The PHS will be equitable and include systematic provisions to ensure that historically underserved communities benefit equally from it, and that systemic health deficits of the past are redressed. This will include ensuring their representation on PHS governing bodies at all levels.

4. The PHS will be comprehensive, encompassing all the segments of healthcare services (see III.1 below). This will require replacing the existing private with public provision.

5. The PHS will be free to use and sufficiently resourced.

6. National standards for key elements of the PHS will be established on the basis of a forward-thinking interpretation of the five criteria and two conditions enshrined in the Canada Health Act. These standards will enable the provinces to organise health services in a decentralised manner with regional/local governance structures to meet local needs and priorities better. Indigenous communities will have autonomous health delivery systems.

7. Conformity with the standards will be monitored and measured via a comprehensive compliance regime that will include appropriate data collection and measurement of outcomes and durable impacts, including data relating to the healthcare access and outcomes for historically underserved groups and communities.

8. The PHS will include risk assessment of emerging novel viruses and other health threats arising from social deprivation, environmental degradation and climate change and from any other health-jeopardising phenomena that emerge over time.

9. The PHS will be designed and implemented on the basis of the Social Determinants of Health approach, which recognises that the conditions in which people are born, grow up, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life have favourable or detrimental effects on one's health. Gathering and using data based on these will help identify needs and design interventions to improve the health and wellness of all Canadians.

III. What We Propose

The People's Healthcare Service designed in light of the above principles will have the following features, which we present in three categories.

III.1 Components of the People's Healthcare Service (PHS)

1. Full-fledged primary healthcare, including ensuring that everyone in Canada has a family doctor.

2. A wellness promotion and disease prevention system that will assess all health risks – whether emerging from social, environmental or other causes – and address them effectively. This nation-wide system will replace the present patchwork of programs that attempt to address issues such as the opioid mental health crises.

3. Provision of specialised, intensive and acute care in adequately equipped and staffed publicly owned hospitals and health clinics.

4. Access of Indigenous Peoples to the same standards of care as those enjoyed by other Canadians in a manner corresponding to their ancestral and constitutional rights, implementing, in particular, Jordan's Principle to:

    a) deliver care without delays in sufficient quantity and quality on reserves and in the off-reserve communities in which Indigenous peoples live;
    b) support Indigenous peoples in (re)building healthcare systems based on traditional healing approaches and customs;
    c) ensure that Indigenous peoples receive adequate and equitable funding, including redress (reparations) for past funding shortfalls and for historical and current omissions and inadmissible practices in the design and provision of healthcare for them, and;
    d) ensure Indigenous control over the design, implementation and administration of their healthcare systems and their prerogative to conclude health design and delivery agreements with Canadian or foreign entities.

5. Seniors' and disabled persons' care in all of its facets:

    a) support services to enable seniors and disabled persons to live at home, including in-home nursing and health aid services, home visits by doctors when required and access to social support programs and networks;
    b) sufficient supply of accessible housing for seniors and disabled persons;
    c) publicly owned/community administered seniors care facilities, including assisted living and long-term care homes;
    d) frontline staff-to-patient ratio ceiling set at 5 to 1 not counting administrative and managerial staff, and providing lower ratios for patient populations with complex and/or multiple health conditions;

e) full-spectrum PPE and other worker and patient protection supplies and equipment;
f) protocols, training and mechanisms designed to ensure that the family caregivers of seniors and disabled persons confined to care homes will be able to continue to assist in times of pandemics, and;
g) significant increases in funding seniors' and disabled persons' care facilities as part of the drive towards adequate funding and the recognition of the historic underfunding in this sector.

6. A universal free prescription drug program that includes alternative treatments of proven effectiveness and safety and does not arbitrarily delist drugs to cut costs. It will be supported by nationally pooled bulk-buying mechanisms designed to reduce drug costs of medications while serving all patients and health units.

7. A national mental health strategy and a suicide prevention strategy to address the growing anxieties plaguing Canadians beset by inequality and poverty, the growing precariousness of work and the lack of affordable housing, the climate crisis, social isolation, resurgent racial aggression and ethno-nationalism, and other harms and risks.

8. A universal, free dental care program that covers dental prostheses and other assistive devices.

9. A universal, free eye care program that covers glasses and other assistive devices.

10. A universal, free hearing care program that covers hearing aids and other assistive devices.

11. Free, timely and equitable access to the full range of diagnostic tests and medical exams.

12. Free and equitable access to health assistive devices including up-to-date prosthetics, wheelchairs, AI assisted instruments, oxygen tanks, CPAP machines, and a host of other wellness support equipment.

13. Free access to all professional health services including counselling, psychological and psychiatric services, physiotherapy, osteopathy and chiropractic care.

14. Prioritisation and expansion of reproductive care, including safe abortion services and meaningful reproductive choices for all, with particular attention to marginalized and racialized Canadians.

15. Access to gender confirming interventions and healthcare, and prohibition of cosmetic genital surgeries on sexually ambiguous children.

16. Increased funding to community-based non-profit organizations delivering frontline health-enhancing services, including testing drugs and providing naloxone kits to treat overdoses, and providing in-home services, day programs, health appointment accompaniment and others.

III.2 Health Workers' Rights and Training

17. Equitable and fair salaries and more appropriate organisation of work and health worker support to alleviate unacceptable workloads and improve working conditions.

18. Assured full-time employment for health professionals at a single institution in accordance with improved labour standards to enhance health workers' safety and reduce the spread of infectious diseases between facilities and in the community.

19. Improved, fair medical treatment, support programs and prosthetics policies by working with provincial governments to strengthen the health provisions of their workers' compensation programs.

20. Significantly increased training capacity for all healthcare professions to ensure an adequate supply of trained personnel to meet the increased staffing requirements of the People's Healthcare Service (PHS) as well as to meet staffing challenges during public health emergencies such as the present pandemic.

21. An external expertise-sharing and capacity-building service to support management teams of all healthcare entities including hospitals, clinics and long-term care and disabled persons' facilities, in times of crises and pandemics.

III.3 People's Healthcare Service's Legal, Structural, Compliance and Financial Framework

22. Increased resources and authority for Statistics Canada to collect and process data on localities, Equity Seeking Groups and other territorial and specific demographic groups, as necessary, to fulfil the disease prevention and health promotion mandate of the PHS and to implement the Social Determinants of Health approach.

23. A nation-wide public judicial enquiry into the federal and provincial governments' response to COVID-19, including the shortcomings and strengths of the seniors' and disabled persons' care institutions with full investigative powers, including the authority to subpoena, to determine responsibility for shortcomings and to make recommendations for the improvement of all concerned institutions.

24. A rigorous inspection-and-compliance infrastructure to monitor and audit, including through unannounced visits, of all healthcare institutions, with special consideration for seniors' and disabled persons' care facilities.

25. Redress and restitution of past funding shortfalls and historical and current omissions and inadmissible practices in the design and provision of healthcare for Indigenous peoples.

26. Replace, in consultation with the provinces and doctors' associations, the fee-for-service model of doctors' remuneration with a negotiated salary or fee-and-salary model to eliminate the dysfunctions associate with the present doctors' remuneration system.

27. Incentivize provinces to establish, re-establish or strengthen local/regional health authorities/boards in order to ensure a measure of community-based governance and control over the setting of health services priorities and their planning and delivery.

28. Decriminalise drug possession to curtail epidemics of drugs abuse, and adopt harm reduction strategies including safe drug injection sites, appropriate medication and clean equipment and medical support to addicts and recovering addicts.

29. Strengthen the approval process of new drugs, vaccines, medical intervention procedures and medical equipment with a combination of independent scientific/medical expertise and stakeholder oversight to raise public confidence in their effectiveness and safety, and to meet the demand for the Health Canada review of urgently needed new treatments.

30. Review Canada's present drug patent laws and provisions and restructure drug production and supply to prevent profiteering by Big Pharma and to encourage the production of financially accessible generics, in Canada and abroad.

31. Strengthen the right of citizens to sue the government or its third-party agencies, and to obtain financial compensation and/or reparatory action, in cases of misfeasance, negligence, inadequate care and failure of duty of care, superseding any provincial legislation or policy to the contrary. This measure will include financial and technical support for people of insufficient financial means to launch legal proceedings, on their own or via a class action.

32. Review and reconfigure the mandates of key professions such as doctors, specialists, nurse practitioners, nurses, midwives and pharmacists in order to improve the planning and delivery of healthcare and to maximise the contribution and impact of each profession.

33. Protect the public blood service by prohibiting for-profit blood collection services and by launching a public education campaign on the economic, political and ethical superiority of blood donation as a 'gift relationship,' as Richard Titmuss called it.

34. Establish a permanent and continuously updated national storage bank of Personal Protective Equipment (PPE) and critical medical equipment and drugs. This bank will be coupled with a national production and purchasing program to ensure the reliable supply of these items.

35. Create a national public drug authority within the People's Healthcare System (PHS) whose purpose will be to enhance Canadian drug sovereignty through made-in-Canada pharmaceuticals and Canadian-controlled supply. Its mandate will be to:

    a) establish a national publicly controlled consortium of university and government drug research and development laboratories with the mandate to create and test new drugs, vaccines and multi-drug therapeutic regimens, and expand its capacity to initiate international collaborations with similarly mandated institutions;
    b) establish a National Pharmaceuticals Policy that will define maximum pharmaceutical prices and oversee supply and timely distribution to all people and regions of Canada in an equitable manner;
    c) ensure the progressive elimination of private and corporate interests in drug research, development and production, and;
    d) ensure the ongoing availability to Canadians of pharmaceuticals in times of great domestic and international demand, including by prohibiting the export and sale of drugs to non-residents, when it is deemed necessary to protect Canada's drug supply.

36. Take the following measures to support and strengthen the World Health Organisation (WHO):

    a) conclude agreements with the WHO and its member States to centre its mandate on the early detection of global health threats and challenges, among other responsibilities, and on the effective orchestration of the world response to these;
    b) enhance the mandate of the WHO by assigning it a scientific data gathering, analysis and dissemination function on the social determinants of world health and on the emerging health threats and challenges;
    c) work with other member states to modify the funding sources and structure of the WHO to ensure its independence, including by eliminating tied funding by governments and funding from private donors, philanthropists, Big Pharma and other medical corporate interests;
    d) mandate the WHO to build added capacity to support countries without the financial and technical means to effectively address emerging global health threats and challenges on their own;
    e) work with other member states to strengthen the WHO's critical events/crisis management and rapid response/intervention capabilities;
    f) support the WHO against unwarranted attacks from external entities, and;
    g) reinstate the Global Public Health Intelligence Network (GPHIN), the early warning system that alerts Health Canada of potential disease outbreaks or other health threats around the world while supplying the WHO with the findings of this network, thereby strengthening the latter's quick threat assessment and global emergency coordination capabilities.