



- crime threat assessment. Vienna, Austria: UNODC; 2010. 303 p. Available from: https://www.unodc.org/documents/data-and-analysis/tocta/TOCTA_Report_2010_low_res.pdf
- United Nations. Transforming our world: the 2030 agenda for sustainable development. New York City, New York: UN; 2015. 41 p. Available from: <https://sustainabledevelopment.un.org/post2015/transformingourworld/publication>
 - Elder D, Kuentz M, Holm R. Antibiotic resistance: the need for a global strategy. *J Pharm Sci* [internet]. 2016 [cited 2019 Jan 09]; 105(2016): 2278-2287. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/27397433> DOI: 10.1016/j.xphs.2016.06.002
 - Mackey T, Liang B, York P, Kubic T. Counterfeit drug penetration into global legitimate medicine supply chains: a global assessment. *Am J Trop Med Hyg* [internet]. 2015 [cited 2019 Jan 09]; 92(6): 59-67. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/25897059> DOI: 10.4269/ajtmh.14-0389
 - Kelesidis T, Falagas M. Substandard/counterfeit antimicrobial drugs. *Clin Microbiol Rev* [internet]. 2015 [cited 2019 Jan 09]; 28(2): 443-464. Available from: <https://cmr.asm.org/content/28/2/443> DOI: 10.1128/CMR.00072-14
 - World Health Organization. Study on the public health and socioeconomic impact of substandard and falsified medical products. Geneva, Switzerland: WHO; 2017. 67 p. Available from: <http://www.who.int/medicines/regulation/ssffc/publications/se-study-sf/en/>
 - Akinyandenu O. Counterfeit drugs in Nigeria: a threat to public health. *Afr J Pharm Pharmaco* [internet]. 2013 [cited 2019 Jan 09]; 7(36): 2571-2576. Available from: DOI: 10.5897/AJPP12.343
 - World Health Organization. Survey of the quality of selected antimalarial medicines circulating in six countries of Sub-Saharan Africa. Geneva, Switzerland: WHO; 2011. 114 p. Available from: https://extranet.who.int/prequal/sites/default/files/documents/WHO_QAMSA_report_1.pdf
 - Bate R, Jensen R., Hess K, Mooney L, Milligan J. Substandard and falsified anti-tuberculosis drugs: a preliminary field analysis. *Int J Tuberc Lung Dis* [internet]. 2013 [cited 2019 Jan 09]; 17(3): 308-311. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/23321423> DOI: 10.5588/ijtld.12.0355
 - World Health Organization. Antimicrobial resistance: global report on surveillance. Geneva, Switzerland: WHO; 2014. 232 p. Available from: http://apps.who.int/iris/bitstream/handle/10665/112642/9789241564748_eng.pdf?sequence=1
 - O'Neil J. Tackling drug-resistant infections globally: final report and recommendations. London, UK: Government of the United Kingdom; 2016. 80 p. Available from: https://amr-review.org/sites/default/files/160525_Final%20paper_with%20cover.pdf



Privatization to Preserve Canadian Public Healthcare

Opinion Editorial

Alexander Babony, Bachelor of Arts and Social Sciences, English and Political Science at University of Windsor

Introduction

The debate over the benefits of public vs. private healthcare services in Canada is stifled by passion, ignorance, and an obscure concept of national identity. While most Canadians agree there should be some form of taxpayer-funded health insurance, disagreements arise over what extent the government should be involved in providing this. The prospect of further privatizing healthcare is something few politicians have had the courage to address. Ontario Premier Doug Ford was recently forced to comment on leaked documents which, according to the opposition New

Democratic Party, suggested that his administration was scheming to implement some degree of increased privatization in Ontario.¹ The public backlash to the alleged plan was swift and harsh. Directly contrary to popular opinion, this article will make the case for Canadians to embrace a new dynamic which allows for a private healthcare industry while preserving the public system that many in our country currently rely on. It will address the merits of this rationale from a values-based and economic perspective in an attempt to convince readers on both sides of the political spectrum.



History

The development of taxpayer-funded healthcare began in the post-World War II period. This was particularly motivated by widows of fallen soldiers and women who were temporarily employed (while most of the country's men were overseas) but could no longer pay to provide care for themselves once the war had ended. In 1947, the Saskatchewan government was the first to introduce publicly-funded health insurance. Other provinces soon followed suit. Since women were heavily outnumbered by men in the workforce, women in particular benefitted from public healthcare by having more control over their treatment and preventative care options as husbands and/or fathers were no longer necessary brokers in the process.² Public health insurance expanded healthcare accessibility to all Canadians at a time when the average household income was considerably lower than it is today.² Since then, representation of women in the workforce has grown. They are earning more money and are more independent than at any time in modern Western history. The structure of contemporary Canadian healthcare was developed for a much different country than it is today. By modernizing the system, Canada could build on the progress which began over 50 years ago. The most morally and fiscally responsible way to do this is to allow Canadians a choice between public or private health facilities.

Improving Care

Allowing for private healthcare facilities to build alongside public ones would lessen the burden currently on the shoulders of the public system.³ While in many ways still similar to the UK and Australian public-private mix framework, the structure proposed in this paper would have both systems operate independently. This is unprecedented in developed countries. By no longer forcing Canadians to receive taxpayer-funded services, this would provide those who can afford it with more treatment options, while allowing the public system to decrease wait times in emergency rooms and for elective surgeries, and improve the level of care and accessibility for patients. In Australia, private healthcare has been credited with enhancing, "Access to timely elective care... and individuals' choice of provider and care options."⁴ Going up against a public system, the private sector has to compete by providing better facilities and services, faster treatment, and

competitive prices. In the UK, "Private care users fare better than public users in obtaining medical care at short notice, having more agreeable opening hours for treatment and getting appointments for treatment with less difficulty".⁵

In contrast, a CBC news article reports that Canadian public health insurance has resulted in a number of clinics limiting patients' appointments to "one issue per visit," in a bid to maximize profitability and increase the number of people seen.⁶ This dynamic highlights an inherent barrier to receiving proper medical treatment in Canada. A fully independent private facility however, provides greater incentives to spend adequate time with patients, and rewards better doctors who are able to earn more based on the demand for their services.

To provide context, provincial Workers' Compensation Boards (WCB) effectively operate alongside public funding in many ways, similar to how a public/private split would. Since WCB covers the costs of missing work and for treatment of injured workers in place of the public system, it has a vested interest in getting workers treated as quickly and effectively as possible to minimize time off work and complications from delays. For example, the British Columbia WCB provides lucrative incentives to doctors/surgeons for expedited and high-quality treatment.⁷ One argument often made against this is that worker's compensation recipients are accused of "jumping the line" in front of more medically-necessary patients. This is one major point in favour of having completely separate private facilities altogether. To be clear, it means that public medical centres would be used only by those billing public insurance providers; and private facilities used only by persons with private funds/insurance. An added benefit of separating the two is that it eliminates the possibility that taxpayers will incur the extra costs of private care providers who might bill for tests/treatments that are not actually needed.

Cost of Public Healthcare

This proactive approach is critical to prevent the inevitable eclipse of a public healthcare funding crisis. Provinces in Canada already spend an average of over 40% of annual budgets on health services and this share is growing rapidly with the increasing proportion of aging Canadians.⁸ In the last fifteen years alone, health care spending has increased 116%.⁸ Privatizing is an opportunity to "reduce costs and demand



pressures on public hospitals”.⁴ Efficiencies in government spending are increasingly hard to come by and Ministry portfolios such as education, environment, infrastructure, and correctional services have little room for spending cuts. The only other option is to add to debt which, in a province like Ontario, with a nearly \$350 billion deficit, is lunacy.⁹ This province owes more than 75% of countries in the world do; the status quo cannot continue.⁹ Since 2011, merely eight years of unchecked Liberal spending ago, Ontario has added another roughly \$115 billion to the public credit card.⁹ That’s a 33% increase in less than a decade.

If Canadians truly care about maximizing quality and ensuring the sustainability of public healthcare for future generations, increasing privatization is the only path forward.

REFERENCES

1. Mandal, J, Ponnambath DK, Parija SC. Utilitarian and deontological ethics in medicine. *Trop Parasitol* [Internet]. 2016 Jan [cited 2019 Mar 6];6(1):5-7. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4778182/>
2. Cause of death [Internet]. Washington DC: World Bank; 2019. Cause of death, by communicable diseases and maternal, prenatal, and nutrition conditions (% of total); 2019 [cited 2019 Jan 20]; [bottom of page]. Available from: https://data.worldbank.org/indicator/SH.DTH.COMM.ZS?year_high_desc=false
3. Bourzac K. Infectious disease: Beating the big three. *Nature* [Internet]. 2014 Mar [cited 2019 Jan 20]; 507(7490):S4-7. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/24611168>
4. Neglected tropical diseases [Internet]. Geneva Switzerland: World Health Organization; 2019. Summary; 2019 [cited 2019 Jan 20]; [full document]. Available from: https://www.who.int/neglected_diseases/diseases/summary/en/
5. Global observatory on health R&D [Internet]. Geneva Switzerland: World Health Organization; 2019. R&D funding flows for neglected diseases (G-FINDER), by disease, year and funding category; 2018 Jan [cited 2019 Jan 20]; [April 2017 version]. Available from: https://www.who.int/research-observatory/monitoring/inputs/neglected_diseases_April_2017/en/
6. Global Health Observatory (GHO) data [Internet]. Geneva Switzerland: World Health Organization; 2019. Disability-adjusted life years (DALYs); n.d. [cited 2019 Jan 20]; [full document]. Available from: https://www.who.int/gho/mortality_burden_disease/daly_rates/text/en/
7. Health statistics and information systems [Internet]. Geneva Switzerland: World Health Organization; 2019. Disease burden and mortality estimates; 2018 [cited 2019 Jan 20]; [DALY estimates spreadsheet]. Available from: https://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html
8. Keenan JD, Hotez PJ, Amza A, Stoller NE, Gaynor BD, Porco TC, Lietman TM. Elimination and eradication of Neglected Tropical Diseases with mass drug administrations: a survey of experts. *PLoS Negl Trop Dis* [Internet]. 2013 Dec [cited 2019 Jan 20];7(12):e2562. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3855072/> DOI: 10.1371/journal.pntd.0002562
9. Global Malaria Programme [Internet]. Geneva Switzerland: World Health Organization; 2017. A framework for malaria elimination; 2017 [cited 2019 Jan 20]; [pages 60-69]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/254761/9789241511988-eng.pdf;jsessionid=DD837419590B077A8558B209EC83D11A?sequence=1>
10. European Respiratory Society [Internet]. Geneva Switzerland: World Health Organization; 2014 Aug. Framework towards TB elimination in low-incidence countries; 2014 Aug [cited 2019 Jan 20]; [first page]. Available from: https://www.who.int/tb/publications/Towards_TB_EIminationfactsheet.pdf?ua=1
11. Fact sheets [Internet]. Geneva Switzerland: World Health Organization; 2019. Dracunculiasis (guinea-worm disease); 2018 Apr [cited 2019 Jan 20]; [first page]. Available from: <https://www.who.int/en/news-room/fact-sheets/detail/dracunculiasis-guinea-worm-disease>
12. Fact sheets [Internet]. Geneva Switzerland: World Health Organization; 2019. Yaws; 2018 Feb [cited 2019 Jan 20]; [first page]. Available from: <https://www.who.int/en/news-room/fact-sheets/detail/yaws>
13. Li XX, Zhou XN. Co-infection of tuberculosis and parasitic diseases in humans: A systematic review. *Parasit Vectors* [Internet]. 2013 Mar [cited 2019 Jan 20];6:79. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3614457/> DOI: 10.1186/1756-3305-6-79
14. Noblick J, Skolnik R, Hotez PJ. Linking global HIV/AIDS treatments with national programs for the control and elimination of the Neglected Tropical Diseases. *PLoS Negl Trop Dis* [Internet]. 2011 Jul [cited 2019 Jan 20];5(7):e1022. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144180/> DOI: 10.1371/journal.pntd.0001022