Courage My Friends Podcast Series III – Episode 1
Privatization of Public Health:
Protecting Universal Healthcare for the Common Good

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ANNOUNCER: You're listening to *Needs No Introduction*.
Needs No Introduction is a rabble podcast network show that serves up a series of speeches, interviews and lectures from the finest minds of our time

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COURAGE MY FRIENDS ANNOUNCER: COVID. Capitalism. Climate. Three storms have converged and we're all caught in the vortex.

STREET VOICE 1: I was already worried about my job, food and housing. So now I have to worry about healthcare as well?

STREET VOICE 2: Seems like we wanna jump back to normalcy so bad that we're not even trying to be careful at this point.

STREET VOICE 3: This is a 911 kind of situation for global climate crisis. This planet is our only home and billionaires space-race is not a solution. The earth is crying for survival. It is time for action.
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COURAGE MY FRIENDS ANNOUNCER: What brought us to this point? Can we go back to normal? Do we even want to?

Welcome back to this special podcast series by rabble.ca and the Tommy Douglas Institute (at George Brown College) and with the support of the Douglas-Coldwell-Layton Foundation. In the words of the great Tommy Douglas…

VOICE 4: Courage my friends; 'tis not too late to build a better world.

COURAGE MY FRIENDS ANNOUNCER: This is the *Courage My Friends* podcast.

RESH: Universal Healthcare in Canada. It was Tommy's gift to us. And since then it has become a hallmark of our identity, a source of national pride and a steadfast Canadian value. But what do decades of erosion and current threats of privatization mean for our public healthcare systems? And what does this say about us now? Welcome back to the *Courage My Friends Podcast*. I'm your host, Resh. Budhu.

In our first episode of this season, *Privatization of Public Health: Protecting Universal Healthcare for the Common Good*, we are very pleased to welcome President of the Ontario Public Service Employees Union, JP Hornick and Palliative Care Physician and Health Justice Activist, Dr. Naheed Dosani.

JP, Naheed, welcome.

JP: Thank you.

NAHEED: Thank you for having us on.

RESH: Lovely having you here.

So it's ironic, perhaps bittersweet that in the opening to this season's *Courage My Friend's Podcast,* named for the famous quote by Tommy Douglas who is the father of Universal Healthcare in Canada, we're talking about the threat of healthcare privatization.

So to get us started, JP, why is universal healthcare so important to the common good?

JP: Well, I've been saying for a long time now that public healthcare and public education are the pillars. I think of any strong democratic society. I mean, these are literally the spaces that we have created collectively to care for one another, to connect with one another.

And we do so without an eye toward profit or power over, but rather literally a foundation of care. Citizens who are healthy, who are educated; these are the ones who can actively participate in civil society. This is where we make strong communities. This is how we demonstrate that we are in it together in a literal, quite a visceral way . So I think keeping profit out of healthcare is an essential feature of building a society that works for all, rather than a privileged few.

RESH: Indeed. And now we are certainly not the only country to have universal healthcare. Nevertheless, universal healthcare has been inscribed into the national identity as a Canadian value. As a healthcare worker and a health justice activist Naheed, what does universal healthcare mean to you?

NAHEED: You know, I think it's important to recognize that while, here in Canada, we enjoy our public healthcare system, we have a, healthcare system that's publicly funded, but privately delivered. And, while we pride ourselves on that public healthcare system aspect, what's really coming to light is that there has been a push towards privatization.

And, when I work on the front lines, I cannot tell you how important public healthcare is. It allows for people to get access to care without paying - although it comes from "taxes" - people who cannot afford or would not normally afford healthcare, can gain access. People who are marginalized are able to gain access.

Through bulk purchasing power and our collective force, we're able to actually bargain for cheaper prices. We are in a position as a society to care for each other. And that collective good is important.

I mean, at the end of the day, never forget that the goal of privatized healthcare is to provide profits for shareholders. Meanwhile, the goal of public healthcare is to provide healthcare for people. And I think at its core, that's what this is all about. People matter more than profits.

RESH: Okay. And this very much goes within your purview of health justice as a health, justice activist. And just so that we can understand a bit more of what that is, Naheed - What is health justice?

NAHEED: So in my day to day work, I work as a Palliative Care Physician and I provide healthcare for people who experience structural vulnerabilities like poverty and homelessness. And this puts me on the front lines of healthcare, particularly for people who suffer from health disparities and inequities, even though we have a "universal" healthcare system.

When I think of health justice, I think of how we are making the leap from equality to equity to justice. Equality is when we give people the same things to be happy and healthy. And that's kind of what our Canadian healthcare system technically offers currently. And I think we do an okay job of that actually.

Where we sometimes, don't, really, hit the mark is with equity. In an equity based healthcare system, people would get what they need to be happy and healthy.

And moving it further, in a health system that's based on justice, people would get the resources they need to make their own decisions about what they need, when they want, how they want, where they want it. And so, in conversations like this, we're often striving for health justice.

We have a long, long way to go. And, publicly funded healthcare is a core pillar to a health system that's really founded and anchored in justice.

RESH: Okay. And JP, could you speak a bit more to the union perspective?

JP: Yeah, for sure. I mean, For OPSEU/SEFPO we represent over 25,000 members in the hospital professional divisions who work in 250 different types of jobs in 80 hospitals across the province.

When I think about healthcare and the union perspective, it's really thinking about it beyond just a single slice of healthcare. We all think of, you know understandably nurses and doctors. But these other folks are working in the medical lab, there's technologists, there's technicians and radiation technologists, respiratory therapists, phlebotomists, profusionists, pharmacists, pharmacy tech. Paramedics. We have ambulance dispatchers in the broadest possible spectrum. Social work, physiotherapy. We have 15,000 members who are home-care workers, personal support workers.

When I think about labor and healthcare, I'm thinking about it in terms of healthcare as a wrap-around service for each and every patient in Ontario, but also their families, their communities, their friends.

So labor and healthcare is looking at fighting off privatization and the profit motive in ways that are often unseen and in ways that are often unaccounted for, but have direct and immediate impact in people's lives. So for example, without accurate and timely medical testing, doctors can't perform their duties and patients don't get the care that they need.

When we're looking about the crisis in long term care. When we look about, the privatization of things like Canadian blood services, where we've just entered into an agreement with Grifols - which is a, private firm outta Spain - about plasma. These are how we start to hive-off and chip away at the foundation of public healthcare funding. Right?

When we are looking at labor, we have to look at it as a bulwark against increased privatization within healthcare, which allows us to protect Ontarians going forward. And protect what we consider to be this really sacred sense of ourselves.

The low funding that's happening in healthcare. I mean, Ontario funds its public hospitals at the lowest rate of any province in Canada. And we have the fewest hospital beds per person. But we also have as a result, an ongoing staffing shortage in every area of frontline and back-of-house services that actually sustain public healthcare. These are the folks that even though unseen often are the ones that provide those key services that allow us to run well. So when you have a Premier who talks solely about beds, who talks solely about one aspect of the sector, it allows them to ignore and hive-off those parts of healthcare that are essential cradle to grave patient care. And that actually are what allow us to move forward in ways that make sure that people are taken care of where they are, rather than based on their income, based on their social location. Right.

We have to fight hard to protect what we have, but also to build back what we used to have. And unions are the front line of that, because of the vast array of healthcare workers that we represent.

RESH: Right. And it is such as you say, such a complex network, of all of these different, professions and sectors that make up our healthcare framework and healthcare, again, as both of you have pointed out is such a fundamental part of our security of our social security, every kind of security within our society.

JP: Can I add one little thing to this? When I'm talking about this broad healthcare network, I think there's also a broad kind of progressive movement network that needs to be formed in order to protect these services too.

So when I think about the labor movement plus progressive political parties, plus members of the broader community. We all need to work together to demand an end to this agenda of privatization. We need to work together - and I really I think this is

boots on the ground, bodies in the street - toward increased funding and progress in moving toward a comprehensive public healthcare system that includes mental health, dental health, all forms of healthcare. Right? We need to really look at where do we wanna be and how can we work together to get there. And labor is a key part of that.

RESH: Absolutely. And in order to understand what we're in danger of losing, I want to go back a bit to really understand what it is that we're trying to protect Naheed you've already talked about how we pay for universal healthcare out of the public purse for the public good. But could you say a bit more about how universal healthcare actually works.

NAHEED: Yeah. So I think this social safety net, this social protection which is our public healthcare system, doesn't come out of thin air. It is something that is, created, through a collective will, collective solidarity and collective good to paying in towards a public system, through our public tax dollars. And, this money is obviously collected, particularly at the federal level. And through healthcare transfers, this money is transferred to the provincial level. And in jurisdictions across Canada, the way the money is spent is typically up to the jurisdictions in each province and how they choose to allot that money. So long as the Canadian Health Act is followed - Which is a national agreement that all the provinces agreed to. Ensuring that people don't have to pay for their healthcare.

We have a publicly funded healthcare system, but it's privately delivered. And in many instances in the provinces that public money is then given to private entities to deliver the care.

In most cases those entities are not-for-profit, but in some cases they are for profit. And I think that's where some people may get confused. You know, I have many friends and people say to me, but when I present my OHIP card, for example, here in Ontario or my Health Card, healthcare is "free" to me.

But that doesn't mean that there isn't the entity of private healthcare in the background. It's always been there to some degree.

I think why we're having this conversation today is cuz we're, hearing that our provincial governments are essentially talking about expanding the private for-profit entity that was there before.

And, so yes, you can have the expansion of private for-profit healthcare in a public healthcare system which ultimately, as JP has so well articulated, can erode the public healthcare system.

It's not coming out in direct words. It's not being said directly. We're often hearing code words, like "innovation" being used, but that often is just a code word for further privatization.

RESH: Absolutely. And JP, did you want to add on in terms of how universal healthcare works or is supposed to work?

JP: I think that Naheed really hits it on the head. Like these code words that are being used such as "innovation". I mean, the irony is that the greatest innovations in society have come from the public sector when they're funded. And what we have is a deliberate attempt to starve the system or that tactic called "starving the beast". So that private options start to look more and more attractive. And like the only way out of what is a deliberately created funding crisis.

It would be one thing if Ford said: I'm just gonna build all these private hospitals. Except they're banned Ontario. As they have been since the seventies, we only have three of them. They were grandfathered in.

But the ban on private hospitals is important because when you introduce the profit motive, you're not improving capacity. Whenever you expand privatization in healthcare, you're siphoning valuable resources away from the public system and you're looking at putting those resources into the pockets of large for-profit companies and corporations.

So healthcare privatization, or the expansion of privatization in the public system, is as Naheed said - it's false to say you just present your OHIP card and everything's free. Because there are also these ancillary fees that get introduced in these private clinics, that get introduced in these private services. So things don't remain free.

What happens is you create over time a tiering of the healthcare system. So those with means and resources have access to better healthcare than those without.

It simply means that we create a society that is dystopian. Your value as a human being is linked to your ability to produce or retain wealth.

And that is not a society that I think that any Ontarian wants to live in.

RESH: Over the last two years of the pandemic, we've seen incredible strain that was put onto healthcare systems. And in the last couple of months, there have been these dire warnings that public healthcare, at least in Ontario, may be on the verge of collapse. So Naheed, are we on the verge of collapse? And what does that right now look like to you?

NAHEED: You're absolutely right to talk about COVID. Undoubtedly, I think we all know COVID had a major impact on our society, but certainly our healthcare system. And has kind of left a real, trauma that has been sustained. Where the healthcare system is in a state of shock. And that state of shock continues.

Health workers face moral injury, compassion fatigue, burnout. And all the while our governments have made decisions around policy that have only made the situations worse when it comes to the pandemic. Such as, eliminating COVID protections.

More recently removing the five day mandatory isolation rules for COVID, which will undoubtedly have an impact on our volumes and wait times and hospitals as we go into the fall and winter months.

And one of the things that has come out of this is poor staffing and understaffing because staff are feeling burnt out. Because our systems don't pay staff enough.

In the meantime we've seen private entities, private nursing agencies - their original purpose, was to provide coverage and fill holes when publicly funded nurses and hospitals weren't available. And what we've seen is actually nurses in many cases who are feeling burnt out and underpaid and undervalued from the public healthcare system - and I totally get where they're coming from - are moving towards the private nursing agencies where they are sometimes paid double. And so what you're seeing in some hospital floors across the province is you'll have a nurse who's getting paid $120 an hour by a private agency working alongside a public nurse who's being paid $60 an hour. So what do you think's gonna happen?

We're seeing nurses leaving the profession in droves. Moving towards the private entity. The private agencies are lining their pockets with profit. And this is all public dollars that is doing this. It's actually an inefficient use of public dollars that is actually just creating profits for a third party.

To actually fix this just fund public healthcare, pay nurses, what they deserve, give them their benefits, give them their overtime pay, give them paid sick days. I think we'd be in a better place.

This is a really good case study of how private healthcare is, impacting, our healthcare system that's in the state of shock due to COVID-19. You can see this becoming more and more common. And it needs to stop.

RESH: So we are seeing a major siphoning from the public sector, the public purse into the private sector, as you say, nurses are, a great example of bleeding from our public institutions into these private clinics and private practices.

JP, could you come in on this and talk about what has been happening in terms of labor policy? Certainly during COVID, but also from before.

JP: Yeah. I mean it's not just nursing. That level of burnout, compassion fatigue, exhaustion, lures into the private clinics; these are things that are affecting all of the healthcare workers that I was talking about earlier. And then you look at what's happening to the paramedics and the dispatchers on the front-lines in terms of even getting patients into this system and the way in which they're faced with emergency rooms that are shut down, right? Closing in smaller communities, and getting closer and closer to major urban centers too. Because it's a deliberate strategy of starving, the system of resources.

I mean, it's clear with Ford and the Conservative Government in Ontario that they're pursuing this policy of increased health privatization. But he's also leading this push among provincial premiers to further this healthcare privatization agenda nationally. And it's building on this willingness among governments - and it's not limited to Conservative governments, there are past Ontario provincial governments who did this - to look to privatization to reduce the cost to government, transfer the cost to citizens and introduce opportunities for private healthcare providers - their friends - to profit.

So you've got a kind of perfect storm that COVID maximized a crisis that was already existing. Decreased funding, unanticipated service cost, then you throw in on top of that supply-chain issues, particularly around PPE, but also, tools and resources. And then you've got an ongoing problem with recruitment and retention of staff. These are the new realities that hospitals have to tackle at the same time, trying to care for patients. And they're not allowed to carry deficits. So in the absence of additional funding, it means that the choices that hospitals regularly resort to are service cuts in order to try and balance budgets.

But all this comes back to a very simple thing. It is a failure to adequately fund healthcare, both before and during the pandemic. And then the deterioration of the public system that results is used as an excuse in itself for increased privatization as an answer to a , as you both said, "broken system." That's the rationale we're faced with, actively promoted by Doug Ford, by the Health Minister, Sylvia Jones, by their communications guru, Nick Cavalas. And they're gonna look at all options and they're gonna fix healthcare. Except the options they're not looking at are the ones that are the answer, adequate funding and removing the profit motive.

These are distinct and deliberate choices. This government had no mandate for privatization and they have never tested this outside of post-election victory. But increasing privatization as a way to solve a crisis in staffing, a crisis in funding, it is foolish, it is dangerous and it is disingenuous.

Disguising it as innovation. It doesn't respect or value the expertise, the dedication of those healthcare workers who have been working throughout the pandemic to provide this care with fewer and fewer resources, but who are involved in the entire arc of patient care. And that's what is gross.

RESH: And, even in that innovation speaking to the newness, this isn't actually all that new. I mean, the pandemic as many have pointed out was not the beginning of this crisis, but merely the breaking point. And JP, you actually penned a letter to Ontario's Minister of Health, Sylvia Jones. And you wrote: "You are using the collapse you created as an excuse to sell off our public healthcare system." So again, going into this point that this is a very deliberate strategy by the government.

JP: Absolutely. What Ford is doing right now is gonna make the healthcare staffing crisis worse. We're having people enticed outta the public system by these private companies, by these private clinics as Naheed said. But when we're looking at it,

there's no new capacity that's introduced into the healthcare system; just an introduction of new ways for private companies to profit.

You've got Bill 124 and the Wage Cap legislation for public service workers. These are things that deliberately make it less attractive to participate in public service, which again is the foundation of who we are in Ontario and in Canada.

RESH: And Naheed, you also share this view that this collapse that we're looking at, isn't just an inevitable outcome of pandemic. In a recent interview, you spoke of this also as a deliberate and an insidious strategy. And to quote you, you said: "It's to make people feel frustrated. To make people think that a private system would be better. To make people feel like they want to give up on an equitable system for all." Was this therefore a foreseeable crisis?

NAHEED: You know, as the famous philosopher and activist Noam Chomsky once said,that's the standard technique of privatization: "Defund. Make sure things don't work. People get angry. And then you hand it over to private capital."

It's happening right under our noses. This is Disaster Capitalism! And as a health worker, who worked on the front lines of the COVID 19 pandemic, this is absolutely insult to injury. And as JP has mentioned, insult to injury to every worker who contributes to the collective good that is our public healthcare system.

I can't believe that after all we've gone through in our COVID-19 pandemic, that this is now the response of our Ontario government. If anything, the COVID-19 pandemic should have shown us the importance of a public healthcare system and what a solid public healthcare system, could and should be.

And so the way that this is being presented, the way that this is being pivoted by the Ontario government is a dangerous rhetoric. It is disaster capitalism at its best. And it is a false narrative that because of the pandemic this has happened.

This is due to years of chronic underfunding and support of our public healthcare system. And what they're trying to make people feel is that the answer is privatization, that the innovation that's needed is privatization. But private-for-profit healthcare is not the answer investing in our public healthcare system is. By investing in public healthcare, we have the potential to improve our primary care systems, access to home-care, decrease surgical, wait-times and keep our emergency departments and hospitals open.

We must be wary of this technique. It's not the first time this has happened, in jurisdictions, across North America and the world. But we must be aware of this, kind of phenomenon.

RESH: And yet so many people could get away with, by this point, still not being aware. They still know that they can go to the ER. They can still go to their General Practitioner. They're not actually seeing it right now, but you as an insider Naheed,

you are seeing it. So you've talked about nursing. Where else are you seeing privatization happening within healthcare systems?

NAHEED: We're seeing evidence that for-profit delivery of healthcare can worsen healthcare outcomes, not just in Canada, but around the world. A recent study from England's NHS found that as outsourcing to the private-for-profit care-sector increased from 2013 to 2020, so did the rates of treatable death. So more people died needlessly.

And so we're seeing that shifting the priority from patient-care to shareholder-profit creates an incentive to really cut corners and decrease the quality of care that's being provided.

We actually don't have to look outside of our borders though. Just look at what happened during COVID-19 in Long-Term Care here in Ontario. Where Ontario's for-profit Long-Term Care facilities had the worst death rates. They diverted almost $4 billion in public funding away from improving care for their residents and towards shareholder profits.

If for-profit Long-Term Care facilities had the same lower death rate as municipal facilities during the pandemic, more than 1400 fewer people would've died in 2020, according to a Canadians For Tax Fairness report.

So we have lots of evidence of, how for profit healthcare is not just making people more sick, but it actually is killing people. And it just blows my mind that with all this evidence and all these examples, we're going right down that pathway again towards more privatization.

RESH: That is an excellent example. And I just want to, turn that point to JP the crisis that was facing, that is facing Long-Term Care Homes, but certainly during COVID was, as Naheed was saying, perhaps the first sign of systemic healthcare failure during the pandemic. So JP what lessons do LTCs offer us about what's happening? Do they give us a glimpse into a possible future for healthcare in Canada?

JP: Oh, absolutely. When you look at LTCs the frontline workers, our members in there, have been sounding the alarm around this for years.

The outcomes that happened in For-Profit Long Term Care Homes and how much worse the death rates were, was not news to anyone who was working on the frontline in Long-Term Care Homes. So when you look at what's happening now, even in terms of healthcare policy, where this notion that, - what Ford literally referred to as "bed blockers" - people who are waiting in hospital to get as ...

RESH: As what? As "bed blockers"?

JP: Yeah, it was referred to as "bed blockers" in one of the articles. These are people, our seniors, our family members, you know our elders who are waiting to get into the Long-Term Care facility of their choice. And these are not the For-Profit Long-Term Care facilities for the most part.

But what happened in Long-Term Care is because those facilities had the higher death rates, they now have empty beds. And no one wants to go to them because they know that the outcomes in those homes are so much worse . And so the Ford government is willing to change policy in order to force people into beds in For-Profit Long-Term Care in order to get the profits up for people that they're buddies with.

When you start to connect the dots, it's not a hard bit of math to figure out why healthcare policy is changing under this government, in order to force people into private systems. They're willing to create effectively a means-based healthcare system, a wealth-based healthcare system and forcing people who can't afford daily fees to stay in the hospitals while they wait for adequate care.

And once again, the answer's easy. You fund it! You fund the Long-Term Care. You make For-Profit Long-Term Care a thing of the past. You create systems and care facilities that are based on outcomes for patients, rather than the efficiency of a technique. You focus it on people, not profit.

And Long-Term Care is just a thin end of the wedge. I mean, we see privatization of diagnostic testing, of rehabilitation. That's also been a flop; where you have testing that's authorized under OHIP that has to compete with a sports clinic or a professional sports franchise in the priority queue, which takes resources out of the the public.

Independent health facilities. These are things that only take the easiest patients. So they perform high turnover procedures on patients with the lowest risks in order to maximize profit. You call it "cream skimming" right? You pull the easy money and you leave all the high cost, high risk procedures to public hospitals; which results in what Naheed described earlier. This kind of lack of faith in the public system to be able to do what we needed to do.

It pulls top-tier healthcare professionals away from the public system, which is already deliberately understaffed. It creates additional cost to boost the profits. We are in the process of creating a two-tiered healthcare system. Long-Term Care is the most stark example of it. And it is, as Naheed said, right in front of our noses.

But at the end of the day, if we've got the resources to splurge on corporate profits, then surely we have the resources to invest properly in Public Not-For-Profit Healthcare and rebuild our capacity to invest in not just beds, but the staffing. To pay every classification of healthcare workers fairly for their heroic efforts in sustaining and keeping Ontarians healthy.

RESH: Right. And just to go back we're talking about this new bit of legislation that was passed by the Ontario Government, Bill 7, which again, would force patients,

mostly seniors, and those with disabilities into Long--Term Care Homes, not of their choosing in order to free up hospital beds because they're being referred to - I find that shocking - as "bed-blockers". And that if they don't go, then they would have to pay a fee.

So to play devil's advocate, Naheed, we're being told that these measures are meant to take the pressure off the public system that is suffering from a shortage of beds and workers - and again, as was brought up, there seems to be more emphasis on the beds than the workers. To deal with backlogs, we're told surgeries will be moved to private hospitals or clinics and those patients who can afford it can also have the option to go to private health facilities to avoid wait times; which would then lessen wait times for everyone. But everyone in one way or another will still get their healthcare. So what's the issue?

NAHEED: Yeah. You know, I think what's being presented is just really one side of the story. When you talk about the government's desire to free up beds, it kind of paints a picture that people are being received in these other places, long-term care beds, other spaces, is that there are no issues there. And the fact is our system is underfunded and understaffed in those spaces as well.

If the Ontario government was serious about addressing the healthcare crisis, they would start by addressing the root issues, which isn't directly about a lack of furniture, beds; it's about a lack of available staff to care for the people in those beds. And whether in a hospital or in a long-lerm care facility, we are seeing issues with staffing and support of our staffing in all of these spaces.

In many long- term care facilities, the ratio of staffing is sometimes one nurse, for example, to 32 patients or one to 64 in some cases and with understaffing, sometimes this can be much, much worse.

This Bill has been seen as a way to blame vulnerable patients who don't want to be waiting in hospitals as long as they can get into LTC homes of their choice, is really just disturbing. And actually in many ways is ageist and ableist.

If we really wanted to fix the root of this issue, we would just fund our public healthcare system, which I feel is the the common denominator to almost every question in this segment, because then we would better be able to staff our system.

RESH: So just, in terms of that, that it all really comes down to funding. And here we are in Canada. One of the wealthiest countries in the world with a fairly small population. And yet what we are being told is that we can't afford healthcare on the public dime, especially now when we are trying to recover from the last two years of the pandemic and whatnot.

So JP, hat are your thoughts on that? That right now everything's tight. And so, there really is no way to fund this publicly.

JP: Yeah, I think that's always the greatest myth. Right. I've never seen a government that says it's feeling flush, first of all. Secondly, absolutely we know that the result of the pandemic has been a slow down of the economy you know, but it's now bouncing back. And what we have to do are make choices with the resources that we have and with the money that we have in order to decide where do we invest it?

Do we invest it in services for Ontarians that keep us healthy, that keep us educated so that we can participate in the ongoing rebuild of a robust economy? Or do we strip it out? Continue to burn out the healthcare workers in every sector of our healthcare ecosystem. Demand that they do more with less. That they just have to work harder. That they have to pull up their bootstraps. And watch them leave in droves so that we can replace them with lower paid folks in the public system. As the folks who have the ability, move out of it and into either other careers entirely or into private clinics and other aspects of the healthcare system.

So it is a stark choice about how we invest our hard-earned tax dollars.

And an investment in healthcare staff is not as though money just walks out the door. These are folks who are also citizens of Ontario, who are then able to participate in the economy as citizens, consumers, etc. So this notion that paying people what they're worth is somehow, a drain on the system, is BS. It just takes a whole element of the economy out of this picture.

And I will argue that as Ontarians, we have an active role to play in pushing the government around the decisions that they make. And each of us, I think, as an individual has a decision to make about whether we are going to stand up and say, it's enough. And to contact our MPPs. To make sure that our voices are known. To get out on the streets.

All of us, every single one of us in this province knows someone who is directly impacted by the choices the Ford government is making to allow for the expansion in healthcare. And I don't know very many people for whom that has been a positive experience. And so it is time to collectively work together to force the changes, not only that we want to see, but that we need, if we want to keep healthcare public.

RESH: One policy that seems to be addressing the workers themselves in terms of the staff shortage is the Temporary Foreign Worker Program where the federal government announced in April, that it would be expanding that program specifically to deal with the labor shortage across many sectors, but very much healthcare and nursing within healthcare.

And so what can we read from that? Because this is about bringing in foreign migrant workers to take up this shortfall.

JP: I think what's interesting about the legislation on that is you have groups that have been working for years in trying to get changes to the recognition of credentials for foreign trained professionals. And that has never been a bad idea.

I mean, Canada is a country that is expanding based on immigration and the ability to recognize those credentials to expand the network and our abilities is a sound goal.

To do it in a way that is exploitative and brings in workers who are then tiered into the lowest paid, less desirable jobs is typically how the migrant worker programs have worked, unfortunately. And so while we can do it, right; I don't have a lot of trust for this government so far in terms of how they've demonstrated their ability to do more than create another exploited class of workers.

RESH: There's a real mobilization around the rights for migrant workers. And I know that OPSEU is very much a part of that as well. And incidentally, our second episode of this season is going to be focusing on the plight of migrant workers in Canada.

Naheed, going back to you. So a couple of years ago, a relative of mine who was in the ER, overheard a resident explaining the difference between the Canadian and US systems to an intern. And he said that in Canada, when you arrive at the ER, the first desk you go to is to triage the patient - blood pressure check symptoms, all of that stuff. And then the second desk is to take care of payment, which is largely covered by our government-issued Health Card. But in the US, the desks are reversed. It's payment first.

Now, with this Ford government strategy of privatization, what would that look like for patients? If I were a patient going into say the, ER, what would this so-called "innovative" approach mean for me?

NAHEED: Yeah, and this is where it becomes really nuanced and insidious. And that's why conversations like this are so important. Because I think when people hear about private healthcare they say; well, I'm not paying, so it's not private. But you can still have private healthcare, even though it's not private pay. And so a public healthcare system in the background can continue to offer private aspects of healthcare.

So, to follow through with your vignette: once you're in the hospital and you're admitted ,as JP mentioned there are many services that are going on in the background. But not just the nurses and doctors and other healthcare workers; the people who take your blood, the companies that analyze your blood, the way that imaging happens, the people that manage the ways that imaging is organized, and so on and so forth.

There's so many services that are ongoing, that can actually be managed under the public healthcare system versus the private healthcare system. And when those services are siphoned off towards the private healthcare system, the efficiency, effectiveness, and overall success of those services starts to diminish. Because the profit motive becomes the focus, not the care motive.

We've mentioned the presence of some private hospitals that were grandfathered and private for-profit hospitals are technically not allowed anymore. What we see

also is that sometimes when there is a private hospital that is allowed to provide care, they can also charge for ancillary services, like overnight stays, other things that are not "covered" by the OHIP system.

And these private institutions can start to cherry-pick the easier cases, the cases with less complexities, the cases that focus on healthier patients while then booting back the more complex patients to the public healthcare system. And this is another insidious way where private for-profit healthcare can really strain the system -Take some of the more professionalized healthcare workers towards the private system, while booting the more complex patients to the public healthcare system.

So along the way and along the journey, there are many ways that private healthcare can present. It's not always obvious, but it can lead to inefficiencies and it doesn't improve the health of Canadians. And that's the bottom line here.

RESH: And just to continue with you Naheed, because you're a health, justice, activist, and you work with many vulnerable populations. So how would this push to privatization impact those populations? For instance, you founded the PEACH program that is about making healthcare more accessible to homeless populations. So how would this impact them?

NAHEED: You know, I have to say that if it were not for public healthcare, that many of the innovations - and I really mean that in the, truest sense - Many of the innovations that have derived health equity, at least in my world and in the world of many of my colleagues, would not be possible.

I have to say that it is due to our collective will and solidarity around a public healthcare system that has allowed us to create healthcare programming that meets people where they're at, particularly for people on the margins. And as you mentioned, I'm the founder and lead of a palliative care outreach program for people experiencing homelessness, the PEACH Program, based out of The Inner City Health Associates in Toronto. And this is a really great example of how our public healthcare system has been molded and utilized to create health system solutions for people who otherwise wouldn't get that support. And as I talk to colleagues around the world, about our PEACH Program, in many of the countries where private for-profit healthcare is more prominent, my colleagues say: This is really great. We would never be able to do this here. We would never be able to create a program that addresses such an important health gap for people who are dealing with significant vulnerabilities. Because the raw reality is that those systems are really not derived around improving care for people they're derived around increasing profits for shareholders and companies.

And so you don't have to look at the extremes of poverty to see the examples of why a public healthcare system is so important. Just look to our neighbors in the United States. There, you can see that costs for many people, working-class people, are very high. And that medical illness can be a leading cause of poverty and even homelessness for many.

So, whether it's around mental health, care for people who use drugs, people experiencing homelessness, working class, low-income folks, public healthcare has been a real saving grace and a real safety-net for many people who are struggling and who are facing significant vulnerabilities in our communities.

And for those listeners who may think, well that's not me. I will say as someone who's provided healthcare for many years, for people on the streets and in shelters, many of us are just a few paychecks away from being on the street or living in a shelter. Or a few bad luck events that can happen in sequence that can put us in a situation like that.

You never know if that will be you. You never know if that could be your family member, your neighbor. And that's why the collective good matters so much. It's our moral obligation. From an ethical perspective, we have a duty to continue to uphold the vision of Tommy Douglas, the vision of public healthcare in this country. It should be our North Star. It should always guide us, in the right direction. It's our collective good.

RESH: Absolutely. And going back to that point, that it is a steep slope, but a fairly quick one that we could go down, particularly given the pandemic.

So many people have been left without housing. The most vulnerable populations have really been hit the hardest by the pandemic. So very much a reality for them.

When we tend to focus on discussions about healthcare, we do tend to focus on the provincial side of it. But JP,as, you mentioned, this is going beyond Ontario. So the Ford government has been meeting with premiers across the country.

What exactly is the responsibility of Canada itself? What should be, or is the responsibility of the Federal level of government here?

JP: Yeah. I mean I think the federal government has a very strong role to play in ensuring that the Canada Health Act is not eroded, that it is enforced that public healthcare , but truly public healthcare, is a right of every Canadian, right? Of every person who is living in Canada, to be quite frank.

When we're looking at the interactions between the federal and the provincial governments right now, it is a lesson to us all how quickly the rights we have enjoyed - this sense of ourselves as part of a collective good, as something larger, as something we can be proud of - how quickly it can be eroded through the actions of a few.

I mean democracy is, if nothing else, a faith-based system. And if we stop believing that change is possible through collective action. If we stop believing that, healthcare, that education, that a social safety net, that these are things that are basics that every single person can enjoy within Canada, then we will lose them with a speed that is absolutely stunning.

And when I look at the history of attempts at privatization, to Harris, and the nineties and the Days of Action in Ontario; it was the collective action of labor, of healthcare workers, of education workers of public servants, of community groups, who not only fought back, but started to reverse some of those changes. These are decades-long agendas, and they are not things that are won overnight. But the collective action of people working together for a collective good for something larger than our individual gain is, a responsibility of each one of us. But it is also a dire need. And without it, we are eroding the very foundations of who we are.

RESH: Indeed. Now the Canadian Universal Healthcare System is not perfect by any means. And often it is these imperfections that are used to justify a departure from universal healthcare by advocates of privatization. As you've both pointed out, we certainly cannot afford to, we don't want to lose universal healthcare in Canada.

So what needs then to be done at this moment to deal with this crisis? What are the priorities? How do we build back better in terms of healthcare? And Naheed, I'm gonna start with you.

NAHEED: If I may use the term innovative I think we need to invest in well-known, innovative, publicly funded solutions that work, on a much larger scale. I'll give you a few examples: Team-based interprofessional models of care that really focus on addressing pain points, like wait times . Pilot projects that we've seen in this country, for example MRIs in spinal surgeries. Drastically reduced wait times. From research in 2012, we've seen how family doctors who are working in collaboration with physiotherapists and chiropractors can reduce the large volume of surgical referrals that are present- And in one study led to a 30% decrease in MRI use and an average wait time of 12 days. We can expand that. Centralized wait-lists are another example with family physicians referring to the next available specialist, rather than to whoever they know or without understanding the information on wait times with particular specialists in an area. Electronic consult services are another way for health workers to receive advice from specialists without requiring a referral or a physical assessment. These innovations can also reduce wait times.

But I also think we need to look into the policies that are impacting workers in this province. We need to do everything we can to support, retain and expand our healthcare workforce. And that starts by repealing Bill 124 here in Ontario, wage restraint legislation for public sector workers, including nurses and many others. And this has affected our ability to retain workers in the public healthcare system, which has affected our ability to build capacity and create faster access to care.

Again, funding people in our public healthcare system, that would really make a huge difference.

And finally, strengthening access to care. Bill 7 in Ontario- if our Ontario government was actually serious about moving people from hospital into other spaces, they wouldn't just be focusing on moving people to long-term care facilities; they'd be better strengthening primary-care. They'd be better strengthening home-care. They'd be better strengthening community-based care so that people can get the care they

need when they want, where they want, while reducing strain on our acute medical care systems.

So the solutions are there. That's just a few of them. They are certainly innovative. We don't lack solutions. What we lack here in Ontario and many jurisdictions across Canada is a commitment from our provincial governments to publicly funded healthcare. And we're losing our focus and that's making things a lot harder. So we need to hold our politicians to account on public healthcare and we need to do it together. We need to do it now.

RESH: Okay. So we've got everything. We just don't seem to have the political will, but that was a very comprehensive list. And JP, the same question to you. What are the priorities right now, to deal with this crisis in healthcare?

JP: Naheed hit the nail on the head and really walk through some of the nitty gritty.

I think that there are the legislative, arms that we need to look at, such as Bill 124. Capping wages at 1% for public service workers and healthcare workers really just means that you're driving people out of the field. There's no incentive to stay, so we lose on the retention end. And there's no incentive to bring people in. So the recruitment, the education end. We need to figure out creative ways of making sure that people are attracted to the field and that we don't lose the mentors who are already there, who've been doing the work.

I also think there's a collective action end, and this is where unions have a really strong role to play. I mean, the expansion of privatization has impacted all parts of the healthcare system: hospitals, long-term care, medical testing, paramedics, Canadian blood services, all of these aspects. And this is where we have unionized workers and where we have multiple unions. So, while OPSEU/SEFPO has tens of thousands of healthcare workers, from respiratory therapists to lab techs, to phlebotomists, to paramedics, to, long-term care workers, we have a need to work together with workers in SEIU, in the Ontario Nurses Association, with CUPE Ontario, with UNIFOR. Everyone, from doctors to nurses, to technologists and technicians to paramedics, to cleaners, are part of an essential ecosystem that supports quality public healthcare in Ontario.

And we need to activate our members. We need to work together, not just within our unions, but between our unions. And to do that work of reaching out to community groups, to community members in order to build that strong coalition that is dedicated to protecting this essential aspect of Ontario.

RESH: A huge part of that ecosystem as well, and a major stakeholder, are patients, are the public. You talked a bit about that in terms of communities. So just a final word. What can listeners of this podcast do in terms of protecting public healthcare for the common good from this looming threat of privatization? So Naheed, what can we do?

NAHEED: Yeah. You know, implore citizens, community members, neighbors, from all walks of life to really recognize that often conversations like this can get tucked away in the category of health policy. This is about much more. This is about our way of life. This is about our way of being. This is really an attack on the common good that is so core and foundational to what it means to be Canadian.

Public healthcare is a national treasure that makes us unique on the world stage. That really allows us to say to each other, I care about you.

And I care about you so much that I will pay into a collective pool with you to care for you. Even if I don't get sick, I care for you. And that doesn't just emanate in the healthcare world and the healthcare sphere that affects the way we treat each other. We care for each other. We communicate with each other.

And that is worth saving. That is worth protecting. That's worth caring about. So I implore everybody in our communities to become more well-versed with these kinds of issues. They are complex topics and that's why conversations like this are important.

I also encourage you to reach out to your colleagues in healthcare who are working on the frontlines, who are clearly going through a very difficult time right now. Offer your support, even just a friendly ear where possible. That can go a long way.

But ultimately I ask everyone who's listening to this to get involved, get political. To really get out there. Contact your local politicians. Ask more of your political bodies. And ask questions that dig deeper around, why our public healthcare system is eroding. And who stands to benefit when our public healthcare system erodes.

Our media, plays a big part in that as well. Put them to task. And do everything we can to protect the future of our healthcare systems. Ultimately, it's about protecting the health of all people in this country.

RESH: Indeed. And JP, same question. What can we do?

JP: Yeah, I think what Naheed said was really a beautiful blueprint. And writing to your MPPs. Asking them about where they stand on healthcare. Reaching out. Looking at the various sites from the various unions about what's happening.

But I do believe that it is that person-to-person connection - talking to your neighbor, your friend, your family member who works in some element of healthcare. Finding out what their issues are, what's happening for them and asking them what they want you to do.

The thing that struck me in what Naheed just said is that taking action in some way - whether it is having that conversation, reaching out and taking that first step to having that conversation, or if it's signing a petition or if it's sending a letter or an email to your MPP, or if it's tweeting during a Twitter storm, or a phone-zap , or

attending a rally - Any of those actions that you take collectively where you have reached out to another person, have attempted to engage in that process of education, of learning, of building something together - Those are acts not just of care, but those are acts of love.

These are things that we can do to demonstrate that we stand together for something that is beyond our individual gain.

When we start to ask questions, when we start to follow the money, when we start to push back into something that is an economy that is built on care, rather than an economy that is built on the maximization of profit; we benefit collectively, but we also benefit exponentially. And we build an Ontario that is rooted in that community of care.

Some of the things that I look at in the privatization of healthcare that we don't really think about are things like parking lots. Hospitals become very adept at allowing for excessive fees and parking at hospitals is one of those, right? Where all of a sudden, you end up paying tons of money to be able to just go and visit with a family member or friend who is in crisis.

One of the worst stories I ever heard in terms of private-public healthcare coalitions was a hospital that was being built in London, England. And this goes to the way in which Ford is trying to use the building of hospitals to expand private-public partnerships as well. In London, they had hired a private firm to build a hospital. And that firm determined that if they took a few centimeters off of either side of the doorways in the patient rooms, that they would save X number of dollars. What they didn't take into account was that once those doorways were built, you couldn't actually bring a stretcher through them.

And so the immediate savings in cutting a few centimeters has an enormous cost to the patient, to the staff, to every single citizen whose taxpayer money is going to be used to support that. And I think we need to talk to each other constantly about what the hidden costs are when we are not caring for each other first, before we're thinking about profit.

Innovation that only benefits a very few, will cost us more in the long run than it will if we had invested in our public services to begin with.

Investing in public services is an act of care. It is an act of love and it is something worth fighting for.

RESH: You know, it's interesting that the Canada Health Act which governs our universal healthcare policy is guided by five principles: That healthcare is Universal; it is our right. It is Accessible; we all have it regardless of our status. That it is Comprehensive; covering all of our medically necessary treatments and everything that goes along with it. It's Portable; wherever you go in Canada, you get it. And that it is delivered and paid for by a Public Administration; out of the public purse and for the public good. And from what you've both said, it seems that a sixth principle would

fit there as well -That it is really overall about our collective care and the love that we should have for each other.

I want to thank the both of you - Naheed and JP, it has been an absolute pleasure.

JP: Thank you for having us on.

NAHEED: Thank you so much.

RESH: That was JP Hornick, President of OPSEU/SEFPO, the Ontario Public Service Employees Union and Naheed Dosani, Palliative Care Physician and Health Justice Activist.

I'm Resh Budhu, host of the *Courage My Friends Podcast*.

Thanks for listening.

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