SUBMISSION TO THE UNITED NATIONS SPECIAL RAPPORTEUR ON THE RIGHT TO PHYSICAL AND MENTAL HEALTH

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The Canadian Health Coalition (CHC) was formed in 1979 with the goal of protecting and extending public health care in order to improve the well-being of the population. For nearly 40 years the CHC has advocated for a national public drug plan as a necessary addition to hospitals and doctors.

The CHC is a public advocacy organization dedicated to the preservation and improvement of public health care. Our membership is comprised of national organizations representing nurses, health care workers, seniors, churches, anti-poverty groups, students and trade unions, as well as researchers and affiliated coalitions in 10 provinces and one territory.

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I. Introduction

The Canadian Health Coalition (CHC) has been working for nearly forty years to protect and improve public health care in Canada. We are made up of national organizations representing nurses, health care workers, seniors, social justice organizations, women, churches and trade unions, as well as affiliated coalitions in 10 provinces and 1 territory. The CHC is submitting this brief to the United Nations Special Rapporteur on the Right to Physical and Mental Health, Mr. Dainius Puras, on the occasion of his visit to Canada in 2018.

II. Overview of Health Care in Canada

In Canada, medically necessary services provided by hospitals and physicians are covered by public health insurance. Jurisdiction over health care rests primarily with the provincial and territorial governments. However, the federal government is responsible for delivering health care to certain groups including refugees, First Nations and veterans. The federal government also provides funding to the provinces and territories (PTs) to deliver health care. In order to access this funding, the PTs must ensure that health care is accessible, publicly administered, universal, comprehensive and portable. These criteria are laid out in the *Canada Health Act*.[1] If provinces don't respect these criteria, the federal government can withhold funding for health care. The *Canada Health Act* also prohibits patients from being billed for health care services that should be covered by public health insurance. The federal government is responsible for enforcing the *Act*.

Many medically necessary services fall outside the scope of public health insurance. For example, prescription medication, seniors care, mental health care, dental care, and vision care often aren't covered by public insurance. As a result, many people in Canada are unable to enjoy the highest attainable standards of health.[2]

III. Privatisation

Canadians share a deeply held belief that access to health care should be based on need and not on the ability to pay. The values of equity and fairness are rooted in our single-payer public health care system. We feel strongly that patients should come before profits.[3]

And yet, private, for-profit clinics have been proliferating across the country.[4] These clinics often engage in illegal billing practices. For example, Saskatchewan recently passed legislation allowing patients to jump the queue by paying out of pocket for diagnostic tests (e.g. MRIs and ultrasounds).[5] Quebec also passed legislation allowing patients to be billed extra fees for health care.[6] Patients in Ontario have been billed thousands of dollars for cataract surgeries, often experiencing financial hardship as a result.[7] Private health care clinics in Alberta and elsewhere are exploiting legal loopholes, charging fees for memberships and services.[8] The federal government has been slow to address these clear violations of the *Canada Health Act*. Patients have had to apply to the courts to stop these illegal billing practices.[9]

Canada does not have enough medical staff or resources to operate a two-tiered (public and private) health care system. Private health care clinics poach health care providers from the public system, making them accessible only to those who can afford to pay for their services. This results in longer wait times in the public system.[10] Private clinics also often deliver poorer quality care.[11]

The CHC is therefore calling on the federal government to take immediate action to enforce the *Act* by withholding health transfer payments to the PTs that allow patients to pay out of pocket for medically necessary services. All people in Canada must have access to the care they need, regardless of their resources.

IV. Pharmacare[12]

Access to medication is a human right.[13] Canada is the only country in the world with a universal public health care system that doesn't include access to prescription medication. Our current system consists of a patchwork of over 100,000 public and private plans that leave many Canadians without access to the medications they need. Drug coverage varies greatly by province and territory. Our system is also rife with excessively high drug prices and overprescribing practices.

Ten percent of Canadians lack any type of drug coverage.[14] One in ten Canadians are unable to afford prescribed medications.[15] Of eleven developed countries, Canada has the second highest rate of cost-related prescription non-adherence.[16] People in poor health, with lower incomes or without insurance are more likely to forgo the medication they need due to cost.[17] Every year, there are 100,000 needless hospital admissions due to cost-related prescription

non-adherence.[18] Many Canadians are forced to choose between filling their prescriptions and putting food on the table.

The CHC is calling on the federal government to adopt a national, single-payer drug plan. The CHC was pleased when the federal government established an Advisory Council on the Implementation of National Pharmacare in 2018 to study this issue.[19] Canada's new pharmacare plan must be public, universal, accessible, comprehensive and portable.[20]

V. Seniors Care[21]

Most Canadians will rely on seniors care (home care, long-term care and palliative care) at some point in their lives. Canada's public health care system is ill-equipped to address the needs of the aging population. The level and scope of seniors care vary between provinces and territories. Eligibility criteria and wait times also vary considerably. A significant portion of seniors care has been privatized to fill in the gaps in the public system. This has led to significant out-of-pocket expenses for seniors. The vast majority of Canadian seniors don't have the financial resources to access suitable health care as they age.[22]

Without a pan-Canadian strategy to ensure a consistent continuum of care, many seniors are falling through the cracks. Tens of thousands of seniors are on waitlists for long-term care,[23] often occupying acute care beds in hospitals while they wait.[24] This causes further backlogs and increased wait times in other areas of the health care system. Other seniors must rely on home care while they wait, without having all their needs met. Due to the shortage of long-term care beds, seniors are often expected to take the first available bed, which could be hours away from their families and communities.[25]

Funding cuts to Canada's health care system are having a negative impact on seniors. For example, the sharp decline in the number of hospital beds[26] and reductions in long-term care bed capacity[27] have created significant barriers to adequate care for seniors. Accessing quality care is particularly burdensome for low-income, racialized, Indigenous and LGBTQ+ seniors.[28] According to a recent international survey, Canadian seniors are less satisfied with their health care than their counterparts in several OECD countries.[29]

The CHC is calling for a National Seniors Care Strategy to establish consistent funding, standards of care and staffing levels across the country. All Canadians should be able to age with dignity, respect and independence.

VI. Paid Plasma and Blood Donations

Blood is a national resource that is vital to the preservation of the lives and health of Canadians. In the 1980s, Canada experienced a tainted blood crisis. At least 2,000 people were infected with HIV, and around 30,000 were infected with hepatitis C through blood and blood products. Eight thousand Canadians are expected to die as a result.

Research evidence proves that voluntary, unpaid blood donations provide for safer blood and blood components, with demonstrated reduced infectious contamination. The World Health Organization and many other international health agencies aim to have 100% voluntary blood and plasma collection globally by 2020.[30]

In 2016, Canada began allowing payment for plasma donations at private centres. Two private centres have been licensed so far. They have been targeting vulnerable populations by setting up in neighbourhoods with high poverty rates and by advertising at universities. The plasma collected at these centres is sold off-shore, therefore it is not helping Canadians.[31] These centres are syphoning donors out of the public donor pool. Voluntary blood donations at CBS have dropped significantly since these centres opened. This is threatening CBS' ability to increase Canada's self-sufficiency in donor plasma.[32]

The CHC is calling on the federal government to ban payment for blood and plasma donations. Four provinces of Canada's largest provinces have already adopted legislation banning paid plasma donations.[33] Canada's Senate is currently considering a bill that would implement a national ban.[34]

VII. Other Issues

Mental Health Care

Mental health care in Canada is largely privatized, leaving services unaffordable for many. Access to public mental health care can take years with long and growing wait lists. Approximately 1.2 million children and youth in Canada are affected by mental illness, but less than 20 per cent receive appropriate treatment.[35] Almost a third of Canadians who seek mental health care report that their needs are unmet or only partially met.[36] Nearly 4,000 Canadians die by suicide each year.[37]

Oral Health Care

Oral health care in Canada is primarily privately financed and delivered. Canada contributes one of the lowest proportions of public funds to oral health care among OECD countries. Only six per cent of dental services in Canada are paid for publicly. Six million Canadians are unable to afford dental care. Those with the greatest need are the least able to afford access.[38]

Vulnerable Populations

Indigenous peoples in Canada continue to face barriers in accessing quality, culturally appropriate health care. They have higher morbidity and mortality and rates and a lower life expectancy than non-Indigenous people.[39] This disparity can be attributed to Canada's colonial history.

Refugee and refugee claimants experience difficulty accessing public health care in Canada. Health care providers are often reluctant to provide care to newcomer communities, including refugees, because they are uncertain of the complex reimbursement system with the federal government.[40]

People with disabilities in Canada also face countless barriers in accessing health care. Adults with disabilities have more than three times as many unmet health care needs as their non-disabled counterparts. Cost is the greatest deterrent to them receiving the services they need.[41]

LGBTQ+ people also face numerous barriers in accessing health care. For example, they may be deterred from accessing care due to previous experiences of discrimination, fear of victimization and stigma. Health care professionals' may also lack knowledge to address their unique health care needs.[42]

People who are part of more than one of these populations can face intersectional discrimination in accessing health care.[43]

VIII. Recommendations

The CHC is calling on Government of Canada to protect and improve public health care in Canada by:

1. **ENFORCING THE CANADA HEALTH ACT TO ENSURE THAT ACCESS TO HEALTH CARE IS BASED ON NEED, NOT ON THE ABILITY TO PAY.**

2. **ESTABLISHING A NATIONAL PHARMACARE PLAN THAT ENSURES PRESCRIBED MEDICATIONS ARE AVAILABLE TO EVERYONE IN CANADA.**

3. **ESTABLISHING A NATIONAL SENIORS CARE STRATEGY THAT ENSURES CONSISTENT FUNDING, STANDARDS OF CARE AND STAFFING LEVELS ACROSS THE COUNTRY.**

4. **IMPLEMENTING A NATIONAL BAN ON PAYMENT FOR PLASMA AND BLOOD DONATIONS.**

5. **ADDRESSING HEALTH CARE DISPARITIES AMONG MARGINALIZED GROUPS, INCLUDING INDIGENOUS PEOPLES, NEWCOMERS AND REFUGEES, PEOPLE WITH DISABILITIES AND LGBTQ+ PEOPLE.**

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