



BACKGROUND INFORMATION



POVERTY

RNAO's Policy Platform Backgrounder **January 2013**

It's hard to imagine that a low-income neighbourhood in Ontario has something in common with Nepal. And yet both share an unsettling statistic. In a part of Hamilton, the average age at death is 65.5 years, tied with Nepal. Perhaps even more surprising is that a few kilometers away in a more affluent neighbourhood within that same Ontario community, the average life expectancy is 86.3 years, which is five years higher than Canada's average life expectancy. This 21 year difference in life expectancy is not due to random chance, but because of the growing gulf between rich and poor. This avoidable and early loss of life is not imaginary, but the day-to-day reality of living in parts of Hamilton.¹

Ontarians who live in poverty because of precarious low-wage employment and those who struggle because of dangerously low social assistance rates are the very Ontarians who are dying years and decades too soon. The evidence is clear that those who live in poverty and are socially excluded experience a greater burden of disease and die earlier than those with better access to economic, social, and political resources.² Poverty is not restricted to certain areas of particular cities, but is pervasive across the province with one in 10 Ontarians (1.3 million) living in poverty every day. Good quality jobs are often a pathway out of poverty, yet the provincial minimum wage has not been increased since March 2010,³ and has not kept up with the cost of living. The current minimum wage of \$10.25 per hour still leaves workers 10 per cent below the poverty line.⁴ A one-person household receiving Ontario Works has a monthly income of \$642 including tax credits. The average monthly rent for a bachelor apartment in Hamilton is \$536 and \$250.45 is needed for food each month. As these figures do not include other basic needs, a one-person household receiving Ontario Works in Hamilton is going at least \$144.45 in debt month after month.⁵ Lack of affordable housing, in Hamilton as in other communities, is a key driver of poverty and resulting ill-health.⁶ To continue using Hamilton as our example, there are 6,062 households that wait an average of two-and-a-half years for rent-geared-to-income housing.⁷ Across the province, there are 156,358 households that wait an average of two to four years for affordable housing, with some waiting 10 years or more.⁸

The good news is that we know public policy can make a difference in people's day-to-day lives and improve health outcomes. Ontario's first *Poverty Reduction Strategy* was released in December 2008. Early investments in increasing the Ontario Child Benefit helped reduce the number of children living in poverty by 29,000 in 2010 compared with 2008 despite the global economic recession.⁹ In May 2009, all three parties voted unanimously to pass Ontario's *Poverty Reduction Act*, which commits successive governments to remain focused on the fight against poverty.¹⁰ It is crucial that we all work together to eliminate poverty so that all Ontarians can live in health and dignity.

Recommendations:

1. **Increase the minimum wage.**^{11 12 13}
2. **Improve access to affordable housing.**^{14 15 16}
3. **Transform the social assistance system to reflect the actual cost of living.**^{17 18 19}

Questions for candidates:

1. **Will you commit to increasing the minimum wage to \$11.50 in 2013, \$12.75 in 2014, and \$14.50 in 2015, with additional increases each year to compensate for inflation?**
2. **Will you commit to investing in new affordable housing stock and repair of aging affordable housing stock that is substandard?**
3. **Will you commit to a transformed social assistance system that ensures adequate income that reflects the actual cost of living?**

References

-
- ¹ Buist, S. (2010). Worlds Apart. *Hamilton Spectator*, August 25, 2010. Retrieved January 23 at <http://www.thespec.com/news/article/251417--worlds-apart>
- ² Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report on the Commission on Social Determinants of Health*. Geneva: World Health Organization. Retrieved January 23 at http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf
- ³ Ministry of Labour. (2012). Minimum Wage. Toronto: Author. Retrieved January 23 at <https://www.labour.gov.on.ca/english/es/pubs/guide/minwage.php>
- ⁴ Workers' Action Centre. (2012). *Why Ontario needs a minimum wage workers can live on*. Toronto: Author. Retrieved January 23 at <http://www.workersactioncentre.org/wp-content/uploads/downloads/2012/10/MinWage-backgrounder-2012.pdf>
- ⁵ Public Health Services, Healthy Living Division. (2012). *Nutritious Food Basket Report*. Hamilton: City of Hamilton, Appendix A. Retrieved January 23 at http://www.hamilton.ca/NR/rdonlyres/022A495D-BB41-4C0D-8218-7497968BB6FE/0/Oct15EDRMS_n364898_v1_BOH12025_Nutritious_Food_Basket.pdf
- ⁶ Wellesley Institute. (2010). *Precarious Housing in Canada*. Toronto: Author. Retrieved January 23 at http://www.wellesleyinstitute.com/wp-content/uploads/2010/08/Precarious_Housing_In_Canada.pdf
- ⁷ Ontario Non-Profit Housing Association. (2012). *Waiting List Survey 2012*. Toronto: Author, 30-35. Retrieved January 23 at http://www.onpha.on.ca/AM/Template.cfm?Section=Waiting_Lists_2012&Template=/CM/ContentDisplay.cfm&ContentID=13281
- ⁸ Ibid, p. 3-4.
- ⁹ 25 in 5 Network for Poverty Reduction. (2012). *Meeting the Poverty Reduction Target: Strong Leadership and Good Policy Required*. Toronto: Author, 3. Retrieved January 23 at <http://25in5.ca/wp-content/uploads/2012/12/Meeting-the-Poverty-Reduction-Target-Dec-4-2012.pdf>
- ¹⁰ Ministry of Children and Youth Services. (2008). News Release: Ontario Passes Historic Poverty Reduction Act. Toronto: Author. May 6, 2009. Retrieved January 23 at <http://news.ontario.ca/mcys/en/2009/05/ontario-passes-historic-poverty-reduction-act.html>
- ¹¹ Registered Nurses' Association of Ontario. (2010). *Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties*. Toronto: Author. 8-15. Retrieved January 23 at http://rnao.ca/sites/rnao-ca/files/CVC_Technical_Backgrounder.pdf



¹² Registered Nurses' Association of Ontario. (2012). *Advocating for Vibrant Communities Briefing Notes 2012*. Toronto: Author, 29-32. Retrieved January 23 at

http://rnao.ca/sites/rnao-ca/files/RNAO_Advocating-Vibrant-Communities_April-2012.pdf

¹³ Workers Action Centre. (2013). Minimum Wage. Retrieved January 23 at

<http://www.workersactioncentre.org/issues/minimum-wage/>

¹⁴ Registered Nurses' Association of Ontario. (2009). *RNAO's Submission to Ontario's Long-Term Affordable Housing Strategy: Housing is a Human Right and Determinant of Health*. Toronto: Author. Retrieved January 23 at

http://rnao.ca/sites/rnao-ca/files/storage/related/5885_RNAO_housing_submission_Dec_2009.pdf

¹⁵ Housing Network of Ontario. (2009). *Moving Forward on Ontario's Long-Term Affordable Housing Strategy*. Toronto: Author. Retrieved January 23 at

<http://rnao.ca/policy/submissions/affordable-housing-strategy>

¹⁶ Housing Opens Doors Campaign. Retrieved January 23 at <http://www.housingopensdoors.ca/>

¹⁷ Registered Nurses' Association of Ontario. (2012). *RNAO Response to Second Discussion Paper, Approaches for Reform*. Toronto: Author. Retrieved January 23 at

http://rnao.ca/sites/rnao-ca/files/RNAO_response_SAR_March_2012.pdf

¹⁸ McGregor, H., & Blickstead, R. (2012). It's time to build dignity into Ontario social assistance. *Toronto Star*, October 9, 2012. Retrieved January 23 at

<http://www.thestar.com/opinion/editorialopinion/article/1268704--it-s-time-to-build-dignity-into-ontario-social-assistance>

¹⁹ Coalition of multiple organizations, including the Registered Nurses' Association of Ontario. *Five Tests for the Review of Social Assistance in Ontario*. Toronto: Author. Retrieved January 23 at

<https://www.ywcatoronto.org/upload/advocacy-2012FiveTestsfortheReviewofSocialAssistanceinOntario-FINAL.pdf>

ENVIRONMENT

RNAO's Policy Platform Backgrounder January 2013

Nurses know environmental determinants of health play a huge role in each community's overall health and well-being, as evidenced in Ontario^{1 2 3 4} and around the world.^{5 6 7 8} Environmental degradation and climate change are not vague future threats, but actual realities that are impacting Ontarians' health. Access to clean air, a safe environment, and reliable and sustainable forms of electricity help preserve our planet and secure the future for our children. That's why RNAO continues to focus on strengthening two key environmental determinants of health: supporting the use of green energy and reducing all exposure to toxics, including from the environment, in homes, in workplaces and in consumer products.

Green energy - RNAO strongly supports an electricity system that is safe, reliable, equitable and environmentally sustainable; one that supports community-sustaining green jobs, and one that does not pollute the air or leave a legacy of toxic waste and bankrupt Ontario residents and businesses.⁹ Healthy public policy demands aggressive conservation and energy efficiency targets as well as phasing out Ontario's dependence on dirty coal and other fossil fuels. RNAO's vision of a clean, healthy energy future is balanced and comprehensive. It includes:

- Closing immediately all remaining coal plants, keeping them on emergency stand-by until permanent closure in 2014 and only operating them if there is no other option to keep the lights on;
- Reducing consumption through conservation and energy efficiency;
- Cancelling plans for construction of new risky and expensive nuclear power plants;
- Strategic use of natural gas to meet peak needs until renewable power is online while ensuring all new natural gas-supplied electricity is not from shale gas extraction ("fracking") and uses highly efficient combined heat and power (CHP); and
- Solid targets and implementation plans for increasing reliance on renewable energy such as community-controlled, appropriately located and scaled water, wind, solar and bio-energy; subject to comprehensive environmental assessments.

Toxics - New toxics are being discovered and released on a regular basis, and the public is often unaware of their presence or effects. Concern has been growing about a worrisome class of toxics called endocrine disruptors. These particular toxics can cause serious health effects, even in very low concentrations and particularly in young children.^{10 11 12} The range of effects are not fully understood, but based on what is known, RNAO calls for extreme caution and tougher protection from the government on toxics by:

- Protecting the public's right-to-know about toxics in their environment, homes, workplaces and consumer products, and taking concrete action on issues such as product labelling.
- Committing to aggressive targets for reductions in the use, creation and release of toxics.
- Requiring mandatory substitution of safer alternatives for toxic substances in production processes.
- Establishing an independent academic institute to build capacity for meeting above requirements.

Recommendations:

1. Closing immediately all coal plants.
2. Ensuring people have the right-to-know about the existence of toxics in the environment, in their homes, in their workplaces, and in consumer products.

Questions for candidates:

1. Will you support immediate standby for all coal plants, leaving them on stand-by until their permanent closure in 2014?
2. What will you do to ensure the right of all Ontarians to know what toxics exist in the environment, in homes, workplaces, and in consumer products?

References

-
- ¹ Ontario Medical Association. (2008, June 6). *Ontario's Doctors: Thousands of Premature Deaths due to Smog*. Retrieved January 24, 2013 at <https://www.oma.org/Mediaroom/PressReleases/Pages/PrematureDeaths.aspx>
- ² Ontario Medical Association. (2005). *The Illness Costs of Air Pollution: 2005-2026 Health & Economic Damage Estimates*. Toronto: Author, 2. Retrieved January 18, 2013 at <https://www.oma.org/HealthPromotion/Smog/Pages/default.aspx>
- ³ Commission for Environmental Cooperation. (2006). *Toxic Chemicals and Children's Health in North America: A Call for Efforts to Determine the Sources, Levels of Exposure, and Risks that Industrial Chemicals Pose to Children's Health*. Montreal: Author, 25. Retrieved January 18, 2013 at www.cec.org/Storage/59/5221_CHE_Toxics_en.pdf. This influential report was cited by the Ontario Ministry of the Environment. (2008). *Creating Ontario's Toxics Reduction Strategy: Discussion Paper*. Toronto: Author, 3. Retrieved January 18, 2013 at <http://www.ebr.gov.on.ca/ERS-WEB-External/displaynoticecontent.do?noticeId=MTA0MzAy&statusId=MTU1ODkz>
- ⁴ Muir, T. & Zegarac, M. (2001). Societal Costs of Exposure to Toxic Substances: Economic and Health Costs of Four Case Studies That Are Candidates for Environmental Causation. *Environmental Health Perspectives*. 109 (S6), 885-903.
- ⁵ Prüss-Üstün, A. & Corvalán, C. (2006). *Preventing disease through healthy environments: Towards an estimate of the environmental burden of disease*. Geneva: World Health Organization, 9. Retrieved January 18, 2013 at http://www.who.int/quantifying_ehimpacts/publications/preventingdisease/en/index.html
- ⁶ World Health Organization. (2013). *Environmental Health*. Retrieved January 18, 2013 at http://www.who.int/topics/environmental_health/en/
- ⁷ Centers for Disease Control and Prevention. National Center for Environmental Health. (2011). *Environmental Hazards and Health Effects*. Retrieved January 18, 2013 at <http://www.cdc.gov/nceh/ehhe/>
- ⁸ European Commission. (2012). *Environment and Health*. Retrieved January 18, 2013 at http://ec.europa.eu/research/environment/index_en.cfm?pg=health
- ⁹ RNAO. (2012). Position Statement: Healthy Energy Solutions for Ontario. Retrieved January 18, 2013 at http://rnao.ca/sites/rnao-ca/files/RNAO_Position_Statement_on_Healthy_Energy_Solutions_-_FINAL_and_dated_March_3_2011.pdf
- ¹⁰ European Environmental Agency. (2012). *The impacts of endocrine disruptors on wildlife, people and their environments – The Weybridge+15 (1996–2011) report*. Retrieved January 18, 2013 at <http://www.eea.europa.eu/publications/the-impacts-of-endocrine-disruptors>
- ¹¹ National Institutes of Health. National Institute of Environmental Health Sciences. (2012). *Endocrine Disruptors*. Retrieved January 18, 2013 at <http://www.niehs.nih.gov/health/topics/agents/endocrine/index.cfm>
- ¹² Solomon, G, and Schettler, T. (2000). Environment and health: 6. Endocrine disruption and potential human health implications. *Canadian Medical Association Journal*, 63(11), 1471-6. Retrieved January 18, 2013 at <http://www.cmaj.ca/content/163/11/1471.full.pdf>



Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

Nursing Care

RNAO's Policy Platform Backgrounder

January 2013

Do you know that Ontario has the second worst RN-to-population ratio in the country? Is that good for Ontarians? Nurses say, NO!

There are 70.8 Registered Nurses (RN) per 10,000 people in Ontario. The national average is 83.4 RNs per 10,000 people.^{1 2} With our population growing and many Ontarians becoming older, the province's RN-to-population ratio is worsening at a time when health needs have increased and become more complex. If action isn't taken quickly, patient care will be compromised. People need access to an adequate supply of RNs, and every RN should be able to contribute their full competencies, knowledge, and skills to their patients. This is how nurses can ensure timely access to quality care that is centred on the health needs of all Ontarians.

The province's RN-to-population ratio is even lower today than it was two years ago having lost 1,037 RN (general class) positions.³ The fact that the number of RNs in Ontario is getting worse should set off alarm bells for the public and for government. In order for Ontario to catch up with the rest of Canada, the province would have to add 16,831 more RNs to its workforce, an increase of 17.8 per cent. This is why government must urgently play catch-up by focusing its attention on increasing RN employment and adding by 2015 at least 9,000 full-time equivalent (FTE) RNs. Not only is this good health policy, it will also begin to close the worrisome gap between Ontario and the rest of the country.

The good news is that more nurses in Ontario are working full time and that's good for patients and health outcomes.^{4 5} Government shares RNAO's commitment to have 70 per cent of all nurses working full-time, which supports the continuity of care and caregiver that are central to good nursing care. Evidence shows that higher proportions of full-time RN staff are associated with lower mortality rates, continuity of care and continuity of caregiver, as well as improved patient outcomes.^{6 7 8} Conversely, excessive use of part-time and casual employment for RNs is associated with decreased morale, an unstable workforce where nurses move to other jurisdictions to find full-time work,⁹ disengagement among nurses, and a lack of continuity of care for patients.^{10 11} The share of full-time employment for RNs rose from 59.3 per cent to 68.6 per cent between 2004 and 2012. This trend has been very positive since 1998, when the share of full-time employment for RNs in the general class was below 50 per cent. Government must stay the course to achieve and maintain its target of 70 per cent of all nurses working full time, because that's what Ontarians need and deserve.

Ontario's nurses also want to work to full scope of practice, allowing the public to benefit from their competencies, knowledge and skills. Moreover, an evolving health system, coupled with the complex care requirements of Ontarians, requires an expanded role of the RN so more people can get timely access to quality care. Right now RNs in Ontario are limited in what they can do compared to other jurisdictions in Canada and abroad. For example, RNs in the United Kingdom can prescribe laboratory tests and medications. That's where British Columbia, Saskatchewan, Manitoba and Alberta are moving, and that



is what Ontario needs. RNAO's groundbreaking report *Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario*¹² -- a product of a provincial task force -- identifies the need to maximize and expand the scope of practice utilization of Ontario's 4,300 primary care RNs and RPNs over two phases. Consistent application of the full scope of practice of these nurses across all primary care models will be the hallmark of the first phase and serves as the initial step towards maximizing the scope of each inter-professional primary care team member.

The second phase proposed by the task force involves legislative and regulatory enhancements to expand the RN's scope of practice to include the ability to prescribe treatments and medication, order diagnostic testing and communicate a diagnosis. These activities are within the competencies, knowledge, and skills of the RN and would be authorized pending completion of a focused university pharmacology course. RN prescribing is a recognized international practice and has been subject to rigorous review within the literature.¹³ The outcomes of this practice have been highly beneficial at the patient, organization and system level.^{14 15} For example, RN prescribing has the ability to enhance patient access and continuity of care and caregiver in every sector. It also improves efficiency and cost-effectiveness within the system, while contributing to greater job satisfaction and retention of mid and late-career nurses.

Like most Canadians, nurses in Ontario want to protect our publicly-funded and not-for-profit health system, and strengthen it for generations to come. While Ontario's nurses know there are fiscal challenges in today's economy, most feel that cost containment cannot occur at the expense of quality and evidence-based patient care. They know there must be better solutions. Nurses say the way to save precious tax payer dollars is by decreasing duplication and substantively improving health-system integration, while anchoring the health system in primary care. To achieve a shift to community-based care, RNAO's second game-changing report: *Enhancing Community Care for Ontarians (ECCO)*¹⁶ proposes a three-year plan that addresses the greatest needs of our system. It urges government to ensure every Ontarian has timely access to comprehensive primary care, with a strong emphasis on health promotion, disease prevention, chronic disease prevention and management, and mental health care. It calls for a person-centred, evidence-based approach that will advance the principles of primary health-care for all. RNAO's ECCO model strengthens health system integration and alignment by enabling Local Health Integration Networks to effectively lead regional health system planning using population-based needs assessments, service agreements, along with appropriate funding, monitoring and accountability for all health-care sectors. At the centre of the ECCO model is the creation of Patient-Family Councils, which bring the voice of patients directly to the planning table.

Ontarians cannot afford to have their tax dollars invested in a costly system fraught with duplication. This is one of the reasons the ECCO model proposes a transition of Community Care Access Centre (CCAC) functions into established areas of the health system. It calls for transitioning the 3,500 Case Managers and Care Coordinators from CCACs into primary care through a carefully crafted labour strategy that anchors their role in serving Ontarians with complex needs and multiple co-morbidities. To achieve this type of renewal, it is imperative to strengthen and organize Ontario's 4,000 individual primary care entities into local primary care networks, configured according to geographical referral patterns. The end goal will be to position primary care as the co-ordinating "hub" of the local health-system. Eliminating the CCAC infrastructure will provide significant cost savings to be re-invested to create more than four



million hours of direct home health-care/support services. Nurses know our system can perform better and this alone provides proof.

As with any transformation, this will take time, however, it is within reach. RNAO challenges government to commit to provide all Ontarians with access to inter-professional primary care by 2020. This can be fully accomplished by expanding existing inter-professional primary care practices that hold infrastructure capacity, and by creating new sites where such capacity does not currently exist. To this end, government must target its investments in Community Health Centres, Nurse Practitioner-led clinics, Aboriginal Health Access Centres, and Family Health Teams, and stop enabling new solo physician practices.

Ontario's 26 Nurse Practitioner-led clinics (NPLCs)^{17 18} have been built from the ground up as a highly successful inter-professional model of primary care delivery that has improved access to care across the province. NPLCs are led by NPs in collaboration with a team of health professionals including RNs, RPNs, social workers, pharmacists, physicians, dieticians and others according to patients' needs. NPLCs offer comprehensive primary care services within a primary health-care framework. Embraced within the community, NPLCs partner with patients to coordinate their care and help them navigate the complexities of the health system.

Although early in their evolution, NPLCs are proving to be exceptional at improving health system cost-effectiveness, access to care and client outcomes. The clinics are well on their way to meeting and even surpassing government-mandated client targets. The Lakehead NPLC in Thunder Bay is just one example of an NPLC that has met its enrollment target and currently has a waiting list for clients desperately seeking primary care in Northern Ontario. Although this clinic has the infrastructure capacity to expand, it currently lacks the government funding to add human resources. Continued investments and expansions within the NPLC model are the right choice for Ontarians and the health system.

Lastly, and no less important, in shifting our health system from an illness-based model of care to a preventative one is securing fair wages for registered nurses working in all sectors of health care. Current wage differentials act as a disincentive to working in home health care as well as other sectors. For example, between 1998 and 2004, the community health sector lost 27 per cent of its nursing workforce, due in part to wage differentials.¹⁹ Also, recruitment and retention issues for public health nurses are tied to disparities in compensation.²⁰ Similarly, long-term care RNs must receive comparable remuneration to the hospital sector in order to sufficiently meet the demand for highly skilled RNs caring for increasingly complex residents.²¹ NPs are also affected. The average maximum salary of a primary care NP in Ontario is \$90,000.²² In contrast, the average maximum salary of a NP in Alberta is \$120,000.²³ The role and responsibilities of the primary care NP have greatly expanded in recent years, yet compensation has remained relatively flat. Wage differentials present significant recruitment and retention implications that can impact the sustainability of Ontario's efforts to improve health in the community.

Recommendations:

1. Hiring 9000 additional FTE RNs by 2015.

2. Ensuring 70 per cent of all nurses work full-time so patients have continuity in their care and care provider.
3. Securing fair wages for nurses and nurse practitioners working in all sectors of health care.
4. Maximizing and expanding the role of RNs to deliver a broader range of care, such as ordering lab tests and prescribing medications.
5. Ensuring all existing nurse-practitioner-led clinics are funded to operate to full capacity, and opening new nurse practitioner-led-clinics where patient need exists.
6. Improving navigation across our complex system by partnering with patients to co-ordinate their care through primary care in community health centres, nurse practitioner-led clinics, and family health teams.
7. Committing to providing all Ontarians with access to integrated inter-professional primary care by 2020.
8. Supporting LHINs to achieve regional health system planning, integration and accountability for all health services, using an evidence-based and person-centred approach rooted within a population health, primary health-care framework.
9. Eliminating Community Care Access Centres by 2015 and transition 3,500 Case Managers and Care Coordinators into primary care through a carefully crafted labour management strategy that retains their salary and benefits.

Questions for Candidates

1. Will you support hiring 9000 additional FTE RNs by 2015 and ensure 70 per cent of all nurses work full-time to improve health outcomes across sectors?
2. Will you support fair remuneration of RNs and NPs across all health-care sectors?
3. Will you support maximizing and expanding the role of RNs to deliver a broader range of care such as ordering lab tests and prescribing medications?
4. Will you commit to ensuring all existing nurse-practitioner-led clinics are funded to operate to full capacity, and opening new nurse practitioner-led-clinics where patient need exists?
5. Will you commit to partnering with patients to co-ordinate their care through primary care, and transition 3,500 Case Managers into primary care through a carefully crafted labour management strategy that retains their salary and benefits?
6. Will you commit to providing all Ontarians with access to integrated inter-professional primary care by 2020?
7. Will you support LHINs to achieve regional health system planning, integration and accountability for all health services, and eliminate Community Care Access Centres by 2015?

References

¹ Interprovincial comparisons are done using CIHI data, which differs slightly from CNO data because CIHI adjusts CNO and other provincial RN workforce numbers for RNs who work on both sides of the provincial border.

² College of Nurses of Ontario. (2012). *Nursing Statistics*. Retrieved January 23, 2013 at <http://www.cno.org/what-is-cno/nursing-demographics/>

³ Ibid.

- ⁴ Registered Nurses' Association of Ontario. (2005). *The 70 Per Cent Solution: A Progress Report on Increasing Full-Time Employment for Ontario RNs*. Toronto: Author. Retrieved January 24, 2013 from <http://rnao.ca/policy/reports/70-percent-solution>
- ⁵ Ministry of Health and Long-Term care. (2010). Message from the provincial chief nursing officer. Retrieved January 24, 2013 at www.health.gov.on.ca/.../nursing_sec/.../nursing_news_20100112.pdf
- ⁶ Estabrooks, C., Midodzi, W., Cummings, G., Ricker, K., & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research*, 54(2), 74-78.
- ⁷ O'Brien-Pallas, L., Thomson, D., Hall, M., Pink, G., Kerr, M., Wang, S., Li, X. & Myer, R. (2004). Evidence-based *Standards for Measuring Nurse Staffing and Performance*. Ottawa: Canadian Health Services Research Foundation. Retrieved January 24, 2013 at <http://www.nhsru.com/publications/evidence-based-standards-for-measuring-nurse-staffing-performance>
- ⁸ Meyer, R., Wang, S., Li, X. & Thomson, D. (2009). Evaluation of a Patient Care Delivery Model: Patient Outcomes in Acute Cardiac Care. *Journal of Nursing Scholarship*, 41(4), 399-410, 408.
- ⁹ McGillis Hall, L., Pink G., Jones C., Leatt P., Gates M. & Peterson, J. (2009) Is the grass any greener? Canada to United States of America nurse migration. *International Nursing Review*, 56(2), 198-205.
- ¹⁰ Grinspun, D. (2003). Part-time and casual nursing work: The perils of health-care restructuring. *International Journal of Sociology and Social Policy*, 23 (8/9), 54-80.
- ¹¹ Meyer, R., Wang, S., Li, X. & Thomson, D. (2009). Evaluation of a Patient Care Delivery Model: Patient Outcomes in Acute Cardiac Care. *Journal of Nursing Scholarship*, 41(4), 399-410.
- ¹² Registered Nurses' Association of Ontario. (2012). *Primary solutions for primary care*. Retrieved January 23, 2013 at <http://rnao.ca/policy/reports/primary-solutions-primary-care>
- ¹³ International Council of Nurses. (n.d.). *Implementing Nurse Prescribing*. Retrieved January 23, 2012 at <http://www.icn.ch/vmchk/English/Implementing-Nurse-Prescribing.html>
- ¹⁴ Ibid.
- ¹⁵ Registered Nurses' Association of Ontario. (2012). *Primary solutions for primary care*. Retrieved January 23, 2013 at <http://rnao.ca/policy/reports/primary-solutions-primary-care>
- ¹⁶ Registered Nurses' Association of Ontario. (2012). *Enhancing Community Care for Ontarians*. Retrieved January 23, 2013 at <http://rnao.ca/policy/reports/rnaos-ecco-report-enhancing-community-care-ontarians-%E2%80%93-three-year-plan>
- ¹⁷ Ministry of Health and Long-Term Care. (n.d.). *Nurse Practitioner-Led Clinics*. Retrieved January 23, 2013 at http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html
- ¹⁸ Nurse Practitioners' Association of Ontario. (n.d.). *Nurse Practitioner-Led Clinics*. Retrieved January 23, 2013 at <http://npao.org/nurse-practitioners/clinics/>
- ¹⁹ Nursing Health Services Research Unit. (2006). *Home Health Nurses in Ontario Fact Sheet*. Hamilton/Toronto: McMaster University/University of Toronto. Retrieved January 19, 2010 from www.nhsru.com
- ²⁰ Capacity Review Committee. (2005). *Interim Report on Capacity Review Committee: Revitalizing Ontario's Public Health Capacity – A Discussion of Issues and Options*. Ministry of Health and Long-Term Care. 32-34. Retrieved January 24, 2013 at http://www.health.gov.on.ca/en/common/ministry/publications/reports/capacity_review05/capacity_review05.aspx
- ²¹ Registered Nurses' Association of Ontario. (2008). *Staffing and Care Standards for Ontario's Long-Term Care Homes: RNAO's Submission to MOHLTC*. Retrieved January 24, 2013 at <http://rnao.ca/policy/reports/submission-to-MOHLTC-staffing-and-care-standards-for-LTC-homes>
- ²² Nurse Practitioner Association of Ontario. *Personal Communication*.
- ²³ Alberta Health Services. (n.d.). *Careers*. Retrieved January 23, 2013 at <http://www.albertahealthservices.ca/careers/>



Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

MEDICARE FOR TODAY AND THE NEXT GENERATION

RNAO's Policy Platform Backgrounder

January 2013

Canada's cherished health-care system came under recent attack in Ontario. In the fall of 2012, RNAO successfully advocated for the government not to sell the Shouldice Hospital to a for-profit U.S. conglomerate,^{1 2} arguing Ontarians need a health-care system that:

- Does not cut corners in order to maximize return on shareholders' investment,
- Does not promote financial incentives that close the door on "unprofitable" patients, and
- Does not provide faster access to those who can afford it.

Over the past decade, Prime Minister Stephen Harper's hands-off approach to enforcing the *Canada Health Act, 1985*³ has allowed jurisdictions to experiment with two-tiered services, delisting, user fees and private for-profit medicine.⁴ Most recently, federal finance Minister Jim Flaherty announced future funding increases earmarked for health would be lower than in the past.⁵ Former Saskatchewan premier Roy Romanow described the Prime Minister's plan for health-care transfers as a deliberate strategy to abandon health care to the provinces and foster the development of more private, for-profit medical enterprises.⁶

Any doubts that a publicly funded, not-for-profit health-care system provides better outcomes and better value are quickly allayed by a look south of the border. Commercialization of health care in the United States has not served its people well. A review of four decades of experience with privatization found that "for-profit health institutions provide inferior care at inflated prices."⁷

Nurses know that flirting with for-profit health care must be rejected in the strongest possible terms based on the overwhelming evidence that for-profit delivery produces worse patient outcomes, diverts resources away from publicly accessible health-care services and is more expensive. Protecting the public thus requires: rejecting competitive bidding for home care; a moratorium on private-finance, for-profit (P3) hospitals; and opposing trade deals that undermine the ability of democratic governments to regulate in the public's interest.

Parties and politicians who attempt to destabilize Medicare with inadequate funding only to profit from investments in for-profit health-care services will be remembered at the polls. RNAO agrees changes are needed to make our system more responsive. Those that tap the knowledge and skills of health-care professionals such as RNs, including nurse practitioners in addition to other members of the health-care team, will help us achieve the kind of system we need. When all health professionals are working to their full scope of practice, truly transformative change will result in a system that is more efficient, more cost-effective and delivers better health outcomes for patients and taxpayers.



Recommendations:

1. **Commit to and expand our publicly funded, not-for-profit health-care system in areas such as home care.**
2. **Reject efforts to commercialize or privatize health-care delivery.**
3. **Focus on well-researched and demonstrated policies and evidence-based clinical practices to optimize the health of people, families, communities, and our health system.**

Questions for candidates:

1. **Will you commit to protecting Medicare and expanding our publicly funded, not-for-profit health-care system in areas such as home care?**
2. **Will you reject attempts to commercialize or privatize health-care delivery?**
3. **Will you commit to demanding a focus on well-researched and demonstrated policies and evidence-based clinical practices to optimize the health of people, families, communities, and our health system?**

References

¹ Registered Nurses' Association of Ontario. (2012). *Action Alert: Ask Health Minister to reject selling Shouldice Hospital to For-Profit US Conglomerate*. Retrieved January 23, 2013 at <http://rnao.ca/policy/action-alerts/action-alert-ask-health-minister-reject-selling-shouldice-hospital-profit-us-co>

² London Free Press. (2012). *The sale of Shouldice Hospital is the first casualty of the Ontario legislature's shutdown*. Retrieved January 23, 2013 at <http://www.lfpress.com/2012/11/16/the-sale-of-shouldice-hospital-is-the-first-casualty-of-the-ontario-legislatures-shutdown>

³ Government of Canada. (n.d.). *Canada Health Act, 1985*. Retrieved January 23, 2013 at <http://laws-lois.justice.gc.ca/eng/acts/C-6/>

⁴ Mehra, N. (2008). *Private clinics report: Eroding public Medicare – Costs and consequences*. Retrieved January 23, 2013 at <http://www.web.net/ohc/Privatization.htm>

⁵ Globe and Mail. (2012). *Flaherty's 10-year health-care plan divides provinces*. Retrieved January 23, 2013 at <http://www.theglobeandmail.com/news/politics/flahertys-10-year-health-care-plan-divides-provinces/article4181493/>

⁶ National Post. (2012). *Stephen Harper's hand's off stance could signal end to national health-care system: Romanow*. Retrieved January 23, 2013 at <http://news.nationalpost.com/2012/01/08/stephen-harpers-hands-off-stance-could-signal-end-to-national-health-care-system-romanow/>

⁷ Woolhandler, S & Himmelstein, D. (2007). "Competition in a publicly funded healthcare system." In *British Medical Journal*, December, Vol. 335. Retrieved January 23, 2013 at www.pnhp.org/PDF_files/BMJ_Woolhandler_Market_Failure.pdf



HOW DO WE PAY FOR THIS?

RNAO's Policy Platform Backgrounder **January 2013**

Ontario is dealing with a significant but not unmanageable deficit and debt. It's important to understand how and why we got into this situation, and why more austerity is not the solution to our economic and social challenges.

During the mid-1990s and early 2000s, the government of Ontario cut revenues and expenditures severely. Government revenues as a share of Gross Domestic Product (GDP) fell from 17.7 per cent in 1996 to 15.5 per cent in 2003. Over the same period, program expenditures were cut from 16.9 per cent to 14.2 per cent of GDP.¹ This created a severe social deficit and limited the ability to deal with it due to lower tax rates. Subsequently, the government restored much of the program spending and brought in more revenue with the introduction of a health tax. With economic recovery, rising revenues pushed the government into a modest surplus. However, the brutal 2008 recession called for major spending to help head off economic collapse. Spending jumped from 17.7 per cent of GDP in 2008-09 to 19.9 per cent in 2009-10.² The deficit spending strategy in Ontario and across the country did succeed in averting a much worse economic decline. A negative side effect was very large deficits at a time when the economy remains fragile.

Ontario must resist the temptation to punish the economy further with untimely spending cuts. Ill-advised austerity policies in Europe are plunging country after country into severe recession and social strife. That doesn't need to happen in Ontario, nor in Canada. The deficit in Ontario is significant but manageable. Thanks to low interest rates, now is a good time to invest in rebuilding the economy. In spite of the growing debt, interest charges on the debt have remained at a fairly flat 1.5 to 1.6 per cent of GDP.³ Enhanced revenue measures, such as reducing tax avoidance, more green taxes, prices on carbon and surcharges on those better able to pay, will help to reduce the deficit and restore Ontario's fiscal capacity.

Recommendations:

- 1. Make sure people pay their fair share of taxes. Tax cuts for wealthy people and cutting spending for social programs hurt our economy.**
- 2. Impose green taxes to help pay for the damage polluters cause.**

Questions for candidates:

- 1. Do you commit to protect social spending and public services despite our fiscal challenges?**
- 2. Are you willing to make sure people, in particular those in upper income levels, pay their fair share of taxes?**

3. Do you support green taxes and prices on carbon in order to make polluters pay for the damage they cause?

References

¹ Statistics Canada. (2009). *Table 385-0002 Federal, provincial and territorial general government revenue and expenditures, for fiscal year ending March 31, annual*. Retrieved January 18, 2013 at <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=3850002&paSer=&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid=>

² Duncan, D. (2012). *2012 Ontario Budget*. Table 2.31, p. 198-199. Retrieved January 18, 2013 at http://www.fin.gov.on.ca/en/budget/ontariobudgets/2012/papers_all.pdf

³ Ibid. Table 2.31, p. 198-199.

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses wherever they practise in Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the health-care system, and influenced decisions that affect nurses and the public they serve.



*for more info about
why your health matters, go to
www.RNAO.ca*

*join the conversation on
Facebook and Twitter*



January 2013