

Creating Vibrant Communities

RNAO's Challenge to
Ontario's Political Parties

2011 Provincial Election



Technical Backgrounder

J a n u a r y 2 0 1 0

MISSION STATEMENT

The Registered Nurses' Association of Ontario (RNAO)

We represent the nursing profession in Ontario, speaking out for health and speaking out for nursing.

Our mission is to pursue healthy public policy and to promote the full participation of registered nurses in shaping and delivering health services now and in the future. We believe health is a resource for everyday living and health care a universal human right.

We cultivate knowledge-based nursing practices, we promote quality of work life, and we promise excellence in professional development services.

Respecting human dignity, we are a community committed to diversity, inclusivity, democracy and voluntarism. We make leadership our mandate, working with nurses, the public, health-care providers and governments to advance individual and collective health.

RNAO's Strategic Directions:

- RNAO influences public policy that strengthens Medicare and impacts on the determinants of health.
- RNAO speaks out on emerging issues that impact on health, health care and nursing.
- RNAO advances nursing as a vital, significant and critical contributor to health.
- RNAO influences the public to achieve greater engagement in health care.
- RNAO inspires every RN and undergraduate basic nursing student to be a member.

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PREFACE

The Registered Nurses' Association of Ontario (RNAO) is the professional organization for registered nurses who practise in all roles and sectors across Ontario. We work to improve health and strengthen our health-care system. Nurses believe health is a resource for everyday living and that access to the conditions that permit health, including access to health care, are universal human rights.

We are proud to share *Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties: Technical Backgrounder*. This document and its companion summary document present our key policy priorities for the provincial election that will take place on October 6, 2011. This election, the first as Ontario emerges from a recession, sees the province at a crossroads. Faced with our social and physical infrastructure badly strained and the manufacturing sector, formerly Ontario's bedrock, fundamentally altered, voters have a crucial choice to make. Some will tell you we need to choose between social programs and deficit-cutting, or between a clean environment and jobs. Forcing such choices is unacceptable.

There is no question that government must be aware of fiscal realities and find new and creative ways to ensure it has the capacity to deliver the services needed by a modern, sustainable society. *Creating Vibrant Communities* identifies progressive sources of revenue that would enhance overall efficiency and send appropriate signals to markets. We know from the mid-1990's that cutting deficits on the backs of nurses, other public sector workers and necessary public services does not work. Nurses believe there is a better way. First, it requires a commitment to better health care, a cleaner environment, prosperity and a brighter future for our children, all in the context of equity and fiscal responsibility. Second, we recognize that the path to prosperity is through economic growth – including the green jobs of the future – not cuts to public necessities. Third, we need the leadership and political will to make it happen. That's what we mean by "vibrant communities."

Creating vibrant communities means:

- Strengthening Social Determinants, Equity and Healthy Communities
- Building Sustainable, Green Communities
- Enhancing Medicare
- Improving Access to Nursing Services
- Building a Nursing Career in Ontario
- Embracing our Democracy, Strengthening our Public Services

Vibrant Communities are built on the following fundamental principles that cross all six of the above areas:

- Equity – In vibrant communities nobody is left behind. There are those who did not share in the prosperity of good times and who are at greatest risk during difficult times. In vibrant

communities, the underlying factors that lead to social inequities must be addressed so that those inequities do not contribute to widening disparities in health and access to health care.

- Dignity – Whether you are a senior looking for basic support to live in your own home and community, or a mid-career nurse who seeks respect in the workplace, or a family requiring emergency shelter, there is the overriding desire and right to be treated with dignity. In vibrant communities, everyone is treated with dignity.
- Accountability, transparency, democracy – These are the touchstones of our parliamentary democracy, essential for positive change and should be apparent in how we relate to each other and in our health institutions.
- Upstream, visionary policies - Upstream, long-term, visionary thinking to address the root causes of ill-health and premature mortality must be the foundation of healthy public policy and multi-sectoral action. In vibrant communities, evolving evidence on the social and environmental determinants of health is used to safeguard the health of the public and reduce health inequities.
- Fairness and respect for our first peoples – Nowhere are the consequences of government inaction, failed policies and inequity felt more profoundly than in Aboriginal communities. Vibrant communities mean respect for the right of our first peoples to self-determination¹ and equitable access to resources, jobs, health care, clean water, good schools and safe housing.
- Health and health care for all - Canadians have a deep and abiding commitment to the *Canada Health Act*² and to the principle of a universal, single-tier, health care system built on core values of equity, fairness, and solidarity.³ People living in vibrant communities have access to a spectrum of high-quality, client-centred health care services based on need rather than ability to pay. This includes expanding Medicare to include coverage of pharmaceuticals and home care. But that is only part of the story. Tommy Douglas’s vision of Medicare included moving to a second stage focused on prevention and keeping people well. This means addressing the social, environmental and other factors that affect the health of Canadians.⁴

All these programs should be designed to keep people well – because in the long run it’s cheaper to keep people well than to be patching them up after they are sick.

Tommy Douglas, Montreal, 1982⁵

Nurses know that if implemented, the practical policies recommended in *Creating Vibrant Communities: RNAO’s Challenge to Ontario’s Political Parties* will, along with the principles above, lead to improved health outcomes for Ontarians and healthy communities – *vibrant communities* – for all of us.

A. STRENGTHENING SOCIAL DETERMINANTS, EQUITY AND HEALTHY COMMUNITIES

Making Our Values Explicit: Access to Health and Health Care are Fundamental Human Rights

In order to be healthy, there are conditions that must be in place. Access to conditions that permit health, including access to health care, are universal human rights according to these foundational international human rights documents:

*Universal Declaration of Human Rights*⁶ (1948): “Everyone has the right to a standard of living adequate for the health and well-being of him[/her]self and of his[/her] family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his[/her] control.” Article 25

*International Covenant on Economic, Social and Cultural Rights*⁷ (1966): “The State Parties to the present Covenant recognize the right of everyone to an adequate standard of living for him[/her] and his [/her] family, including adequate food, clothing and housing, and to the continuous improvement of living conditions.” Article 11

“The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) the improvements of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) the creation of conditions which would assure to all medical services and medical attention in the event of sickness.” Article 12

*Declaration of Alma-Ata, International Conference on Primary Health Care*⁸ (1978): “The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.” Section 1

Although Canada ranks near the top of the Human Development Index of the United Nations Development Program and “has the capacity to achieve a high level of realization of all Covenant rights,”⁹ the United Nations has identified areas of concern where Canada is not meeting its human rights responsibilities. The Committee on Economic, Social and Cultural Rights, for example, reported in 2006 that Canada had not implemented 1993 and 1998 recommendations that would facilitate Canada fulfilling its legal obligations under the Covenant.¹⁰ The United Nations’ Human Rights Council’s Special Rapporteur, Miloon

Kothari, conducted a mission to Canada in October 2007. In his report, Kothari noted that as early as 1999, the Human Rights Commission expressed concern that homelessness was leading to serious health problems and death in Canada.¹¹

Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties is built on human rights as a primary value and evolving evidence on what is needed to safeguard health and reduce health inequities.

Strengthening Human Rights in Ontario

In explicit accordance with the Universal Declaration of Human Rights, the *Ontario Human Rights Code* states “it is public policy in Ontario to recognize the dignity and worth of every person and to provide for equal rights and opportunities without discrimination.”¹²

The Committee on Economic, Social and Cultural Rights has identified as an area of concern “Canada’s restrictive interpretation of its obligations under the Covenant, in particular its position that it may implement the legal obligations set forth in the Covenant by adopting specific measures and policies rather than by enacting legislation.”¹³ The Special Rapporteur affirmed previous recommendations by the Committee on Economic, Social and Cultural Rights that “human rights legislation in all Canadian jurisdictions be amended to fully include economic, social and cultural rights and that they be included in the mandates of all human rights bodies.”¹⁴

RNAO’s Recommendations:

Make Ontario a leader in human rights protection by:

- **urging the federal government to fulfil its obligations under international conventions and treaties by implementing the recommendations of the Committee on Economic, Social and Cultural Rights and other international bodies;**
- **amending provincial human rights legislation to fully include economic, social, and cultural rights;**
- **amending the *Ontario Human Rights Code* to explicitly list gender identity as a prohibited ground of discrimination and harassment and include sexual orientation as a prohibited ground of harassment;¹⁵**
- **providing adequate funding for the Ontario Human Rights Tribunal to enhance enforcement of equality rights through the *Ontario Human Rights Code*.**

Addressing the Social Determinants of Health and the Production of Health Inequities

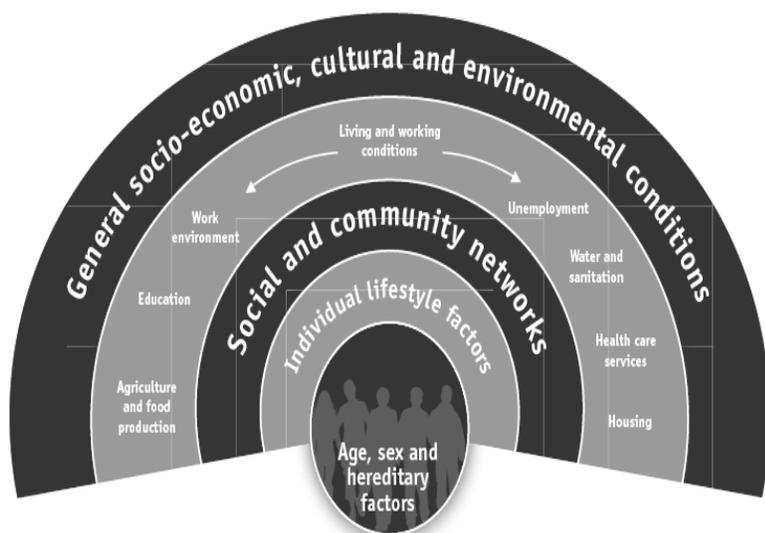
The health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and nationally, the consequent unfairness in the

immediate, visible circumstances of peoples’ lives—their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics.¹⁶

WHO Commission on the Social Determinants of Health

The social determinants of health are the “circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness.”¹⁷ These circumstances are, in turn, shaped by a wider set of political, economic, social, cultural, and environmental conditions and forces. The determinants of the general health of the population may be viewed as “rainbow-like layers of influence” as demonstrated below

Main Determinants of General Health¹⁸



Source: Dahlgren and Whitehead (2006)

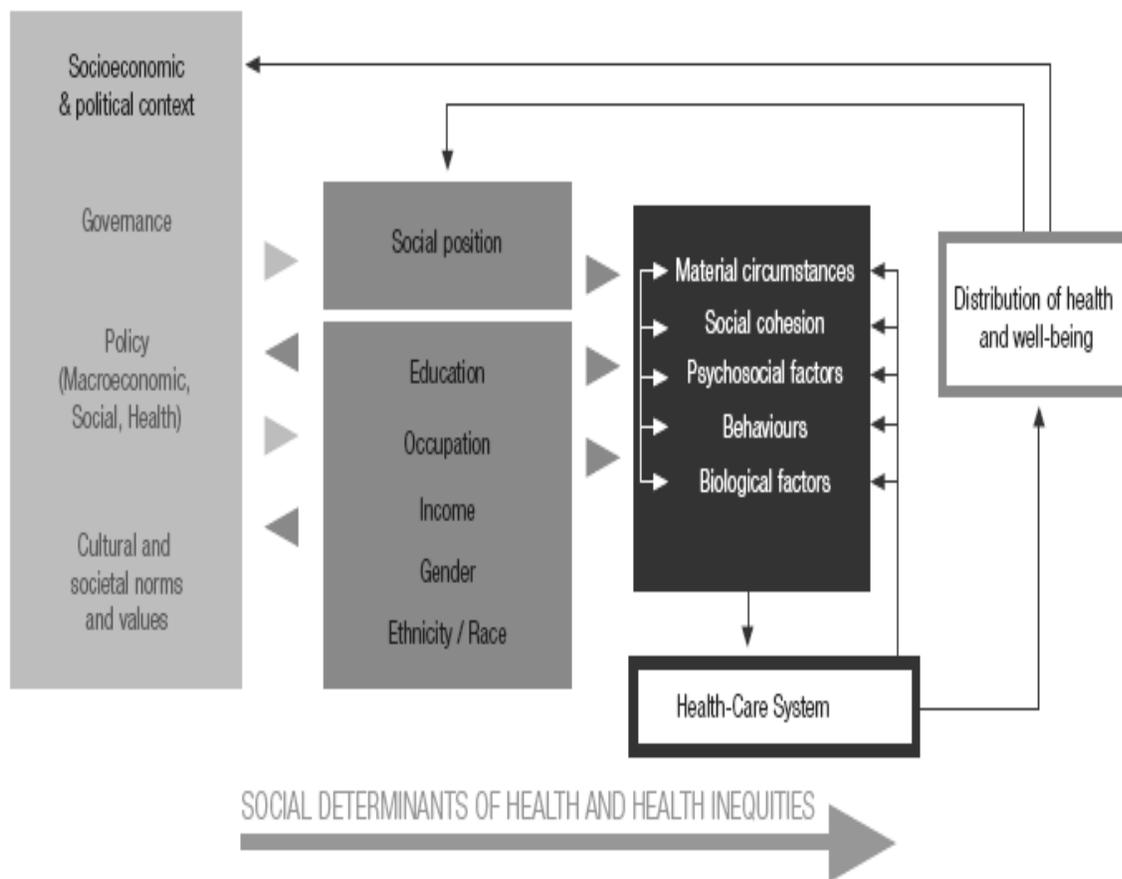
Across the globe, people with lower socio-economic status tend to have worse health. Not only do people living in poverty have worse health outcomes, there is also a social gradient in health that runs from the top to the bottom of the socio-economic spectrum. This is a worldwide phenomenon observed in high, middle, and low income countries. The social gradient in health means that health inequities affect everyone.¹⁹

A dramatic example of how health disparities mirror income disparities may be found in a Statistics Canada analysis of mortality data from 1991-2001. The remaining life expectancy at age 25 years for men with the lowest incomes was 48.6 years compared with 52.9 years for men in the middle income group, and 56 years for men in the highest income group.²⁰ A clear socio-economic gradient is also shown in the remaining life expectancy at age 25 years for

women with 56.5 years for the lowest income groups compared with 59.4 years for the middle group and 61 years for the highest income group.²¹ While the contrast of 7.4 years for men and 4.5 years for women of additional life expectancy between highest and lowest is striking, it is also important to note the extra years of life expectancy between the middle and highest income groups. When these researchers considered health-related quality of life they found that the morbidity gaps were even greater: those in the highest income group for men had 11.4 more years of healthy living and women in the highest income group had 9.7 more years of healthy living compared with those in the lowest income groups.²² Once again there was a gradient evident when comparing those in the middle to the most affluent groups with an extra 4.2 years of health-adjusted life expectancy for men and 3.8 years for women.²³ For comparison, cancer, the leading cause of death in Canada,²⁴ only reduces health-adjusted life expectancy at birth by 2.8 years for men and 2.5 years for women.²⁵ The Globe and Mail's Andre Picard's review of this report concluded that "the data tell us that the most powerful tool that we have in our health-care armamentarium is income redistribution."²⁶

Health inequities are the avoidable inequalities in health between groups of people both within countries and between countries.²⁷ There has been an evolving understanding over the last few decades^{28 29 30 31 32 33 34 35} that health inequities are inexorable reflections of social inequities. The World Health Organization's Commission on the Social Determinants of Health (2005-2008)³⁶ and its Knowledge Networks³⁷ were commissioned to collect, collate, and synthesize the global evidence on the social determinants of health and their impact on health inequities.³⁸ The Commission's final report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, was released in August 2008 and provides a compelling conceptual framework, evidence, and principles for action.³⁹

Commission on Social Determinants of Health Conceptual Framework⁴⁰



Source: Amended from Solar & Irwin, 2007

The Commission on the Social Determinants of Health's analysis of the evidence leads to three principles of action:

- Improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age.
- Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.⁴¹

The World Health Assembly has issued an urgent call to reduce health inequities through action on the social determinants of health⁴² and we are living in a context where jurisdictions such as the European Union,^{43 44} United Kingdom,^{45 46} United States,⁴⁷ and Canada^{48 49 50} (including regional health authorities in British Columbia,^{51 52} and the Saskatoon Health

Region⁵³) are making progress in utilizing public health science on health disparities to improve public policy and ultimately health outcomes.

The Standing Senate Committee on Social Affairs, Science and Technology's Final Report of the Subcommittee on Population Health highlighted the striking and widening disparities between Aboriginal⁵⁴ and non-Aboriginal Canadians in health status and most health determinants.⁵⁵ Life expectancy at birth, for example, shows dramatic differences between Inuit women at 68 years, First Nations women at 77 years, and non-Aboriginal women at 82 years.⁵⁶ The same trend is visible when comparing life expectancy at birth for Inuit men at 70 years, First Nations men at 69 years, and non-Aboriginal men at 76 years. A compelling National Collaborating Centre for Aboriginal Health report identifies the distal determinants of Aboriginal health (the macro factors in the left-hand column of the CSDOH framework above) as colonialism, systemic racism, social exclusion, and the repression of self-determination.⁵⁷ Experiences of trauma such as the residential schools had a profoundly negative impact on the health and well-being not only of the survivors, but also on their children and grandchildren as well.⁵⁸ Self-determination influences all other determinants and has been cited "as the most important determinant of health among Aboriginal peoples."⁵⁹

Given the evidence that ill-health and premature death are not natural phenomenon but the predictable result "of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics," the recommendations in *Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties* are offered in the spirit of commitment to working together to build a better province for all Ontarians.

Vision of a Poverty-Free Ontario

Creating Vibrant Communities is guided by the vision of a poverty-free province where all Ontarians have the opportunity to achieve their full potential and contribute to and participate in a prosperous and healthy Ontario.

Every day registered nurses across the province work with their patients, clients and neighbours as they struggle to meet basic needs for nutritious food, affordable shelter, and human dignity. Poverty is such a threat to the health and well-being of individuals, families, and communities that RNAO welcomed the release of *Breaking the Cycle—Ontario's Poverty Reduction Strategy*⁶⁰ in December 2008 as a strong start to building a stronger, healthier, more inclusive society. Now, more than ever, in these challenging economic times, bold and sustained leadership is required because the promise of this strategy must be fully realized in improved living conditions and healthier, longer lives for all Ontarians.

Poverty remains a distressingly large and persistent problem in Ontario. The 2006 Census Canada data reveal that approximately 1.3 million Ontarians had an after-tax income at or below the Low Income Cut-Off (LICO).⁶¹ In 2007, when Ontario was showing strong economic growth, almost one in nine or 317,900 children and youth under 18 years of age were living in poverty in Ontario.⁶² This puts Ontario's child poverty (based on the Low Income Measure After Tax) rate at 11.7 per cent, which is well above the 9.2 per cent rate in 1989⁶³

when the all-party resolution in the House of Commons to end child poverty in Canada was much-heralded.⁶⁴

Poverty is not random. Those found to be more vulnerable to persistent low income include: single parents (most frequently mothers); individuals aged 45-64 years who are living alone; recent immigrants; persons with a work-limiting disability; Aboriginal people; individuals who drop out of high school;^{65 66} women;⁶⁷ and racialized group members.⁶⁸ Racialization of poverty⁶⁹ merits particular concern as the poverty rate for the racialized family population in Toronto increased steadily from 20.4 per cent in 1981, to 25.5 per cent in 1991, to 29.5 per cent in 2001. This is significantly higher than the 11.6 per cent poverty rate in 2001 for the non-racialized family population.⁷⁰ Racialization of child poverty is most evident in the Greater Toronto Area (GTA), which is home to 80 per cent of Ontario's immigrants and visible minorities and was recently described as "the child poverty capital of Ontario."⁷¹ According to the Children's Aid Society, 50 per cent of Ontario's children in poverty now live in the GTA, compared with 44 per cent in 1997.⁷² An illustration of the extent to which Aboriginal people are consistently over-represented among people living in poverty is made visible in the following statistics. In 2000, the incidence of low income for persons 15 years and older living in families was 37.3 per cent for First Nations, 24.5 per cent for Métis, 21.9 per cent for Inuit and 12.4 per cent for non-Aboriginal Canadians.⁷³ Unattached individuals for the same year and demographic groups fared even worse with their incidence of low income with 59.8 per cent for First Nations, 51.7 per cent for Métis, 56.8 per cent for Inuit, and 37.6 per cent for non-Aboriginal Canadians.⁷⁴

"Social exclusion" is used by the government of the United Kingdom as "a short-hand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, bad health and family breakdown."⁷⁵ Forms of exclusion are often combined and mutually reinforcing, thereby creating webs of vulnerability.⁷⁶ Racialization of poverty in Canada, for example, has increasingly been made visible by segregated neighbourhoods where racialized groups are relegated to substandard housing, limited access to employment, and inadequate social services.⁷⁷ Evidence for this alarming trend is that the low-income racialized family population went from making up slightly more than one-third of the total low-income family population in Toronto's higher poverty neighbourhoods in 1981 to more than three-quarters by 2001.⁷⁸

Where one falls along the income gradient is literally a matter of life and death. There is overwhelming evidence from academic research and our own nursing practice that those who live in poverty and are socially excluded experience a greater burden of disease and die earlier than those who have better access to economic, social, and political resources.^{79 80 81}

Differences in social and economic status are directly linked to inequitable health outcomes. Canada's Chief Public Health Officer has noted that if all Canadians had the same rate of premature mortality as the most affluent one-fifth of Canadians, there would be a 20 per cent reduction in early death across the population.⁸² Just to give perspective, this would be equivalent to wiping out all premature deaths from either injuries or cardiovascular disease.⁸³

Nurses know that “recessions hit poor the hardest.”⁸⁴ People whose health and dignity was already compromised by dangerously low assistance rates and subsistence wages during prosperous economic times do not have savings tucked away for a rainy day.

The income gap between rich and poor that was at a 30-year high in prosperous times⁸⁵ has widened as “income polarization always gets worse during recessions.”⁸⁶ At the same time the health disparities are increasing. As a report from the Community Social Planning Council of Toronto and the Wellesley Institute notes, although high income does not guarantee good health, “low income almost inevitably ensures poor health and significant health inequity in Canada.”⁸⁷ Those at the bottom quintile of household income have significantly higher incidences of endocrine and metabolic conditions, circulatory conditions, eye diseases, diseases of the nervous system and developmental disorders, respiratory diseases, musculoskeletal conditions, and mental and behavioural disorders.⁸⁸ An annual increase of \$1,000 in income for the poorest 20 per cent of Canadians would lead to almost 10,000 fewer chronic conditions and 6,600 fewer disability days every two weeks.⁸⁹

In addition to the human costs of poverty, there are compelling economic reasons why we cannot afford not to act on poverty. Poverty in Ontario costs the federal and provincial governments between 10 and 13 billion dollars each year. Private and public (or social) costs combined are \$32.2 to \$38.3 billion (equivalent to 5.5 to 6.6 per cent of Ontario’s Gross Domestic Product (GDP)).⁹⁰ Sound social investment is both good social policy and good economic policy.

Pathways to a Poverty-Free Ontario: Employment and Working Conditions

Approximately 200,000 people in Ontario earn the minimum wage, and approximately 1.2 million workers earn less than \$10 per hour.⁹¹ While the McGuinty government did increase the minimum wage to \$8/hour in February 2007, \$8.75/hour in March 2008 and \$9.50/hour in March 2009, working people earning the minimum wage are still far below the poverty line.⁹² The proposed increase in the minimum wage to \$10.25 by 2010 in Ontario’s 2007 Budget⁹³ is too gradual for people struggling in poverty today.

Aboriginal people are less likely than other Canadians to participate in the labour force and if they are in the labour force, their level of unemployment is between two and three times higher than it is for other Canadians.⁹⁴ Whether considering full-time, full year employment or part-time employment, annual earnings from employment are considerably lower for Aboriginal people compared with other Canadians.⁹⁵ The total median income for Aboriginal people in Canada, 15 years of age and over from the 2001 Census was \$13,525 compared with \$22,431 for non-Aboriginal people.⁹⁶

With 37 per cent of all jobs now being “non-standard” as part-time, temporary, contract, or self-employed work, many low-income families juggle multiple jobs with little security.^{97 98} The Auditor General of Ontario found in 2004⁹⁹ and 2006¹⁰⁰ that the Ministry of Labour fails to protect vulnerable workers by not adequately enforcing the *Employment Standards Act*. The *Employment Standards Act* must be strengthened to better protect vulnerable workers,¹⁰¹ and the government of Ontario must better enforce employment standards.

Employment Insurance (EI), formerly termed Unemployment Insurance (UI), is the major program that historically was used by the federal government to help Canadians weather the financial risks of unemployment. Canada's unemployment benefits are very low compared to the vast majority of OECD nations and so fall much below the OECD average.¹⁰² The maximum weekly benefit in 1996 was \$604 (in today's dollars). After a decade-long freeze on maximum insurable earnings, it is now only \$435, with the average benefit being just \$335 per week.¹⁰³ This is not enough to ensure that a single person is not in poverty, let alone enough to support a family.

Changes to the program have left many unemployed people unable to access benefits. While 74 per cent of unemployed workers in Canada were entitled to receive UI benefits in 1990, only 36 per cent were able to access benefits under the new EI program in 2004.¹⁰⁴ Broken down by gender, coverage for women dropped from 69 per cent in 1990 to 32 per cent in 2004.¹⁰⁵ Ontario's unemployed workers fared worse than the national average as only 26 per cent received EI in 2004 (28 per cent for men; 23 per cent for women).¹⁰⁶ In addition to women being especially affected, recent immigrants, many young people, part-time, temporary, and seasonal workers often do not have enough hours to qualify for EI, especially in large cities.¹⁰⁷ The result of the deep cuts to EI benefits paid to unemployed workers is that the EI program accumulated a surplus of \$54 billion since the mid-1990's, however, successive federal governments refused to use this EI surplus to improve EI benefits or stop EI premium increases.¹⁰⁸

There is a broad consensus that EI entrance requirements across the country should be uniform and reduced to 360 hours so that more workers will qualify. The 55 per cent benefit rate is too low a rate for many people, especially the most economically vulnerable workers with low wages and dependents.¹⁰⁹ In addition, longer benefit periods of up to 50 weeks are needed so fewer unemployed workers exhaust a claim.¹¹⁰ Reforming the EI system so that the workers who have paid into the system can access the benefits when they need them is only just. Preventing Canadians from sinking into poverty when they lose their jobs is essential to help safeguard health and well-being as the detrimental impacts of poverty are incontrovertible. In addition to being a social safety net for those who have become unemployed, increasing access to EI benefits will serve as an economic stimulus measure¹¹¹ as people will spend those benefits in their communities.

Reforming Social Assistance So That People May Live in Health and Dignity

For many years, social assistance rates have been far below any liveable or acceptable level. A comparative study of protection in 18 industrialized countries saw Canada plummet from 10th place in 1990 (\$8,512)¹¹² for a single-person household to 17th place (\$5,469) in 2005.¹¹³ Moving from one of the leading Canadian provinces in the provision of minimum income protection, Ontario was specifically mentioned in a discussion of social assistance "laggards" due to the more than 20 per cent cut to social assistance in 1995.¹¹⁴ The years from 2000 to 2005 in Ontario are on record as having the lowest levels of social assistance income since 1986, with recipients receiving only 34 per cent to 58 per cent of the poverty line in 2005.¹¹⁵

Social assistance rates did increase by eleven per cent between 2004 and 2009.¹¹⁶ However, even with the latest two per cent increase that came into effect in November 2009 for the Ontario Disability Support Program (ODSP) and December 2009 for Ontario Works (OW), a single person receiving ODSP has only a monthly benefit rate of \$1,042 while a single person receiving OW has only \$585.¹¹⁷

Deficiencies in the administration and service delivery of the ODSP that adversely affect clients have been documented by the Auditor General of Ontario,¹¹⁸ the Ombudsman of Ontario,¹¹⁹ and the Street Health Community Nursing Foundation.¹²⁰ Increasing access to ODSP by addressing barriers within the disability support system would provide significant benefit to Ontario's most vulnerable people, including those who are homeless.

In their current form both Ontario Works and ODSP deepen poverty and increase social exclusion of recipients. RNAO looks forward to a comprehensive approach to the government's promised "person-centred" reviews of the social assistance programs.

In 1998 the social assistance system that had been in place in Ontario for more than thirty years was reformed with the adoption of new legislation. With these changes, people who have disabling conditions caused solely by drug and/or alcohol addictions were excluded from eligibility for ODSP benefits.^{121 122} A recent Divisional Court decision found that "not only are addictions disabilities, but also to deny people ODSP benefits because their sole condition is an addiction is discriminatory, and contrary to *Ontario Human Rights Code*."¹²³ The government of Ontario is appealing this decision to the Ontario Court of Appeal.^{124 125}

Food Security: A Basic Human Need and Fundamental Human Right

A visible sign of Ontario's inadequate policy response to the most vulnerable members of our community is the existence of hunger and food insecurity. From 2001 to 2007, Ontario experienced a 14.3 per cent increase in the number of Ontarians served by food banks.¹²⁶ During these brighter economic times, 318,540 Ontarians relied on this assistance per month.¹²⁷ With the province's loss of 225,000 full time jobs in a year, more than 350,000 Ontarians turned to food banks every month in 2009.¹²⁸ This increased demand coincided with decreased corporate and individual donations of food and money so that one in four food banks in Ontario needed to reduce the average amount of food distributed in hampers in 2009.¹²⁹

In 2004, of the estimated 379,100 food-insecure households in Ontario, 55 per cent were reliant on wages or salaries, 23 per cent on social assistance, and 13 per cent on pensions or seniors' benefits.¹³⁰ Three potent socio-demographic correlates of household food-insecurity in Ontario are low income adequacy, social assistance as the main source of income, and not owning one's dwelling.¹³¹ Aboriginal people off reserve were almost three times more likely to be living in households experiencing food insecurity than was the case for Canadians overall in 1998-1999.¹³²

Food insecurity erodes health and well-being. More and more, average monthly incomes for households in Toronto supported by social assistance cannot afford a nutritious diet.¹³³ Food

intake for women decreases in proportion to drop in income.¹³⁴ Low-income single mothers compromise their own nutritional intake in order to feed their children.¹³⁵

There is clear evidence that lack of adequate income support directly compromises health. An analysis of the 1996/1997 National Population Health Survey showed that as income level deteriorates the risk of reporting food insufficiency increases.¹³⁶ Household food insufficiency is clearly linked with poorer reported and functional health, including higher odds of restricted activity, multiple chronic conditions, major depression, heart disease, diabetes, high blood pressure, and food allergies.¹³⁷ Infants and toddlers who experience food insecurity are at a greater risk for poor health, growth problems, and hospitalization.¹³⁸

Although community-based initiatives such as food banks have been the dominant response to food insecurity in Canada, emerging research challenges the presumption that such initiatives are reaching those most in need.¹³⁹ In a survey of low-income families in Toronto, two thirds of the families were found to be food insecure over the last 12 months and over one quarter were severely food insecure.¹⁴⁰ Only one in five families used food banks within the last 12 months, one in 20 families used a community kitchen, and use of community gardens was even lower.¹⁴¹ What was relatively common was delayed payment of bills or rent or termination of services such as phone or pawning possessions—strategies that tend to compound vulnerability “by causing them to incur debts, risk eviction, exhaust social support networks and become more socially isolated.”¹⁴²

On the way to implementing the necessary structural changes to ensure that all Ontarians are food secure, RNAO has joined our community partners¹⁴³ and our public health colleagues¹⁴⁴ in challenging the provincial government to introduce a \$100 monthly Healthy Food Supplement to help all adults on social assistance with their food security and nutritional needs.

Valuable momentum must not be lost. Far from being a time to slow down, an economic downturn is when action to reduce poverty is most needed, and strongly justified.

RNAO’s Recommendations:

- **Implement the Poverty Reduction Plan with multi-year sustainable funding to allow all Ontarians to have the opportunity to achieve their full potential with dignity and contribute to a prosperous and healthy Ontario.**
- **Monitor implementation of the Poverty Reduction Plan to ensure action for populations that have historically been overrepresented in poverty such as racialized and Aboriginal communities.**
- **Immediately increase the minimum wage to \$13.25 per hour, with automatic annual increases indexed to the cost of living.**
- **Enforce and strengthen the *Employment Standards Act* to improve protection of vulnerable workers.**

- **Work with the federal government to ensure that unemployed Canadians in this time of economic turmoil will be able to access Canada’s Employment Insurance (EI) system by expanding eligibility and improving benefit levels.**
- **Transform Ontario’s social assistance system from a punitive, incoherent tangle of contradictory rules and regulations to a person- and family-centred system that treats clients and staff with dignity. This includes raising the rates significantly to reflect the actual cost of living.**
- **The provincial government should withdraw its appeal of the court finding that addictions could be considered in deciding whether an individual is disabled and thereby act in accordance with the *Ontario Human Right Code*.**
- **Introduce a \$100 per month Healthy Food Supplement as a down-payment towards addressing the gap between dangerously low social assistance rates and nutritional requirements.**

Healthy and Affordable Housing

A comprehensive provincial housing plan is currently being developed against the backdrop of a province that has an affordable housing crisis. Ontario’s housing costs are the highest of any province, with a median household shelter cost of \$10,878.¹⁴⁵ Nearly half of tenant households in Ontario spend 30 per cent or more of their income on housing,¹⁴⁶ money that is then unavailable to spend on such essentials as food, medicine and child care. In fact, the Daily Bread Food Bank in Toronto, which averages 85,881 client visits per month, found their clients were paying 76 per cent of their income on rent/mortgage, including utilities.¹⁴⁷ At the same time, Ontario is the worst among the provinces in terms of provincial investment in affordable housing. In the fiscal year ending March 31, 2009, Ontario spent \$64 per capita on affordable housing, about half the provincial average of \$115 per person.¹⁴⁸ Lack of government action has left an affordable housing crisis. As the Auditor General reported, the number of Ontario households on waiting lists for social housing as of December, 2008, totalled about 137,000.¹⁴⁹ The average wait time to secure social housing was more than five years in many urban centres and one municipality reported a wait time of 21 years for all categories except seniors.¹⁵⁰

Safe, affordable housing is essential to good health. People who are homeless are sicker and have higher death rates than the general population. A study of men using homeless shelters in Toronto found mortality rates 8.3 times and 3.7 times higher than rates among men in the general population aged 18-24 and 24-44 respectively.¹⁵¹ Homeless women aged 18-44 years were 10 times more likely to die than women in the general population of Toronto.¹⁵² Living in shelters, rooming houses, and hotels is a marker for much higher mortality than would have been expected on the basis of low income alone.¹⁵³ A Street Health Nursing Foundation 2007 survey found that the daily lives of homeless people were stressful, isolating, and dangerous where people were often hungry, chronically ill, and unable to access the health care that they urgently required.¹⁵⁴

However, it is clear that some groups and individuals face even greater barriers in finding affordable housing. As the Ontario Human Rights Commission has revealed, people with

disabilities, racialized groups, seniors, and those with mental health issues are among those who are confronted by discrimination from potential landlords.¹⁵⁵ One third of housing stock located on First Nation reserves were found to be in need of major repairs compared to only 8 per cent of Canadian dwellings overall.¹⁵⁶ The First Nations Regional Longitudinal Health Survey revealed that almost half of the respondents found mould or mildew in the home in the 12 months preceding the survey.¹⁵⁷ In terms of living in crowded dwellings, 31 per cent of Inuit and 15 per cent of First Nation people experienced crowded conditions compared with three per cent for Métis and non-Aboriginal people.¹⁵⁸

Creating Vibrant Communities recommends enshrining the human right to adequate housing in federal and provincial legislation and fast-tracking the provincial housing plan to ensure access to safe, affordable, appropriate housing that meets the changing needs of individuals and families throughout their life cycles.

RNAO's Recommendations:

- **Enshrine the human right to adequate housing in federal and provincial legislation.**¹⁵⁹
- **Implement the recommendations of the Ontario Human Rights Commission to address discrimination in rental housing.**¹⁶⁰
- **Fast-track the provincial housing plan, including: capital subsidies to build new affordable housing or renovate existing housing stock that is substandard; rent supplements to ensure affordable housing for low and moderate income households; and, supportive community-based housing and services for those with physical, cognitive and/or mental health needs.**

Early Childhood Development, Child Care, and Ongoing Education

Ontario's political parties are strongly urged to adopt a platform policy agenda that recognizes the close link between healthy childhood development and long-term health and well-being. The Province needs both universal approaches to early childhood development such as a provincial breastfeeding strategy, access to early learning, child care, and high-quality education as well as targeted initiatives given the detrimental impact of poverty from childhood into the adult years.

One of the goals of the revised *Ontario Public Health Standards (2008)* is "to enable all children to attain and sustain optimal health and development potential."¹⁶¹ A key societal outcome that will assist in addressing this child health goal is "an increased rate of exclusive breastfeeding until six months, with continued breastfeeding until 24 months and beyond."¹⁶² Evidence is clear that breastfeeding provides children with the best start.^{163 164 165 166}

Yet, most of our youngest Ontarians are not receiving the benefit of exclusive breastfeeding for the first six months of their lives. Data from the Canadian Community Health Survey indicate more than 80 per cent of mothers in Ontario reported breastfeeding initiation in 2003 and 2005 but the rate of exclusive breastfeeding at six months was less than 20 per cent for those years.¹⁶⁷

Policy-makers should start by implementing breastfeeding best practices such as those in the guiding principles and policies of the Baby-Friendly Initiative™ and RNAO's *Breastfeeding Best Practices Guidelines for Nurses*.¹⁶⁸ The Baby-Friendly Initiative™ is an evidence-based, global program of the World Health Organization and the United Nations Children's Fund that improves breastfeeding outcomes for mothers and babies by improving the quality of their care.¹⁶⁹ Women and Children's Health Coordinators would be useful to promote the uptake of RNAO's *Breastfeeding Best Practice Guidelines for Nurses*¹⁷⁰ among nurses and other health disciplines within each Local Health Integration Network (LHIN). This would ensure consistent messaging and effective, practical support for breastfeeding.

A provincial breastfeeding strategy^{171 172} has the potential to improve individual, family, and community health by addressing broad systemic factors that impact health such as discrimination. The Ontario Human Rights Commission has affirmed "women should have the choice to feed their baby in the way that they feel is most dignified, comfortable, and healthy."¹⁷³ Although the *Ontario Human Rights Code* prohibits discrimination in services, accommodation, or employment because of breastfeeding,¹⁷⁴ it is still too common for those who breastfeed in public to have experiences of being harassed, disrespected, and humiliated.^{175 176 177} A provincial breastfeeding strategy would facilitate education opportunities and cultural norms that support a more inclusive society that welcomes breastfeeding as a basic human right.

Building on the cumulative evidence on the significance of early childhood development,¹⁷⁸ the Premier's Special Advisor on Early Learning, Charles Pascal, has concluded that the "smartest thing we can do right now—to make a major contribution to Ontario's future—is to ensure that all Ontario children have an even-handed opportunity to succeed in school, become lifelong learners, and pursue their dreams."¹⁷⁹ Pascal recommends a seamless system that would offer a continuum of services for children from birth to 12 years including: full-day learning for 4 and 5 year olds; after-school and summer programs for school children; and expanded parental leave of up to 400 days on the birth or adoption of a child.¹⁸⁰ Best Start Child and Family Centres would provide one-stop services including: early learning and care options for children up to 4 years of age; prenatal and postnatal information and supports; parenting and family supports, including home visiting, family literacy, and playgroups; nutrition and nutrition counselling; early identification and intervention resources; and links to special needs treatment and community resources.¹⁸¹

While RNAO fully supports the rapid implementation of the *With Our Best Future in Mind* recommendations,¹⁸² we are also mindful that other valuable public health programs and services with proven outcomes such as Healthy Babies, Healthy Children, Wellness for Tots and the presence of nurses in our schools have been curtailed, weakened, or stopped due to funding constraints. We must invest both in universal early childhood services and care to strengthen resiliency and we must invest in children to help mediate some of the negative health and developmental impacts of living in poverty.^{183 184 185} The first Nurse-Family Partnership program in Canada is being piloted in Hamilton. This effective, evidence-based program has proven transformative in other jurisdictions in improving the health, well-being and self-sufficiency of low-income first time parents and their children.^{186 187} Ontario's

registered nurses look forward to exploring how their knowledge, skills, and experience will be able to contribute to transforming our province to help our youngest Ontarians get the best start possible.

The Ontario Coalition for Better Child Care reports that there are tens of thousands of children on child care waiting lists across the province.¹⁸⁸ In 1992, there was sufficient regulated child care space for only 8.1 per cent of children under 12 years in the province. By 2008, the percentage for Ontario children had only increased to 13.6 per cent.¹⁸⁹

Ontario now has the highest university tuition fees in Canada¹⁹⁰ and a post-secondary education is becoming more and more out of the reach of many Ontarians. In 2009, undergraduate fees in Ontario exceeded the national average by over \$1,000 and graduate tuition fees surpassed the average by \$2,600.¹⁹¹ With fees increasing between 20 and 36 per cent since 2006¹⁹² and in a context where the economic downturn caused high summer student unemployment,¹⁹³ the gap is growing between those who have higher education and those who cannot afford to go to college or university. In 1990, tuition fees constituted 20 per cent of Ontario university revenues but by 2006, tuition had climbed to make up 45 per cent of university revenues.¹⁹⁴ Shifting the financial burden from public to private has implications not only for individual students and their families but it also for the common good. The burden of repaying large student debt can drive people away from socially valuable but moderately compensated professions to careers that are more lucrative.¹⁹⁵

RNAO's Recommendations:

- **Implement a provincial breastfeeding strategy that would improve health services by providing mothers/families with effective, practical breastfeeding support, and encourage cultural norms that would welcome breastfeeding as a basic human right.**
- **Fully implement the recommendations of the *With Our Best Future in Mind* report.**
- **Support the increased presence of school nurses, to promote health education, and public health measures in the school environment.**
- **Advocate for a national affordable, regulated, not-for-profit child care program.**
- **Designate funding to save threatened child care subsidies and build new affordable child care spaces.**
- **Invest in a public education system that focuses on equitable access. Freeze tuition fees and increase access to needs-based grants for post-secondary education.**

B. BUILDING SUSTAINABLE, GREEN COMMUNITIES

A diverse manufacturing sector has made Ontario one of the worst releasers of toxics in North America.¹⁹⁶ Ontario communities not only suffer a great deal of pollution coming in from south of the border, they also have a lot of home-grown health hazards. The Ontario Medical Association (OMA) has concluded that 9,500 deaths per year in Ontario are attributable to a limited number of air pollutants alone,¹⁹⁷ and the health costs associated with these pollutants exceed \$8 billion per year.¹⁹⁸ The cumulative cost in Canada of four environmentally-related health outcomes (diabetes, Parkinson's disease, neurodevelopmental effects and hypothyroidism, and neurodevelopmental effects and IQ deficits) is in the range of \$46 billion-\$52 billion/year, of which up to 50 per cent could be caused by environmental factors.¹⁹⁹ This amounts to an annual cost to Ontario for those four outcomes of up to \$10 billion.²⁰⁰

Evidence of the connection between the environment and health is well established. The World Health Organization (WHO) estimates that environmental factors account for 24 per cent of the world's burden of disease and 23 per cent of all deaths.²⁰¹ Environment is estimated to play a larger part in some diseases, such as asthma (44 per cent).²⁰² While the costs to human health are higher in developing countries, environmental factors have a significant impact on many diseases across the globe. Seventeen per cent of deaths in developed regions were attributed to environmental factors.²⁰³ In developed regions, environment plays a more significant role in chronic diseases such as lung cancer (30 per cent).²⁰⁴

These adverse health impacts have been acknowledged by Canadian authorities. The *Canadian Environmental Protection Act, 1999* reads: "It is hereby declared that the protection of the environment is essential to the well-being of Canadians and that the primary purpose of this Act is to contribute to sustainable development through pollution prevention."²⁰⁵ Environment Canada states that "[a]sthma, lung cancer, cardiovascular disease, allergies and many other human health problems have been linked to poor air quality."²⁰⁶ Both international and Canadian evidence show that these impacts are disproportionately borne by lower income and older people.^{207 208 209 210 211 212 213} Environmental protection is thus not only a matter of health, but also of social justice and equity.

Like all Ontarians, registered nurses have become increasingly concerned about climate change and the impact of environmental toxics on the health of their families and communities. Recent polling has shown that Ontarians are very concerned about toxics in their environment, believe they should have the right to know about these toxics, and believe it is very important to substitute safer chemicals for more dangerous ones.²¹⁴

Creating vibrant communities means building healthier environments through cleaner air and water; creating good green jobs on a base of equity and environmental sustainability; getting serious about climate change; and reducing toxic substances and other pollutants in the environment, in our workplaces, in our consumer products, and in our food and water.

The Ontario Environmental Bill of Rights

Ontario recognizes the right to a healthy environment in its *Environmental Bill of Rights, 1993*.²¹⁵ The Bill establishes an Environmental Registry which gives Ontarians a window to view and comment on government policy as it relates to the environment. The Bill confers the right to participate in government decisions significantly impacting the environment, improves access to the courts, and protects those who report workplace environmental hazards from reprisal by the employer.²¹⁶

The Precautionary Principle

Given the seriousness of consequences of environmental pollution, we must take a precautionary approach to protecting human health and the environment. A commonly accepted statement of the precautionary principle is: "When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically. In this context the proponent of an activity, rather than the public, should bear the burden of proof. The process of applying the precautionary principle must be open, informed and democratic and must include potentially affected parties. It must also involve an examination of the full range of alternatives, including no action."²¹⁷

Respect the principle of environmental justice or equity

The costs of environmental damage and climate change are disproportionately borne by lower income people, particularly Aboriginal and racialized communities. This is particularly true at the global level with climate change; it is the most vulnerable people in developing countries that are at greatest risk of inequity. Furthermore, in many cases, the solutions to environmental problems may disproportionately bear on more vulnerable populations (e.g., pricing carbon could impose proportionally higher costs on lower income people). The RNAO urges endorsement of the principle of environmental justice or equity. There are a number of definitions of environmental justice, and we suggest the following for consideration:

A condition of environmental justice exists when environmental risks and hazards and investments and benefits are equally distributed with a lack of discrimination, whether direct or indirect, at any jurisdictional level; and when access to environmental investments, benefits, and natural resources are equally distributed; and when access to information, participation in decision making, and access to justice in environment-related matters are enjoyed by all.²¹⁸

Environmental rights – clean air and safe water – must be recognized as human rights.

Promote Clean Green Energy, Get Serious About Climate Change

Registered nurses are concerned about climate change because of its serious environmental and health implications. Human-generated greenhouse gases that further global warming are likely

to exacerbate droughts in sub-Saharan Africa and threaten a “catastrophic reversal in human development.”²¹⁹ However, climate change also affects Ontarians' health, by contributing to extreme weather events, killer heat waves, poor air quality, and vector-, rodent-, food- and water -borne diseases. By fighting global warming, we are not merely protecting the environment – we are protecting the health of Ontarians. And we would be contributing to environmental justice because the most vulnerable populations are the poorest in both Canada and developing countries. These are the people who did the least to cause global warming.

There is very strong agreement among most scientists that global warming is a reality, and that this warming is principally due to human activity. For example, the respected Intergovernmental Panel on Climate Change (IPCC)²²⁰ concludes that warming is unequivocal.²²¹ It states with a very high level of confidence that this warming is strongly affecting terrestrial biological systems.²²² And it states with high confidence that marine and freshwater biological systems are being impacted.²²³ The IPCC concludes that the indisputable rise of temperatures is very likely due to the observed increase in greenhouse gases released by human activity.²²⁴

The combined concentration of greenhouse gases has risen sharply since the start of the Industrial Revolution in 1750: from 278 parts per million (ppm) of CO₂ equivalents (CO₂e) to a current level of 436 ppm – an astonishing 57 per cent increase.²²⁵ This concentration has been rising at an alarming rate. The IPCC reports that current atmospheric concentrations of two key greenhouse gases – carbon dioxide and methane – are far higher than they have been at any time in the past 650,000 years.²²⁶

Business as usual is not a responsible option. As the widely cited Stern Review²²⁷ points out, this would very likely cause a global average temperature rise of over two degrees Celsius from pre-industrial times until as early as 2035. By the end of the century, there would be at least a 50 per cent risk of the temperature rising over five degrees Celsius. Even a two degrees Celsius increase would likely have devastating effects in vulnerable areas, such as drought-prone areas in Africa, coral reef ecosystems and ice sheets. Further warming carries with it increased risk of dramatic climate shifts through feedback effects such as massive releases of the potent greenhouse gas methane, currently trapped in permafrost.²²⁸

Stern concluded that the losses to GDP from failure to act on climate change far exceed the costs of stabilizing greenhouse gas levels. For example, estimates of the annual costs of stabilizing at the level of 500-550 ppm CO₂e would amount to one per cent of world GDP (this would translate into a rise in average global temperature of two to three degrees Celsius).²²⁹ ²³⁰ In contrast, the annual cost of business as usual was put at 20 per cent in per capita consumption.²³¹ Failure to act is not just unconscionable, it is also bad economics.

Canada and Ontario must do their share. Sadly, Canada has been one of the worst performers when it comes to reducing its carbon footprint. The latest report from Environment Canada indicates that not only has Canada failed to meet its obligations under the Kyoto protocol (which was to reduce its greenhouse gas emissions to six per cent below 1990 levels by 2008-12); Canada grossly increased its releases, and is still increasing them: Total greenhouse gas (GHG) emissions in Canada in 2007 were 747 megatonnes (Mt) of carbon dioxide

equivalent,²³² an increase of four per cent from 2006 levels, and of 0.8 per cent from 2004 levels. Overall, the long-term trend indicates that emissions in 2007 were about 26 per cent above the 1990 total of 592 Mt. This trend shows a level 33.8 per cent above Canada's Kyoto target of 558.4 Mt.²³³

With Prime Minister Stephen Harper's embarrassing failure to show leadership at the December 2009 Copenhagen climate change summit, Canada's efforts to address climate change constitute an epic and dismal failure. Ontario's performance has been somewhat better than the national average: the latest data, for 2007, show that Ontario's greenhouse gas emissions were 13 per cent higher than 1990, and 20 per cent higher than Canada's Kyoto target of six per cent below 1990 levels.²³⁴

Confronting these health and environmental impacts requires a renewed commitment to implementing policies that will address climate change. For Ontario, an important first step would be to promptly complete the phase-out of coal-fired power generation which the Liberal government promised by 2014. While advancing the closure of four coal-fuelled units to 2010 was a good start, it left a total of 11 units still in operation in the province.²³⁵ Ontario could make up any power gap by a combination of increased conservation strategies and energy efficiency, more renewable energy such as wind power, and by converting the coal plants to natural gas.^{236 237}

At a minimum, RNAO calls on Ontario to commit to lower greenhouse gas emissions by at least 25 per cent below 1990 levels by 2020 and 80 per cent by 2050.²³⁸ This would put Ontario well ahead of the federal government's target of reducing greenhouse gas emissions by 20 per cent from 2006 levels by 2020 and 60 to 70 per cent by 2050. Note that even the U.S. is aiming higher than Canada with a goal of reducing emissions by three per cent from 2005 levels by 2012, another 17 per cent by 2020, 42 per cent by 2030 and 83 per cent by 2050.²³⁹ Ontario has taken steps in the right direction. Under the 2007 Climate Change Action Plan, Ontario is undertaking to reduce greenhouse gas emissions to six per cent below 1990 levels by 2014, 15 per cent by 2020 and 80 per cent below by 2050.^{240 241} These are significant steps, but they still fall short of the modest target of at least 25 per cent below 1990 emissions by 2020.

Putting a Price on Carbon

There is a general consensus that there should be a price put on greenhouse gas releases, to correct for the *de facto* subsidy on carbon use, as users do not have to pay for the cost they impose on society and on the planet when they add to the greenhouse gas burden. This market-friendly step would serve a number of purposes:

- It would be a signal to consumers to use fewer products that are more carbon-intensive.
- It would also be a signal to producers to use inputs which are less carbon-intensive.
- It would provide market incentives to investors and innovators to find and develop methods for reducing carbon emissions

It would do all this by combining all the information into one simple metric – price changes.

The government is considering one carbon-pricing option – a cap-and-trade system, in which a fixed number of permits (corresponding to the desired level of emissions) are issued to release greenhouse gases. Users of carbon and owners of permits could exchange these permits in a market, which would establish the price for these permits.

Another approach to putting a price on carbon is a carbon tax. Each approach has certain advantages. A cap-and-trade system would directly establish the level of emissions, and this provides a measure of certainty. Through the carbon credit system, rewards are provided for activities that reduce greenhouse gas emissions. And it is more popular with major carbon users, perhaps because they feel it will cost them less, particularly if they are successful in getting permits issued free of charge.

On the other hand, a carbon tax has some significant advantages over cap-and-trade:

- A carbon tax is much simpler and faster to set up, because it can make use of the existing tax system.
- A carbon tax is much cheaper to administer, again because it would use the existing tax system, and would not require monitoring and enforcement of these market exchanges.
- It is easier to cover more emissions using a carbon tax.
- To the extent that emission permits are given away, a carbon tax would provide more revenue that could be used to promote green alternatives and also reduce or eliminate other less efficient taxes.
- A carbon tax provides certainty about price (unlike a cap-and-trade system, which would face fluctuating and uncertain market prices of permits).
- A carbon tax avoids the considerable risk of cheating and gaming under cap-and-trade.
- If phasing in is desired, a carbon tax can do that through an escalating price. A cap-and-trade system could be phased in through a falling number of permits and through an expanding share of permits that are auctioned, but this is much more difficult to manage.
- In contrast, a cap-and-trade system would create an entrenched constituency to lobby and keep it in place, even if it proves to be less workable than a carbon pricing system.
- To the extent that permits are given to existing firms, cap-and-trade would be a barrier to entry to new firms. This will stifle competition and slow the pace of innovation.

The experience to date with cap-and-trade systems is mixed, and has borne out the very problems listed above. In contrast, a carbon tax has been implemented in a number of countries, including Finland and Sweden. In Canada, British Columbia²⁴² and Quebec have successfully introduced carbon taxes.²⁴³ The National Roundtable on the Environment and the Economy, whose members are appointed by the federal cabinet, has called for a carbon tax or similar market incentive for Canada.^{244 245}

We urge all parties to keep the carbon tax option open. If Ontario does proceed with a cap-and-trade system, then it must take all necessary measures to minimize the considerable risks and disadvantages.

The Green Energy and Green Economy Act provides incentives to clean renewable energy like wind and solar power, and this is a significant step. But we must be much more aggressive in setting ambitious targets for the production of green, renewable energy.

RNAO is convinced that one alternative -- an expansion of nuclear power -- is not the answer. Nuclear power plants are prohibitively expensive, take years to build, present radiation risks and produce large amounts of radioactive waste that must be stored in perpetuity (and no solution for such storage has been found).²⁴⁶ Ontario relies on expensive, risky nuclear power for half of its electrical power, and it is time to put those resources into clean energy.

Finally, the transportation sector is a major user of energy, and is also a major contributor to greenhouse gases and air pollution. The government has committed to a major investment in mass public transit, and must move quickly on that commitment. Creating vibrant communities around active transportation (such as walking and bicycling) would reduce the impact of the transportation sector, be more equitable, reduce barriers to the growth of active transportation, and improve health through greater physical activity.²⁴⁷

RNAO's Recommendations:

- **Implement a climate change plan that would make Ontario a national leader by adopting clear, tough and achievable targets for reducing greenhouse gas emissions, reducing greenhouse gas emissions by at least 25 per cent from 1990 levels by 2020 and 80 per cent by 2050.**
- **Commit to aggressive targets to dramatically increase the green share of energy, and to sharply reduce consumption through conservation.**
- **Make conservation and green energy, including combined heat and power, priorities in planning, regulation, procurement and operation.**²⁴⁸
- **Commit to terminating all coal burning at Ontario's power plants by 2012.**²⁴⁹
- **Cancel plans for the construction of new nuclear plants in Ontario.**
- **Commit to phasing in a carbon tax and other environmental levies and regulations.**
- **Ensure that any system of greenhouse gas emissions trading includes: a tight cap on the number of permits in order to realize the above greenhouse gas reduction targets; minimal exclusions of emissions in terms of sectors and emitters; auction of all permits (instead of free distribution); ensuring that permits do not confer a permanent right to emit; and, a ban or strict limit on offsets for activities that lower carbon emissions in other jurisdictions. Offsets must be for real, verifiable, permanent reductions in greenhouse gas emissions. Emissions trading is clearly inferior to a carbon tax because: (a) it is slow and difficult to implement; (b) it is complex; (c) it is bureaucratic; and (d) it invites evasion and corruption. In the event that emission trading is implemented, we must take all of the above steps to minimize**

its inherent weaknesses, so sadly evident in the current emissions trading programs in Europe.

- **Quickly implement the promised expansion of rapid transit, while reviewing proposed or future expansions of highways.**
- **Expand support for greater access to active transportation and reduce barriers to walking, cycling and other means of active transportation in our communities. This requires a continuous and safe network of bike lanes, sidewalks and trails that is well connected with other modes of transportation.**²⁵⁰

Tougher Protection from Toxics

On June 5, 2009, Bill 167, the *Toxics Reduction Act*, received Royal Assent.²⁵¹ RNAO was disappointed that the legislation was missing key elements, including targets, an independent Toxic Use Reduction Institute to support industry reductions in toxics, and mandatory substitution of safer chemicals for more toxic ones.^{252 253} In addition, the RNAO was critical of the first draft regulations written under Bill 167²⁵⁴ for broad exemptions from reporting and insufficient commitment to make toxics reduction happen.²⁵⁵ RNAO continues to work to make the associated regulations as tough as possible, and will continue to advocate for policies, programs, investments, and legislation that toughens protection against toxic substances.

Ontario's Ministry of the Environment points out that the province is the second-largest emitter of certain toxics in North America.²⁵⁶ This is a problem because chronic conditions such as asthma, cancer, developmental disabilities, and birth defects have become the primary causes of illness and death of children in industrialized countries, and there is growing expert recognition that chemicals in the environment are partly responsible for these trends.²⁵⁷ The Ministry of Environment's own discussion document on toxics reduction identified the above adverse pollution outcomes in children, and added learning and behavioural disabilities.²⁵⁸ We know the exposure is there; large numbers of dangerous chemicals showed up in the blood of Canadians tested for toxics.^{259 260 261 262}

Of particular concern is the safety of children who are much more vulnerable to toxics. They are exposed to more toxics per body weight, absorb ingested substances differently, have developed fewer protections against toxics, face additional risks while undergoing development, face higher exposures due to activity and behaviours, and have much more time to develop disease from toxics.^{263 264 265 266 267} A Canadian government study points to some alarming data and trends: cancer is one of the three biggest killers of children ages one to four; the increased incidence of certain types of cancers in young adults may be related to childhood exposures; and the prevalence of childhood asthma has quadrupled over two decades, in spite of falling exposure to one known cause of asthma, second-hand cigarette smoke.²⁶⁸

This is not just a huge human cost, but a huge economic cost as well. As noted above, this cost could approach \$10 billion for four environmentally-related outcomes alone.²⁶⁹

A key component of toxic use reduction is a concept known as community right to know about environmental toxics, which has not only given citizens in other jurisdictions vital information,

but has also triggered sharp reductions in toxics releases. RNAO and other partners campaigning for right to know won a tremendous victory on December 3, 2008, when Toronto City Council voted 33 to 3 in favour of a right-to-know program.^{270 271} Currently only about 20 per cent of toxic releases in Toronto are reported because the vast majority of facilities releasing toxics have releases below the reporting threshold. Toronto's program will collect information on 25 substances of concern, and this information will be publicly available by January 2012. At last, Torontonians will be able to know what is being dumped into their environment, and who is putting it there. This is a tremendous precedent. All Ontarians deserve a similar right to know about toxics.

Ontario's Economy Needs Toxics Reduction

The Canadian and Ontario economies are experiencing unprecedented stress and abrupt change. The costs to those working in affected industries are dramatic. Many are losing their jobs; replacement jobs often fail to provide an adequate package of wages and benefits; and workers' pensions in many cases are under threat.

Instead of being perceived as antagonistic, the campaign for a cleaner environment is a complement to the creation and protection of good jobs. Indeed, Ontario must focus on a green economic recovery built on equity and environmental sustainability. Change is happening, and we must get it right. The economy and businesses require a supportive hand to direct our system during the inevitable restructuring to a more sustainable, greener economy. Bill 150, the *Green Energy and Green Economy Act* provides substantial resources to conserve energy and increase cleaner renewable energy. Similar assistance is required on the toxics front. The costs of toxics pollution are simply too high.

In fact, taking action on toxics is good for business and trade. Toxic use reduction proved on balance to save companies money in Massachusetts (over \$14 million net, and the program was funded out of user fees),²⁷² so action on toxics should not be feared in Ontario. If the government elects to fund such a program, then cash-strapped corporations will not have to incur up-front costs. Moreover, this assistance will give Ontario exporters a necessary boost in complying with the European Union's Registration, Evaluation, Authorisation and Restriction of Chemical substances (REACH) program. REACH began to come into effect in 2008, and will soon require all suppliers to the European Union to meet more stringent chemical regulatory standards.

RNAO's Recommendations:

Toughen protection from toxics by:

- **Committing to aggressive targets for reductions in the use, creation and release of toxics;**
- **Committing to the goal of comprehensive coverage of toxics, not limited to a set number of toxics or industries;**

- **Including mandatory substitution of safer alternatives for toxic substances in production processes;**
- **Establishing an independent academically based institute to build capacity to meet the requirements of toxics reduction, safe substitution and green chemistry. This would include support to businesses, employees and communities.**

Ensure public right to know about toxics in their environment, workplaces and products by:

- **Collecting all necessary toxics data and making it available in a readily searchable format;**
- **Making data available that is collected under the *Toxics Reduction Act*, and all other environmental legislation; and,**
- **Identifying toxic content in products through labelling or by other understandable means.**

Strengthen Cosmetic Pesticides Ban

On April 22, 2009 (Earth Day), Ontario introduced the strongest cosmetic pesticide regulations in North America, banning the use and sale of pesticides for nonessential purposes. Polling shows strong support for the ban that extends across all political parties, age groups, and gender. There are many epidemiological and laboratory studies linking a range of health problems to pesticide exposure. The problems include: cancer, birth defects, reproductive damage, neurological and developmental toxicity, immunotoxicity, and endocrine disruption.^{273 274 275 276 277} The risk to health comes not only from active ingredients, but also from so-called inert substances.^{278 279 280} Finally, synergistic and cumulative effects can heighten health damage due to pesticides.^{281 282}

One weakness of the cosmetic pesticide legislation is that it exempts golf courses. RNAO believes this exemption should be phased out.

Some policy-makers have talked about repealing this legislation, which, in RNAO's view, would be a terrible step backwards. The implementation of the regulations has been proceeding smoothly, and Ontarians are accepting the ban. However, uneven enforcement across the province is a major concern. Several municipalities have exploited exemptions written into the bill to carry on business as usual, and a stronger response from government is required.

RNAO's Recommendations:

- **Commit to supporting full implementation of the *Cosmetic Pesticides Act* and regulations.**
- **Commit sufficient resources to enforcing the *Cosmetic Pesticides Act* and regulations.**
- **Phase out the exemption of golf courses from the pesticide ban in the *Cosmetic Pesticides Act*.**

Clean Water is a Right

Ontario has been credited by environmental organizations for having the best source water protection legislation in Canada (*Clean Water Act, 2006*) and accordingly earned the highest grade in a report card on water quality issued by the Sierra Legal Defence Fund.²⁸³ This legislation implemented many of the recommendations of the Walkerton Inquiry.²⁸⁴ It represents a significant step forward, but critics such as the Canadian Environmental Law Association point out that more legislative and policy measures are required to fully implement the recommendations of the Walkerton Inquiry.²⁸⁵ In the meantime, certain communities still suffer from poor drinking water quality – particularly Aboriginal communities. Some communities have raised concerns about the adequacy of protection of their drinking water.

One threat comes from garbage dumps, which may compromise local drinking water. A particularly active campaign is around Dump Site 41, where local community members were arrested in August 2009 for activities opposing the opening of the site.²⁸⁶ The campaign resulted in a strong Simcoe County council majority (22-10) in favour of a one-year moratorium in order to allow local consultation. The celebration was tempered by the fact that the Council did not give up the Certificate of Approval permitting the dumpsite.²⁸⁷ However private member's Bill 32²⁸⁸ at the Ontario Legislature would ban dumping at the site and revoke the Certificate of Approval. That Bill passed second reading on November 19, 2009.

There is also considerable controversy over the widespread use of sewage sludge on farmlands. The Ministry of the Environment claims that existing controls are adequate,²⁸⁹ but critics charge that this sludge includes dangerous materials with the nutrients such as heavy metals and pathogens that damage the soil and contaminate drinking water through runoff.^{290 291} They are concerned that proposed changes in regulations²⁹² could loosen controls and accountability for sewage spread on farmlands.

An unfortunate response to concerns about water quality has been the burgeoning resort to bottled water, which rose from 28.4 to 64 litres per capita in Canada between 1998 and 2006.²⁹³ Canadians bought 2.15 billion litres in 2006, with Ontario taking almost half (48.2 per cent).²⁹⁴ The bottled water industry is a massive industry, and has a huge footprint, with its use of plastic and energy. The plastic industry itself estimated that by 2002 alone, Ontario generated over 50,000 tonnes of plastic beverage bottles, of which only 35 per cent are recovered for recycling.²⁹⁵ The rest ends up discarded in the environment or thrown into dumps. Large amounts of energy are consumed making the plastic and shipping the water. All of this is unnecessary when safe drinking water is available from the tap. Furthermore, there remains controversy over the risk of plastic migrating from the bottle into the drinking water.

Bottled water may have its place in the event of temporary water quality issues, but it is a costly and unnecessary private solution to the real or perceived problems of accessing safe drinking water. It is far better to solve water quality problems rather than apply a bottled solution that allows us to ignore environmental problems or access issues (e.g. water fountains have largely disappeared from public spaces, which helps to drive demand for bottled drinking water).

Indeed, water is one of the canaries in the environmental mineshaft. When we address water quality, we reap co-benefits by dealing with underlying environmental issues, such as unsafe practices in handling municipal or toxic waste.

If Ontario is to allow the continued use of bottled water, at the very least, it must apply a levy to the water used in this environmentally destructive activity. It must work with municipalities to ban the sales of bottled water in publicly-owned spaces.

RNAO's Recommendations:

- **Strengthen source water protection to ensure that municipal waste and municipal sewage do not compromise the quality of drinking water.**
- **Recognize that access to safe, clean drinking water is a human right. This includes monitoring drinking water quality and safety, and self-determination for Aboriginal communities to provide them control over their own resources.**
- **Work with municipalities to ban the sale of bottled water in publicly owned places. Our shared resource should not be bottled for huge profits where safe, clean public drinking water exists.**

C. ENHANCING MEDICARE

In difficult economic times we are reminded why Canadians cherish their publicly-funded, not-for-profit health-care system; 86 per cent of Canadians support not-for-profit solutions to strengthen Canada's universal health-care system.²⁹⁶ Canadians, and Ontarians, have made it very clear that they value, support and rely on our publicly funded health-care system and they look to our political and health-care leaders to commit to defending and enhancing it.

Before Medicare, many Canadians without financial means faced an early death and great hardship as they were denied access to hospital care and other health services.²⁹⁷ This is still the situation today in the United States where an estimated 137,000 working-aged adults died prematurely between 2000 and 2006 because they did not have access to health insurance.²⁹⁸ Many deaths are attributed to inadequate access to care, where the absence of insurance or underinsurance results in fatal delays in seeking treatment.²⁹⁹ Unpaid medical bills are the leading cause of bankruptcy in the United States³⁰⁰ with health problems contributing to about half of all bankruptcies.³⁰¹ In contrast, under the *Canada Health Act* essential health-care services are part of the cost-efficient single-payer system. It is a more equitable system that offers universal access to health care that would otherwise be unavailable to many people with low and moderate incomes.

However, in many ways the job in Canada is only half complete. First, the health-care system must constantly evolve to meet the changing needs of an aging population, such as ensuring equitable access to home care and medications. Second, and critically important, Tommy Douglas's original vision of Medicare included prevention and confronting the social, environmental and other factors that make people unwell in the first place:³⁰²

Those of us who talked about Medicare back in the 1940's and '50's and '60's kept reminding the public that there were two phases to Medicare. The first phase was to remove the financial barrier between those who provide the services and those who need them. We pointed out repeatedly that that phase was the easiest of the problems we would confront. In governmental terms, of course it means finding revenue. It means setting up organizations and exercising controls over cost. But in the long run it was the easiest problem. The phase number two would be the much more difficult one. That was to alter our delivery system so as to reduce costs and to place emphasis on preventive medicine.

Tommy Douglas, SOS Medicare Conference, Ottawa, 1979³⁰³

For-Profit Costs More

Commercialization of health care in the United States has not served its population well. There were 46.3 million Americans (15.4 per cent of the U.S. population) without any health insurance in 2008³⁰⁴ while the U.S. was still the outlier nation in terms of health expenditures among OECD countries. Total health spending accounted for 16.0 per cent of GDP in the United States in 2007 compared with the average of 8.9 per cent in OECD countries.³⁰⁵ In terms of total health spending per capita, the United States with \$7,290 USD (adjusted for

purchasing power parity) spent more than twice the OECD average of \$2,964 USD in 2007.³⁰⁶ Total health spending in Canada accounted for 10.1 per cent of GDP in 2007, with spending of \$3,895 USD per capita.³⁰⁷

Within a market-based approach to health care, some health-care expenditures are diverted as profit, some are diverted through fraud, and some are used to finance complex and often redundant private bureaucracies.^{308 309} Following the money through fragmented funding streams helps to account for the much higher administrative costs evident in the United States of \$1,059 per capita in 1999 compared to \$307 per capita in Canada.³¹⁰

David Himmelstein and Steffie Woolhandler, co-founders of Physicians for a National Health Program, argue that the “failings of private contracting in the United States are underappreciated” at the same time as the “major success story” of the government owned and operated Veterans’ Administration (VA) system of hospitals and clinics has been overlooked.³¹¹ The VA system has emerged as a leader in quality improvement and has outperformed private sector alternatives by providing more equitable health care of higher quality at comparable or lower cost.^{312 313}

Not-For-Profit Means Better Care

There is abundant experience and research on the hazards of a market approach to health care compared with the advantages of not-for-profit financing and delivery of health-care services. A review of four decades of experience with privatization in the United States with a combination of public funding and private health care management and delivery found that “for-profit health institutions provide inferior care at inflated prices.”³¹⁴ Private contracting in the U.S. Medicare program for seniors through the Medicare health maintenance organization (HMO) contracting program is a cautionary tale in that it evolved into a multi-billion dollar subsidy for HMOs who often cherry-pick the healthiest clients while refusing those most acutely and expensively ill.³¹⁵ The experience of public-private competition in the United States is that for-profit “firms carve out the profitable niches, leaving a financially depleted public sector responsible for the unprofitable patients and services.”³¹⁶

Considerable evidence is available on quality of care differences between for-profit and not-for-profit delivery across sectors. Studies show that the quality of care in for-profit institutions is lower.^{317 318 319 320 321} The most conclusive evidence comes from systematic reviews and meta-analyses of peer-reviewed literature on for-profit versus not-for-profit health care, which found higher patient mortality rates in for-profit as compared to not-for-profit centres.^{322 323 324} One compelling example is that patients attending for-profit dialysis had 8 per cent higher death rates than those who received care at non-profit facilities. This translates into an estimated 2,000 premature deaths each year in the United States linked to for-profit dialysis.³²⁵ Furthermore, worse health outcomes have also come with higher costs: a systematic review and meta-analysis of peer-reviewed literature concluded that for-profit hospitals charge a statistically significant 19 per cent more than not-for-profit hospitals.³²⁶

Canadian evidence from the long-term care sector has found that staffing levels were higher in not-for-profit facilities than in for-profit facilities,³²⁷ and health outcomes were better in not-

for-profit facilities.^{328 329} Differences in staffing were likely to result in the observed differences in health outcomes.³³⁰ A review of North American nursing home studies between 1990 and 2002 similarly concluded that for-profit homes appeared to deliver poorer quality care in a number of process and outcome areas.³³¹ A systematic review and meta-analysis published in 2009 confirmed that the evidence suggests that, on average, not-for-profit nursing homes deliver higher quality care than for-profit nursing homes.³³² This meta-analysis estimated that pressure ulcers in 600 of 7,000 residents with pressure ulcers in Canada and 7,000 of 80,000 residents with pressure ulcers in the United States are attributable to for-profit ownership.³³³

The research evidence is clear – Canadians will benefit most from strengthening the public financing and public delivery of health services and utilizing all health professionals to their full scope to improve timely access to quality care. There are of course always systemic and clinical improvements to be made but these are best accomplished through strengthening Medicare. This is achievable as Michael Rachlis has identified many success stories in the public, not-for-profit system in improving clinical services, reducing wait times and decreasing costs.^{334 335 336}

Despite this compelling evidence, threats to Medicare continue. Privatization advocates achieved a limited victory in the June 2005 Supreme Court *Chaoulli* decision.³³⁷ While the decision applied only to private health insurance in Quebec, it is widely seen as opening the door to attempts to expand two-tier health care across the country.³³⁸ Other challenges are being initiated in the courts and it is incumbent on governments at all levels to join Canadians in standing up for our not-for-profit health-care system that is a part of our national fabric.³³⁹
^{340 341}

Enforce Medicare Acts

On October 6, 2008, the Ontario Health Coalition (OHC) released a groundbreaking report documenting 130 for-profit health-care clinics across Canada. They sell surgeries, MRIs and access to physician care. Most of these clinics have opened in the last five years and the situation is exacerbated by chains and U.S.-led multinational companies aggressively promoting two-tier health care. The OHC report *Eroding Public Medicare: Lessons and Consequences of For-Profit Health Care Across Canada*³⁴² found 89 potential violations in five provinces of the *Canada Health Act* requirement for equal access to hospital and physician care and prohibition on extra-billing patients. This included 11 in Ontario, ranging from the sale of medically necessary services to the facilitation of queue jumping.³⁴³

Most of the documented for-profit clinics maximize revenue by both charging patients and billing their provincial health plans. Not only are the prices charged by for-profit clinics too high for the majority of Canadians to afford, but they take scarce health-care professionals away from the provision of universally accessible health-care services. One example where government must be diligent in preventing the expansion of for-profit health care is the growth of clinics selling laser eye surgeries. Many also sell medically necessary cataract surgeries. Patients are encouraged to pay upfront for “faster” service than they might receive in a public hospital. Sometimes the private clinics say patients are paying for the lens and “follow up”. In

one example cited in the OHC Report, OHIP is charged for the surgery but the patient is charged for the lens. The special lens can cost anywhere from \$1,200 to \$2,800 per eye which the patient is forced to pay out-of-pocket.³⁴⁴

RNAO's Recommendations:

- **Enforce the *Canada Health Act* and the principle of a single-tier, not-for-profit health care system.**
- **Support the federal government's use of its power to withhold health transfers to provinces when violations to the *Canada Health Act* occur and ensure that federal funds are used exclusively to deliver necessary health services that are timely, universally accessible and not-for-profit.**
- **Enforce the *Commitment to the Future of Medicare Act*³⁴⁵ to prevent private for-profit clinics from delivering medically necessary health-care services in Ontario.**

No Privately Financed and Operated Hospitals

The Ontario government has continued a program of alternative financing and procurement (AFPs), a form of public-private partnership (P3), to build and operate hospitals and other public infrastructure. Its position is that AFPs are not P3s because they remain publicly owned and controlled. However, AFPs are still privately financed and partially operated by parallel private administrations. Currently there are more than 12 large P3/AFP hospital projects underway or being considered in Ontario. These are generally 20 to 30 year deals that finance, build and service privatization.³⁴⁶

In his report released December 8, 2008, the Auditor General of Ontario found the Brampton P3 hospital cost taxpayers considerably more than if it had been built by traditional public/not-for-profit procurement. He found the difference in cost to have been \$194 million in 2003 dollars, not including an additional \$200 million difference because of the higher financing costs of the P3 and a further \$63 million in additional modifications. On top of that, the P3 hospital took longer to build and opened with 479 instead of the promised 608 beds originally planned.³⁴⁷

While the Auditor acknowledged the government's claims that the newer AFP projects have improved public disclosure, transparency and evaluation over the P3 hospitals, there is no evidence in his report that those claims are justified. They remain privately financed, and the government has yet to commit to public operation of these facilities. Many of the problems associated with public-private partnerships, including higher costs and lower quality of service, arise from private financing and operations.^{348 349 350 351 352 353 354 355 356}

In addition to the direct impacts on finance, delivery, and quality of each project, there are the broader political and policy implications of the P3/AFP method of financing. It creates a new and powerful stakeholder group – the private consortia – whose clear long-term interest is the expansion of health-care privatization. Although the current government has restricted the scope of private intrusion into the public sector, these are decisions that a future government

with a different philosophy could easily reverse, using the AFP structure created by this government to pursue a much more aggressive privatization strategy.

RNAO's Recommendations:

- **Adopt the principle that all hospitals and community health facilities must be equitably and publicly operated and financed, with no disadvantage to those in rural, remote or low-income areas.**
- **Establish an immediate and indefinite province-wide moratorium on Infrastructure Ontario's private-finance, for-profit alternative financing and procurement (AFP) projects in the hospital sector. Do not approve or announce any additional AFP projects for which contracts have not been signed.**
- **Request the Auditor General to conduct a full review into the financial details of the government's AFP deals to determine whether the public is getting the value it has been promised.**
- **Provide full transparency with total disclosure of all financial aspects of AFP/P3 (public private partnership) contracts that have already been signed.**
- **Shift the hospital financing method to a traditional (non-AFP) method for projects where AFP contracts have not yet been signed.**
- **Ensure that publicly-financed and built hospital projects follow comprehensive evidence-based guidelines for health-care facility design and construction.**

Access to Primary Care for All Ontarians

In a province as progressive as Ontario the fact that access to primary care remains a key challenge is unacceptable. In 2008, nearly one in 12 adults did not have a nurse practitioner, family physician, or other primary care provider.^{357 358} Nurse practitioners (NPs) in community, long-term care and hospital settings have been shown to augment other roles^{359 360} and improve access to essential health services. However, many NPs in Ontario are not being fully utilized and are unable to practise to their full scope.³⁶¹

Nurse practitioners are experienced registered nurses with additional education and specialty registration who demonstrate competence to autonomously diagnose and manage disease, order and interpret diagnostic and laboratory tests, prescribe medications and perform treatment within their legislated practice.³⁶²

The need for NP-led clinics offering primary care is undeniable. NPs possess the knowledge and skills to provide a point of entry to health promotion and disease prevention as well as curative, rehabilitative and supportive services for individuals and families throughout their lifespan. Nurse-led clinics in other countries have alleviated pressure³⁶³ from shortages in health human resources, resulting in: decreased wait times; more fully integrated pathways of care; enhanced continuity of care; improved access to care; and cost containment.³⁶⁴

With the government's commitment to open 25 new NP-led clinics by 2011, communities across Ontario will build on the legacy of Sudbury where the NP-led clinic opened in 2007 and has already improved access to primary care and improved quality of life for thousands of patients and their families³⁶⁵

There is widespread interest in establishing additional NP-led clinics, with dozens of communities just waiting for the green light from the provincial government.

RNAO's Recommendation:

- **Establish 50 additional nurse practitioner-led clinics by 2015, as part of enhanced access to primary care**

Access to Home Care

Home care is about enabling people to live with dignity and as independently as possible, not merely about saving money or relieving congested emergency rooms. Vibrant communities depend on everyone having the opportunity to live at home with dignity whatever their background, wherever they live and whenever required.

Patients in alternate level of care (ALC) are defined by the Ministry of Health and Long-Term Care as "individuals in hospital beds who would be better cared for in an alternate setting, such as long-term care, rehab or home. Having more home care and community services enables patients in ALC to leave hospital sooner, availing beds to patients in ER who are waiting to be admitted to hospital."³⁶⁶ ALC, therefore, is too often defined more in terms of freeing ER beds than in ensuring the most appropriate health care for residents and patients.

With current pressure to reduce wait times by moving patients in ALC out of hospitals and the system-wide drive to cut costs, there is a serious risk that residents who have acute care needs will be placed inappropriately in long-term care homes, particularly in interim, short-stay beds. It is crucial that access to long-term care, acute care and home and community care be designed with the needs of residents in mind, not budget imperatives and government policies operating as silos. As the Elder Health Coalition wrote to the Minister in June 2009, adequate funding for the government's Aging-at-Home strategy to ensure the availability of high-quality age-appropriate care must be in place if the ALC strategy is to succeed.

Many people who are able to stay at home longer are only able to do so with a significant amount of informal care giving by family members, friends or neighbours. Though often considered a family obligation, there can be financial implications for the caregiver.

In June 2008, the Ontario Health Coalition held public hearings on Home Care in Ontario. Clients and caregivers told the panel how they value integrated care and continuity of care and how both are adversely affected by competitive bidding. Others emphasized key principles of home care such as respecting client choice, and maintaining client independence and dignity. Those working in home care talked about how competition had undermined cooperation among agencies and how working in a nursing home or hospital offered better pay, guaranteed

hours, greater safety and more security. Both the hearings and the panel's recommendations raised serious questions about the appropriateness of using market mechanisms to allocate home care contracts.³⁶⁷

Indeed, experiments in introducing competitive bidding in the health-care sector have proven unsuccessful both in Ontario and internationally. The reasons for this are extensive and complex. They include: our limited ability to fairly price and cost health-care services and different levels of complexity in these services; the expensive nature of systems required to capture and audit information; and low measurability of health-care services, which impedes effective performance monitoring.³⁶⁸ For competitive bidding to be effective, we must be able to measure not only the services themselves, but also their quality. Yet we cannot effectively quantify these services, or their quality. Price, on the other hand, is easily quantified, and that leads inevitably to a competitive bidding process biased toward awarding on price rather than quality. This makes competitive bidding an expensive, inefficient way of attempting to ensure quality services and value-for-money in health-care services.

In Ontario, competitive bidding has resulted in serious disruptions in continuity of care and continuity of caregiver for patients, decreased morale amongst caregivers and, as a consequence, adverse impacts on the availability of community-based care and access and quality of care the public receives. Yet, in December 2008, ignoring the overwhelming evidence of the harmful effects of competitive bidding, the government quietly lifted the moratorium placed on competitive bidding of home care contracts. That moratorium had followed a public outcry in Hamilton in January 2008 when residents protested the disqualification from the bidding process of two non-profit agencies, the Victorian Order of Nurses (VON) and St. Joseph's Home Care. Both agencies had served the community for more than 100 years.^{369 370 371} By allowing the resumption of competitive bidding, the government chose the antithesis of good patient care. People compete rather than collaborate, pitting one health-care provider against another, leaving the patient on the sidelines. High quality home care is based on trusted relationships and best practices where innovation is shared rather than hoarded for competitive advantage.

When the moratorium on competitive bidding was lifted, various accountability measures were announced in its place. However, these do nothing to address the fundamental problem with competitive bidding. Competitive bidding has never yielded the economic benefits touted by some. It is a flawed process based on a flawed philosophy, which costs more and delivers less.

RNAO's Recommendations:

- **In order for the Alternate Level of Care (ALC) strategy to succeed, provide adequate funding to support Aging at Home and the availability of age-appropriate care from home and community care, long-term care and hospital care.**
- **Increase investment in home care services, including homemaking and professional services, to support persons with chronic conditions and/or older persons so that they continue to remain active and vibrant members of our community.**
- **Provide incentives for collaboration of all community health-care partners, including mental health and chronic disease management, in addition to home care services.**

- **Abandon competitive bidding as a method of allocating funding for home care and for health service providers in Ontario.**
- **Advocate for a comprehensive national home care strategy following the same principles and spirit of the *Canada Health Act* to enable people to live with dignity and as independently as possible in their communities.**

Time for a National Pharmacare Program

As with home care, increasing and improving access to health care, equity and sustainability – all the elements of a vibrant community – requires an expansion of Medicare to cover the cost of pharmaceuticals.

In 2009, spending on drugs accounted for 16.4 per cent (\$30 billion) of health expenditures in Canada.³⁷² The share of health care spending on drugs has nearly doubled over the last 30 years and now makes up the second largest proportion of health care spending, after hospital care.³⁷³ With drugs being a major driver of health care costs, priority should be given to a standardized, national, publicly funded and publicly controlled pharmacare program covering essential drugs. Since 1997,³⁷⁴ calls for a pan-Canadian pharmacare program have accelerated, including high-profile recommendations such as those arising out of the Romanow Commission.^{375 376 377} Such a program would provide equal access to prescription drugs across the country and keep the rising cost of prescription drugs in check. Progress, tentative as it may be, has been made on a national pharmacare plan by the Federal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy, which was created out of the 2003 First Ministers' Accord on Health Care Renewal.³⁷⁸ RNAO is looking to the Ontario government to pick up the ball and lead a cross-country campaign for a national pharmacare plan.

RNAO's Recommendation:

- **Take a leadership role in advocating expansion of Medicare to include a national pharmacare program.**

Healthy Community Hospitals and Health Services with Continuity of Care and Continuity of Caregiver

In a report released on December 2, 2008, the Ontario Health Coalition (OHC) warned of a major round of hospital restructuring and cuts that was underway across the province.³⁷⁹ With the province setting funding levels for hospitals at less than the rate of inflation, hospitals were finding they could not maintain existing programs and services. Over 50 per cent of hospitals were in deficit in 2008-2009 and almost 70 per cent were projected to have been in deficit in the fiscal year 2009-2010. Cabinet-appointed Local Health Integration Networks (LHINs) are forcing hospitals to eliminate their deficits.

Hospital unions estimated that 5,000 jobs would be lost, including 4,000 through attrition and 1,000 more through layoff. It appeared that job losses would affect all professions and classifications, including nurses, physicians, other health professionals, support staff and administration.³⁸⁰ At the community hospital level, proposed and implemented cuts included closure of emergency departments, closure of local birthing services, cuts to hospital beds and departments, privatization of physiotherapy, chiropody and support services, increased fees for patients, and other measures. Emergency departments were proposed to close or indeed did close in Hamilton, Port Colborne, Fort Erie, Leamington, Wallaceburg and Petrolia and ambulance services were being strained, prompting citizens in a number of communities to organize to fight what was essentially the closure of their rural and small community hospitals.³⁸¹

Driven at least in part by cost-cutting and fuelled by expensive consultants, a number of hospitals put restructuring plans in motion. These included, in a growing number of cases, detrimental changes to the model of nursing care delivery and reduction of the RN workforce, often directly contrary to the literature and what is best for the patient and for nursing.^{382 383 384} A number of hospitals experimented with models of nursing care that moved away from continuity of caregiver where each patient is assigned one nurse per shift, RN or RPN, with RNs assigned total nursing care for complex and/or unstable patients with unpredictable outcomes, and RPNs assigned total nursing care for stable patients with predictable outcomes. These new models were called different names, but they were all about fragmenting care, de-skilling patient care and saving money and, as the literature clearly points out, represented a giant step backward for patient care.^{385 386 387}

The RNAO has developed evidence-based clinical and healthy work environment Best Practice Guidelines (BPGs) that, when applied, serve to support the excellence in service that nurses are committed to delivering in their day to day practice. Specific guidelines include: *Client Centred Care*,³⁸⁸ *Developing and Sustaining Effective Staffing and Workload Practices*,³⁸⁹ and *Collaborative Practice among Nursing Teams*.³⁹⁰ These BPGs should be used as foundational in all staffing and scheduling practices and models of nursing care delivery.

RNAO's Recommendations:

- **Guarantee hospital and health services funding, including community and primary care, and invest in collaborative programs that meet community needs and reflect inflation and population growth.**
- **Ensure that models of nursing care and the delivery of health services reflect the best evidence and provide the continuity of care and continuity of caregiver from the most appropriate provider – based on the complexity and predictability of the patient's outcomes - that provides access to the best possible patient care.**
- **Require all hospital consultancy contracts to be approved by Local Health Integration Networks (LHINs) where they are subject to public scrutiny under the *Freedom of Information and Protection of Privacy Act*.**³⁹¹

- **Invest in health services research focused on improving system effectiveness, health human resources impacts and outcomes, and the use of technology and treatment alternatives to manage costs.**

Standards of Long-Term Care

Over 75,000 Ontarians live in long-term care (LTC) homes. Creating vibrant communities requires timely access to a high standard of long-term care. As with home care, it is crucial that access to long-term care be designed with the needs of residents in mind. If the Ministry's Alternate Level of Care (ALC) strategy is to be successful, there must be adequate funding for both ALC and the Aging-at-Home strategies to ensure the availability of high-quality care when and where it is needed. According to the Ontario Health Quality Council report on LTC issued in 2009, wait times for LTC placements have doubled in the past two years from an average of 49 days to 106 days, noting that parts of the province experience wait times that are much worse than others.

Investments made by the Aging-at-Home strategy should result in increased services available in the community. With evidence that many seniors now serviced by long-term care can be safely cared for in the community if proper supports were available,³⁹² the current demand for long-term care home beds and long waiting times for LTC admissions should reduce. Given this expected outcome, the RNAO calls for the adoption of strict standards to ensure equitable access to high-quality, age-appropriate long-term care for those who need it, including a 30-day guarantee of access to a long-term care home or supportive housing from the community and a seven-day guarantee of placement in a long-term care home from an acute care facility.

Nurses applauded the introduction of the *Long-Term Care Homes Act, 2007* with its provision that long-term care homes have at least one registered nurse on duty and on-site 24 hours a day, seven days a week.³⁹³ RNAO is concerned about the ability of long-term care homes to attract staff to fulfill this obligation and the ministry's ability to enforce this legal requirement. Providing equitable compensation and healthy work environments for nurses in long-term care homes may help improve nurse staffing levels. However, RNAO has stated consistently and firmly that patient care would be compromised if the Act and regulations did not prescribe a minimum daily number of hours of nursing and personal care for residents. It is for this reason that the RNAO was profoundly disappointed when the draft regulation was released in spring 2009 with no mention of minimum daily number of hours of nursing and personal care in long-term care homes.

Given that the needs of many long-term care residents have become more complex, with an increase in acuity of 29.7 per cent from 1992 to 2007,³⁹⁴ there are two crucial elements to be considered in determining the appropriate level of care: the first is levels of care and the second is the mix of care providers.

According to the Sharkey Report, levels of care in long-term care homes in Ontario in 2007 were averaging 3.1 hours of nursing and personal care per resident day, including .762 hours of regulated care (RN and RPN).³⁹⁵ This fell short of the no less than .59 RN hours per resident per day and 3.06 hours per resident per day overall nursing and personal care recommended by

the Casa Verde Coroner's inquest,³⁹⁶ and the 3.5 hours per day that the Ontario Health Coalition,^{397 398} RNAO,³⁹⁹ and Ontario Nurses' Association⁴⁰⁰ have been calling for that would bring Ontario into line with care standards in other jurisdictions.

While the Sharkey Report recommended against a regulated care standard, it did support raising personal support worker (PSW) and nursing hours "up to" 3.5 hours, although not necessarily on average.⁴⁰¹ In fact, the current recommended average of 3.5 hours of nursing and personal care is based on average acuity and will need to increase as the acuity of long-term care home residents continues to rise. Sharkey recommends that "provincial guidelines should lead to the achievement of up to four hours of care per resident per day over the next four years, pending adjustments and learning that will occur during the annual evaluations over the four-year period".

Staffing and standards of nursing and personal care also relate to the crucial factor of continuity of caregiver. In her report, Sharkey explained that fragmented staff complements due to staffing shortages and absenteeism had adverse impacts on quality of care. Replacement staff members were often not as familiar with individual needs and routines as full-time nurses.⁴⁰²

With respect to the appropriate mix of care providers in long-term care homes, Sharkey's report documents data from 2007 indicating that health-care aides provide 67 per cent of care, licenced staff 24.5 per cent and program staff 8.5 per cent.⁴⁰³ An inter-disciplinary staffing model best facilitates high quality, resident-centred care that addresses the range of physical, psychological, emotional, spiritual and social aspects. Nurse practitioners, RNs and RPNs should be working to full scope of practice in each home, assisted by personal support workers to provide safe and comprehensive care. Other health professionals such as physiotherapists, occupational therapists, recreational therapists and social workers fill essential roles in the model to enhance the residents' well-being. A number of studies have established strong links between staffing, particularly RNs, in long-term care homes and resident outcomes, including lower death rates, higher rates of discharge to home, improved functional outcomes, fewer pressure ulcers, fewer urinary tract infections, lower urinary catheter use, and less antibiotic use.^{404 405}

Utilizing nurse practitioners to provide primary care to residents and leadership to nursing staff has been demonstrated to improve access to care for residents,⁴⁰⁶ enhance quality of care for residents,⁴⁰⁷ prevent hospital admissions,⁴⁰⁸ and provide a role model for nurses in assessment skills and problem-solving medical issues.⁴⁰⁹ The success of the Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project^{410 411} showed the potential positive outcomes for residents, staff and the health care system of nurse practitioners in the long-term care sector. While extrapolation from the pilot project is difficult, key informants suggested the ratio of NPs to long-term care home should be 1:1 or one NP for up to 200 to 300 residents.⁴¹² In addition, advanced practice nurses engaged as clinical nurse specialists have been demonstrated to improve resident outcomes in nursing homes.^{413 414}

Given the available evidence and staffing standards in other jurisdictions,⁴¹⁵ RNAO recommends a staff mix established by regulation of: one nurse practitioner for every long-

term care home (and no less than one NP for every 200 residents), 20 per cent registered nurses, 25 per cent registered practical nurses and 55 per cent personal support workers. This staffing model would result in substantive improvements in residents' clinical and social outcomes such as reduced rates of pressure ulcers and falls, decreased aggressive behaviours with improved dementia care, and increased residents' and families' satisfaction.

While the *Long-Term Care Homes Act* mandates a home to provide an organized program of recreational and social activities to meet the interests of residents,⁴¹⁶ there is a lack of set standards and requirements or outcome measures. A daily minimum of 0.5 hours per resident of activation and recreational programs should be required in order to promote socialization, engagement in social activities, and mental and physical stimulation.

There are other omissions in the draft regulations circulated by the Ministry. Restraint minimizing provisions should recognize the use of chemical restraints by extending the requirement of a minimizing restraining policy to apply to pharmacological use. This should include defined policies and procedures for obtaining informed consent from the resident or substitute decision maker prior to administration of chemical restraints. No assistance is assured for long-term care homes, especially those in smaller communities, to fulfil the essential duties of coordinating and implementing an infection prevention and control program. Also, there is little protection against inappropriate admission of residents with mental health concerns (i.e. acquired brain injury) and other complex care requirements and not enough recognition of the need for people to live close to their families, communities and support systems.

RNAO's Recommendations:

- **Adopt strict standards to ensure equitable access to high-quality, age-appropriate long term care when and where it is needed, including a 30-day guarantee of access to a long-term care home or supportive housing from the community and a seven-day guarantee of placement in a long-term care home from an acute care facility.**
- **Legislate and fund a daily minimum of four hours of direct nursing and personal care for residents of long-term care homes, attached to average acuity. This would include no less than .59 RN hours per resident per day with greater acuity requiring more hours of care.**
- **Require by regulation and fund a daily minimum of 0.5 hours of activation and recreational programs that promote socialization, mental and physical stimulation and / or rehabilitation for each long-term care home resident.**
- **Establish by regulation a long-term care home staffing model that would improve clinical and social outcomes, including enhanced access to dementia care and reduced rates of pressure ulcers and falls. This calls for a staff mix in long-term care homes of one nurse practitioner (NP) for every long-term care home (and no less than one NP for every 200 residents), 20 per cent registered nurses (RN), 25 per cent registered practical nurses (RPN) and 55 per cent personal support workers (PSW), supported by adequate funding.**

- **Ensure funding of an appropriately educated registered nurse dedicated to infection control in every long-term care home in order to implement the infection prevention and control program consistent with best practices and professional standards.**
- **Develop an appropriate framework for managing mental health care within long-term care homes in order to develop admitting and discharge criteria for residents with risk-related mental health concerns.**
- **Recognize an individual's need to age in place and be placed in a long-term care home that is either within their previous continuum of care facility or close to their family and community, if requested.**

Physician Assistants Are Not The Answer

The Registered Nurses' Association of Ontario (RNAO) is committed to supporting change within the Ontario health-care system designed to meet the needs of citizens, when those changes are evidence-based, support continuity of care and continuity of caregiver, and enable full scope of practice for regulated health professions. On the basis of those principles, the RNAO has fundamental concerns regarding the introduction of physician assistants (PAs) in Ontario. As currently defined in Ontario, physician assistants have limited education, training and experience and are not accountable to a regulatory body that would ensure they practise to acceptable and safe standards. Introducing PAs has the potential to fragment patient care within interprofessional teams, confuse the public understanding of roles within the health-care system,⁴¹⁷ and significantly increase costs to a system that is struggling to achieve financial sustainability.

There are better, safer, more cost effective alternatives. For over 30 years, nurse practitioners have had the knowledge, skills and competencies to provide access to essential health services in the community, long-term care and hospital settings, yet they continue to be under-utilized in Ontario and face barriers to being able to practise to their full scope.

A physician assistant (PA) is an unregulated health-care provider who, under the supervision and delegation of a physician, can perform such acts as to: take client histories, conduct physical examinations, write orders, interpret test results, diagnose and treat illness, counsel on preventive health care, write prescriptions and assist during surgery.

PAs in the Canadian Forces have a long history and it is not the RNAO's intention to question the fine and valuable service they continue to provide. Civilian PAs in Ontario do not have the training and education of their military counterparts, and are not subject to the consistent standards of practice and supervision. By the time a soldier commences the Military PA course they have had at least 12-15 years in the military working as a medical assistant, and have likely served on several missions at home or overseas. Soldiers enter the Military PA program with a great deal of experience in the medical field.⁴¹⁸

Unlike nurse practitioners (NPs) who need to have completed a 4 year Baccalaureate of Science degree in Nursing, and a minimum of two years in clinical practice prior to applying to

the NP program, the limited prerequisite requirements for application to a PA program in Ontario do not build on a health care or scientific background.

Applicants to the McMaster University⁴¹⁹ and the University of Toronto/ Northern Ontario School of Medicine (UofT/NOSM)/ Michener Institute collaborative⁴²⁰ programs need only have finished two years of a general four-year undergraduate degree program. This education can be in any discipline (e.g. arts, engineering, or journalism). No preference is given to one program over another, though the UofT/NOSM/Michener Institute requires completion of courses in human anatomy, chemistry and physiology. A complete undergraduate degree is not required.

In addition, the requirement for prior clinical work experience varies. Whereas McMaster does not have any prerequisite clinical requirements, the U of T/ NOSM/ Michener Institute requires only one working year (equivalent to 1680 hours) of patient contact in a professional setting.

In contrast to the post-baccalaureate level education that nurse practitioners receive and the baccalaureate or additional education of registered nurses and advance practice nurses, PAs are educated at the undergraduate level in Ontario and start assessing and treating patients after only one year of general didactic (classroom) education, and one year of general clinical exposure.^{421 422} Given the growing acuity and complexity of the health-care needs of Ontarians, RNAO believes civilian PA education to be inadequate. There has been no evidence that PAs in this education model can support their practice safely. The insufficient level of education and narrow clinical experience may compromise recognition of the limits of expertise and may, as a consequence, jeopardize client safety.

Physician assistants in Ontario are not accountable to a regulatory body, as nurses, physicians, pharmacists and other health-care professionals are. These bodies ensure that regulated health professionals practise to acceptable and safe standards, an expectation not in place in Ontario for PAs.

PAs do not work autonomously as independent practitioners, and will not bring greater efficiency to the health-care system. All work performed by the PA must be supervised by a physician who is legally responsible for all the PA's client care. However there is no legal requirement or assurance that the supervising physician will actually be physically present. The primary supervising physician needs only to be accessible for verbal consultation at all times, and does not need to be on site.

Physician assistants and the attendant requirement for physician supervision add a significant cost burden to Ontario's health-care system. PAs enter the workforce with earnings comparable or higher than substantially more educated and experienced nurses at the top of their range. In 2009, registered nurses with up to five years of experience earned \$64,623, and those with 25 years of seniority or more were earning only \$78,000 a year.⁴²³ The salary for a graduate NP working in primary health care ranges from \$74,038 to \$89,203.⁴²⁴ The salary range for PAs reflects differing levels of experience, with PA base salaries ranging from \$78,000 to \$86,700 per annum.⁴²⁵

Besides the base salary and benefits, the MOHLTC also reimburses prospective PAs up to \$500 per person per employment interview (with an average of three interviews per hospital) for travel costs, and \$4,000 for relocation expenses, in order for a PA to undertake employment in Ontario. This includes household utility connections, professional moving company fees, gasoline, temporary hotel accommodation, food expenses, and any fees for Canadian work permits or Canadian work visas. In contrast, very few organizations cover exam, liability or registration fees for other regulated professions because of potential conflicts.

In addition to having the full-time services of a physician assistant at their disposal, each primary supervising physician in the demonstration project is paid a stipend to “encourage participation,” as well as to “compensate for potential lost earnings and productivity.” This stipend is currently up to \$72,000 over two years per physician.⁴²⁶ Supervising physicians in the demonstration project also receive a \$5,000 completion bonus for supervising their assistants.⁴²⁷

Finally, when the need for consultation arises, the physician would also receive compensation for his/her attendance or services. Overall, the cost of introducing just one physician assistant to the Ontario health-care system would average over \$150,000 per year.

RNAO is committed to interprofessional collaboration with a view to improving the public’s access to safe, high-quality and universally accessible health services. Evidence shows this can be done effectively and efficiently through expanding the scope of practice of existing self-regulating health professions in accordance with their education and competencies. For example, expanded roles for registered nurses to enable them to work to their full scope of practice will maximize health-care resources and improve access to services. Registered nurse first assists (RNFAs) with additional certification in surgical assistance have been shown to reduce wait times, facilitate continuity of care and have a positive impact on patient outcomes.⁴²⁸ Clinical nurse specialists (CNSs) are advance practice nurses who have made a significant contribution since being introduced in the early 1940’s.⁴²⁹ Nurse practitioners have the knowledge, skills and competencies to provide access to essential health services in community, long-term care and hospital settings.^{430 431} Yet NPs are still not being fully utilized in Ontario and face barriers limiting their ability to practice to their full scope.⁴³² It is in this context that the RNAO does not support introduction by the government of the new category of unregulated physician assistants (PAs).

RNAO’s Recommendations:

- **Recognize that physician assistants are not the answer to the need to provide access to high-quality, client-centred, cost-effective health care utilizing all health professionals to their full scope.**

Access to Mental Health and Addiction Services

One in five people in Ontario has a mental health problem at some point in his or her life. Only about 30 per cent of these people seek any kind of help. There are several reasons for this.

They may not recognize they have a problem, or they may not know what kind of help is available. Or they may know what exists but not be able to use the services because of barriers such as cost, language and transportation. Often the appropriate services are not nearby when needed.

In October 2008, the Minister of Health and Long-Term Care established an Advisory Group composed of people with lived experience with mental illnesses and addictions, family members, service providers and researchers. Members of the Advisory Group were selected to reflect a range of perspectives, such as children and youth, Aboriginal, workplace and women. Their mandate was to develop a ten-year comprehensive strategy to “transform mental health and addiction services in Ontario.”⁴³³

Simultaneously, an All-Party Select Committee on Mental Health and Addictions was appointed by the Ontario Legislature in February 2009 to determine the mental health and addiction needs that currently exist. Input from both committees is intended to inform a long-term strategy for mental health and addictions with the specific outcome of ensuring investment in community mental health and addiction services in order to help reduce wait times, emergency room visits and hospitalizations.⁴³⁴

Tackling mental health and addictions issues is vital for the health of individuals, families, and communities. It is estimated that at least 60 per cent of individuals diagnosed with a mental illness also have addictions. Mental health and addictions account for nearly 12 per cent of the overall burden of disease, yet Ontario consistently spends only five per cent of the provincial health budget on mental health and addictions.

The government’s report, *Every Door is the Right Door*,⁴³⁵ points out that in total, including lost productivity, law enforcement, and disability claims, drug costs, and employee assistance claims, mental health and addictions cost Ontario at least \$39 billion per year. Every dollar spent on mental health and addictions saves \$7 in health costs and \$30 in lost productivity and social costs.

The importance of strategic investment in mental health and addictions services cannot be over-estimated. Crucial to this strategy is adopting RNAO’s recommendations under *Vision of a Poverty-Free Ontario* above, notably: transforming the Ontario Disability Support Program and Ontario Works; significantly increasing social assistance rates; introducing a \$100 per month healthy food supplement; building new affordable housing, particularly supportive, community-based housing and services for those with physical, cognitive and/or mental health needs.

Education in mental health and addictions across all professions enabled by secured funding is needed in order to promote early screening, assessment, determination of early recognition and diagnosis, and immediate intervention. This education needs to be implemented as a basic entry to practice requirement. This will increase efficiency in care and provide the opportunity to clearly address mental health and addictions stigma issues when these professionals are new graduates. Increasing access to robust mental health services across the province will be facilitated by ensuring the development of specialized post graduate education in mental health

and addictions, such as a nurse practitioner specialty in this area, and continuing education for all health professionals throughout the career span.

A systematic and seamless mental health-care system must be developed for all Ontarians, delivered at the individual's preferred location, with special consideration for: members of Aboriginal communities; older adults tackling new and ongoing mental health and addictions challenges; people from racialized communities; new Canadians; people with disabilities; discharged members of the Canadian Forces, especially those who were in combat roles; children and youth requiring increased and enhanced mental health and addictions services; and, inmates in correctional facilities and rehabilitated ex-convicts.

It is imperative that people facing mental health and addictions challenges receive respectful, equitable, appropriate, and seamless client-centered access to health and social services. Stigma in perceptions, attitudes, and actions needs to be addressed. A coordinated, comprehensive approach to mental health and addictions is needed, so that there are opportunities for building resiliency throughout the life cycle through prevention, assessment, intervention, treatment, and ongoing support that demonstrate our societal commitment to respect every Ontarian.

A radical shift in beliefs and paradigms about persons with mental illness and addictions is required, fostering an open dialogue and a systemic belief in recovery. People need to be able to access mental health and addictions prevention and treatment services through every door but it is critical that this occurs well before the individual hits the criminal justice portal. Indeed, when persons with mental health challenges arrive at the criminal justice portal, it is highly likely that the Ontario mental health and addictions system has not met all of that person's mental health needs.

RNAO's Recommendations:

- **Develop an integrated and seamless mental health-care system for all Ontarians, with interprofessional collaboration, delivered at the individual's preferred location, with special consideration for members of Aboriginal communities, older adults tackling both new and ongoing mental health and addictions challenges, people from racialized communities, new Canadians, people with disabilities, discharged members of the Canadian Forces, children and youth requiring increased and enhanced mental health and addictions services, inmates in correctional facilities, and rehabilitated ex-convicts.**
- **Implement secure funding for professional education in mental health and addictions, in order to promote early screening, assessment, determination of early recognition and diagnosis, and immediate intervention across all professions.**
- **Support the development of specialized post graduate education in Mental Health and Addictions by introducing a new Nurse Practitioner Specialty in Mental Health and Addictions, and supporting continuing education throughout the career span.**

D. IMPROVING ACCESS TO NURSING SERVICES

Access to registered nurses is an essential component of vibrant communities and optimal health outcomes. There is clear evidence linking care provided by registered nurses with better health outcomes in a variety of settings such as hospitals,^{436 437 438} long-term care,^{439 440} and the community.^{441 442 443 444} Models of nursing care delivery that undermine the importance of RNs' knowledge and reduce direct care hours provided by RNs result in reduced continuity of care and continuity of caregiver, fragmented care, and higher morbidity and mortality. The evidence is that in hospitals, long-term care and the community, RNs are more effective in improving patient outcomes and reducing cost.^{445 446 447 448 449 450 451 452 453 454 455 456 457 458}

A systematic review of the literature found that greater RN staffing was associated with lower hospital mortality such that an increase by one RN full-time equivalent (FTE) per patient day would save five lives per 1,000 hospitalized patients in intensive care units, five lives per 1,000 hospitalized medical patients, and six lives per 1,000 hospitalized surgical patients.⁴⁵⁹ In long-term care, a richer skill mix with a higher proportion of RNs providing direct care has been associated with fewer pressure ulcers, hospitalizations and urinary tract infections, and less weight loss, catheterization and deterioration in ability to perform activities of daily living.⁴⁶⁰

Nurse Practitioners in both community and hospital settings have been shown to augment other roles^{461 462} and improve access to health services. In a variety of settings, RNs and NPs have proved beneficial to clients with chronic care conditions by successfully decreasing utilization of health-care resources, improving patient satisfaction, and enhancing quality of life.^{463 464 465}
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Ontario's RN workforce is aging. In 2009, the average age of a RN employed in nursing was 46.3 years compared with the average age in 2001 of 43.3 years.⁴⁶⁷ In 2009, 27.7 per cent were over 54 years of age, which is close to the average age of retirement for nurses. This is up from 11.2 per cent in 1992.⁴⁶⁸ At the same time, the RN workforce is lagging in size behind population growth, with the number of RNs/10,000 population being 71.3. This is down from 80 in 1989, but up from a low of 67.7 in 1999.⁴⁶⁹ With an aging nursing workforce serving the needs of a growing and aging population, efforts are required to attract more individuals to nursing, retain the current workforce, absorb and retain new graduates, and, reduce workloads.

Secure an Adequate Supply of Nursing Human Resources

Successive governments have made progress in the past decade towards recruiting and retaining RNs in Ontario. The public has gained access to almost 11,000 additional RNs since 2000, with the largest improvement happening since 2003, thereby proving that commitments to hiring additional nurses can be achieved.⁴⁷⁰ But spending on new nursing hires was delayed when, in the fall 2008 economic update, the brunt of government cutbacks was borne by nurses (\$50 million). This creates fear among nurses that may once again destabilize the profession.

Even before the budgetary cutbacks, Ontario's nurse to population ratio was lagging behind that of the rest of Canada. At a RN-to-population ratio of 71 per 10,000, Ontario has a considerable distance to go to recover to the levels prevailing in 1980s, when the ratio

exceeded 80.⁴⁷¹ When RNs talk about burnout, the RN-to-population ratio helps to explain this condition. If anything, this ratio is an underestimate of workload, as the general population has aged and health needs have increased and become more acute.

To bring the nurse-to-population ratio up to the equivalent of the rest of Canada would require employment of almost 15,000 more RNs in Ontario.⁴⁷² To make progress toward closing this gap, we are asking all parties to commit to increase the RN workforce (general class) by 9,000 FTEs by 2015. These RNs would be in addition to the 9,000 FTEs pledged to be hired by 2011 and must be employed in all roles and all practice sectors across Ontario.

RNAO Recommendations:

- **Commit to increasing Ontario's RN workforce by an additional 9,000 general class FTEs by 2015.**
- **Fund 350 additional primary, adult and paediatric nurse practitioner positions in each of the next four years - and an additional ten NP- anaesthesia positions a year - to staff community health centres, public health, long-term care homes, community care access centres, NP-led clinics, hospitals (including inpatient, outpatient and emergency), family health teams, home care and other community services.**

Secure 70 Per Cent Full-Time Employment for all Nurses

Evidence shows that workforce stability, with higher proportions of full-time RN staff, is significantly associated with lower mortality rates, continuity of care and continuity of caregiver, and improved patient behaviours.^{473 474 475} Conversely, excessive use of part-time and casual employment for RNs has been associated with decreased morale, an unstable workforce where nurses move to other jurisdictions to find full-time work,⁴⁷⁶ disengagement among nurses, and lack of continuity of care for patients.^{477 478}

RNAO has long campaigned for 70 per cent full-time employment⁴⁷⁹ for all nurses. Full-time RNs increased from a low of 50 per cent in 1998 to 65.4 percent in 2009 (65.6 per cent if nurse practitioners are included).⁴⁸⁰ This is dramatic progress that has resulted in better retention, better quality of patient care, and more people wanting to enter the profession.

There is no question that 70 per cent full-time employment for nurses is an achievable target. Certainly, it has been achieved in the US, where the latest federal survey data show that 70.1 per cent of RNs are full-time.⁴⁸¹

RNAO's 2005 survey, *The 70 Per Cent Solution*, found that the strongest progress in full-time RN employment took place in the hospital sector, which had conditional, targeted funding.⁴⁸² Achieving 70 per cent full-time work across the nursing workforce will require an increased policy intervention. It will require more targeted, conditional funding for the hospital sector, and the introduction of such funding to the long-term care and home care sectors.

RNAO Recommendations:

- **Commit to achieve 70 per cent full-time employment for all nurses, with the goal of achieving this target across Ontario in all health-care sectors by 2015. This commitment should be backed up by increased targeted, conditional funding in the hospital sector, and the introduction of targeted, conditional funding in the long-term care and home care sectors.**

Secure Continuity of Care and Continuity of Caregiver

RNAO strongly supports the development of a health-care system utilizing a patient/client-centred model, where Ontarians have access to continuity of care and continuity of caregiver from a primary provider. RNAO also strongly endorses strengthening of inter-professional care so all health disciplines work closely to support high quality patient care.

Adhering to the appropriate skill-mix and nursing model of care delivery is paramount to optimize patient, staff and organizational outcomes.

Excellence in patient/client centred care is supported by three pillars:

- Models of nursing care delivery that advance continuity of care and continuity of caregiver by assigning each patient one nurse per shift, that nurse being an RN or an RPN working to full scope of practice and accountable for delivering the total nursing care required by that individual patient. As set out in RNAO's *Client Centred Care Best Practice Guideline*,⁴⁸³ continuity of caregiver enables nurses to provide holistic patient or client care, facilitate higher coordination, and create clear accountability. This is in contrast with team nursing, where three different roles – RNs, RPNs and unregulated providers – each provide one component of nursing care. The result is fragmentation of care where the incidence of medication error increases, assessments are overlooked and patient safety is put at risk.⁴⁸⁴
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- Assignment of the most appropriate caregiver based on the patient's complexity and care needs and the degree to which the patient's outcomes are predictable, with RNs assigned total nursing care for complex and/or unstable patients with unpredictable outcomes, and RPNs assigned total nursing care for stable patients with predictable outcomes. Patients whose condition is unclear remain under the care of RNs to prevent shifting of patients back and forth between RNs and RPNs. When unregulated staff are utilized, they are assigned to assist RNs or RPNs, under supervision and where appropriate, with attention given to prevent disrupting the continuity of care provided by the assigned nurse.
- Workforce stability, by achieving 70 per cent full-time employment for nurses across all sectors, supports continuity of care and continuity of caregiver, improves intra and inter-professional team work, reduces costs and facilitates staff satisfaction and retention.

While sometimes looked to in aid of hospital re-engineering and budget-cutting efforts, models that are not based on continuity of care and continuity of caregiver have not proven to save costs.⁴⁸⁷ In fact, the assumption that RN care is financially unsustainable is not supported by the evidence. Research relates increases in RN staffing levels with reduced hospital lengths of

stay, thereby saving both lives and money.⁴⁸⁸ A higher proportion of RNs can prevent adverse events that prolong a patient's hospital stay. Also, the higher knowledge and skill levels of RNs can lead to more effective nursing care and lower patient resource consumption.⁴⁸⁹ A US study found that increasing the proportion of RN time over LPN time without increasing overall nursing hours both reduces hospital mortality and cuts costs.⁴⁹⁰ Another study, focusing on long-term care concluded that increasing RN staffing levels can result in significant cost savings from a reduction in adverse outcomes, estimating an annual saving of \$3,191 per patient in high-risk, long-stay nursing homes.^{491 492}

Health administrators seeking to cut costs should be looking at strengthening the full-time RN workforce.

RNAO Recommendations:

- **Guarantee that models of nursing care delivery reflect the best evidence, where each patient is assigned one nurse per shift, RN or RPN, depending on the level of complexity and predictability of outcomes for the patient. RNs should be assigned the total nursing care for complex or unstable patients with unpredictable outcomes, and RPNs should be assigned the total nursing care for stable patients with predictable outcomes. Patients whose condition is unclear remain under the care of an RN to prevent shifting patients back and forth between RNs and RPNs.**

Equalize Remuneration for All Nurses

A shift from an illness-based model of care to a preventive one will require a shift of nursing services out of the hospital sector and into the community. At the same time that community needs are increasing, a recent graduate facing an overwhelming debt is often attracted to the higher pay, benefits and better hours of a hospital environment.

Wage differentials, which act as a disincentive to nursing employment in home care, must be addressed.⁴⁹³ The community sector lost 27 per cent of its nursing workforce between 1998 and 2004, and saw an increase in the share of older nurses working in the sector.⁴⁹⁴

Disparities in compensation from one public health unit to another and employment instability were identified as recruitment and retention issues for the public health workforce, a majority of which is composed of public health nurses.⁴⁹⁵ To meet the increasingly complex needs of clients in long-term care settings with appropriate staffing, it is also essential that nurses in this sector receive comparable remuneration to the hospital sector.⁴⁹⁶ In summary, to retain and attract RNs across all sectors, inequitable gaps in remuneration and working conditions must be urgently addressed.

RNAO Recommendations:

- **Equalize remuneration and working conditions for RNs working in the hospital, primary care/family practice, home care, public health, and long-term care sectors.**

Secure Violence-Free Workplaces

Violence in the workplace is defined in *Preventing and Managing Violence in the Workplace Best Practice Guideline*,⁴⁹⁷ part of the RNAO Best Practice Guideline Program, as “a multi-dimensional phenomenon involving the misuse of power and resulting in physical, psychological or sexual abuse.” It includes:

Incidents in which a person is threatened, abused or assaulted in circumstances related to their work ... This definition would include all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery and other intrusive behaviours.⁴⁹⁸

Workplace violence can involve patients, clients, family members, present or past staff members, personal relationships or a perpetrator who is not known to the organization.⁴⁹⁹

Many nurses who experience violence don't talk about their experiences for fear of losing their jobs or enduring retaliation and further confrontation. For years, violence against health professionals was rarely discussed, but cases such as the tragic death of Lori Dupont in 2005 brought the issue poignantly to the forefront. Dupont was a registered nurse at Windsor's Hotel Dieu Grace Hospital. She was murdered while on duty by her former partner, an anaesthesiologist who worked at the same hospital.

In Bill 168, the *Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace, 2009)*, the government took a significant step to prevent, recognize and manage violent acts in the workplace. However, the legislation fell short in several critical areas, notably: (1) the need for a broader definition of workplace violence that does not, as Bill 168 does, distinguish between workplace harassment and workplace violence; (2) the need for whistleblower protection; and (3) the need to address the structural power imbalance in the health-care workplace by replacing medical advisory committees (MACs) with inter-professional advisory committees (IPACs).

Every worker has the right to work in a supportive environment where workplace violence, in all its forms, is not tolerated.

RNAO Recommendations:

- **Strengthen the *Occupational Health and Safety Act* to adopt an inclusive and evidence-based definition of workplace violence such as the one incorporated in RNAO's *Preventing and Managing Violence in the Workplace Best Practice Guideline*: “Incidents in which a person is threatened, abused or assaulted in circumstances related to their work... This definition would include all forms of harassment, bullying, intimidation, physical threats or assaults, robbery, and other intrusive behaviours.”**
- **Protect those who report incidents or potential incidents of violence in the workplace with explicit whistleblower legislation.**
- **Equalize power bases, which is a key contributor to workplace violence. This includes amending the *Public Hospitals Act* to transform Medical Advisory Committees**

(MACs) into Inter-professional Advisory Committees (IPACs) which would allow all health-care providers to participate fully and equally in creating a healthy work environment and excellence in patient care.

Expand the Roles of Nurse Practitioners

Shifting health care needs, the scarcity of health human resources, the heavier burden of chronic disease and increasing complexity of treatment point to the value of the nurse practitioner role in all its distinct practice specialties – primary health care, adult, paediatric and anaesthesia.⁵⁰⁰ According to a Harris-Decima survey, 88 per cent of Canadians would be comfortable being treated by a nurse practitioner (NP) at a walk-in clinic and 74 per cent would be willing to have their regular physical done by a NP.⁵⁰¹

Nurse practitioners are experienced registered nurses with additional education and specialty registration who demonstrate competence to autonomously diagnose and manage disease, order and interpret diagnostic and laboratory tests, prescribe medications and perform treatment within their legislated practice.⁵⁰²

NPs in both community and hospital settings have been shown to augment other roles⁵⁰³ and improve access to health services. However, many nurse practitioners are not being fully utilized and, for a variety of reasons, are unable to practise to their full scope.^{504 505 506 507}

Bill 179, the *Regulated Health Professions Statute Law Amendment Act, 2009*, kept a promise to expand the scope of practice of nurse practitioners and all RNs and health professionals. RNAO successfully advocated for amendments that fixed serious omissions in Bill 179. In a significant victory, the government amended the Bill to open the door to open prescribing of pharmaceuticals for NPs. Passage of Bill 179 by the Legislature triggered the onset of the regulation-making process and the RNAO made it a priority to push for the ability of NPs to admit, treat and discharge in in-patient facilities. These areas are well within the knowledge and expertise of nurse practitioners. Further expansion of the scope of practice of NPs, within their knowledge, expertise and competency, will reduce wait-times, benefit patients and be cost-effective for the health-care system.

RNAO Recommendations:

- **Amend statutes, regulations and policies to allow nurse practitioners to use their full knowledge, skills and experience and practise to their full scope. This includes authorizing nurse practitioners to admit, treat and discharge in in-patient settings.**
- **Support the full integration of specialty (hospital-based) nurse practitioners.**
- **Expand opportunities for NP continuing education with a focus on specialized NP practices.**

Expand the Roles for RNs

Ontario has provided some leadership in new roles for registered nurses, including RN First Assists (RNFA), RNs who perform flexible sigmoidoscopy and nurse endoscopists. However, these roles are yet to become permanent, and episodic funding has created a movement of nurses in and out of roles leading to cancellations of services, delays in care, and loss of RNFAs to other jurisdictions. It is imperative that stable funding be allocated to ensure the security of these roles.

Better utilizing the knowledge and skills of registered nurses in different roles is urgently needed to secure high-quality health care for the people of Ontario. Expanded roles for registered nurses to enable them to work to their full scope of practice maximize health-care resources, and enhance access to services. Supporting these roles will help Ontario keep more registered nurses in our health-care system and act as a magnet for those considering a career in nursing.

Registered nurses in many European countries practise in a number of expanded roles and in a diversity of venues, including emergency departments and nurse-led clinics, to provide care and support for clients and their families. These services have been shown to achieve positive outcomes for clients and practitioners.⁵⁰⁸

Clinical Nurse Specialists (CNSs) have made a significant contribution since being introduced in the early 1940s. A CNS is an advanced practice nurse with a nursing program education at the master's or doctoral level and a focus in clinical specialization and education.⁵⁰⁹

New and emerging roles for nurses include:

- Mental Health and Addictions Nurse Practitioner
- Continence Nurse Specialist
- Nurse Hysteroscopist
- Forensic Nurse Examiner
- Critical Care Flight Nurse
- Nurse Psychotherapist

Registered Nurse First Assists (also known as Surgical First Assists) are registered nurses with additional certification in surgical assistance. RNFAs work with the surgeon and operating room team to provide safe patient care before, during and following surgery.⁵¹⁰ Patient outcomes have been shown to be positively impacted by implementation of the RNFA role as indicated by decreased patient anxiety, facilitation of continuity of care,⁵¹¹ and decreased surgery time and turnover time between cases.⁵¹²

In evaluating the RN Surgical First Assist Pilot Project, the Ministry of Health and Long-Term Care found strong support for the role and practice of RNFAs both in reducing wait times by

addressing the shortage of surgical staff, and increasing retention by presenting nurses with new opportunities for career enhancement and learning new skills.⁵¹³

Committing to 50 per cent funding of RNFA positions on July 31, 2009 was a good first step by the Minister of Health and Long-Term Care, but it is essential that RNFAs be permanently funded at 100 per cent, independent of hospital nursing budgets. As of March 1, 2009, there were 42.1 RNFA FTEs practising at 24 sites across the province. With the proven success of RNFAs in reducing surgical wait-times and improving patient outcomes, expanding the role of surgical first assists is clearly an excellent investment.

RNAO Recommendations:

- **Provide base funding for expanded practice nurses such as nurse endoscopists (NE), RNs who perform flexible sigmoidoscopy and Registered Nurse First Assists (RNFAs), independent of hospital nursing budgets.**
- **Support Clinical Nurse Specialists (CNS) and new and emerging roles for nurses.**
- **Reduce surgical wait times by investing in an additional 25 Registered Nurse First Assists each year over the government's mandate.**
- **Maximize use of RNs' knowledge, skills and experience and allow RNs to practise to full scope by amending the following legislation and regulations:**
 - *Nursing Act, 1991*, to authorize RNs to sell and compound drugs;
 - *Nursing Act, 1991*, to authorize RNs to communicate a diagnosis, order simple x-rays of the chest, ribs, arm, wrist, hand, leg, ankle, foot, and mammograms;
 - *Nursing Act, 1991*, to authorize RNs to set or cast simple bone fractures or joint dislocations.

Create Rural and Northern Opportunities

Small communities are particularly hard hit by deficit-related cost-cutting of hospital and health services. In northern and rural communities, local hospitals not only provide essential health-care services, they are also hubs for the community and major employers in those communities. Any northern and rural hospital cutbacks represent a disproportionately large blow to the people served by, and serving in, those hospitals.

Northern and rural communities also suffer greatly from the government's shortfall on delivering an appropriate supply of RNs, and this is further aggravated by shortfalls in full-time employment opportunities. Nurses employed in small hospitals in rural and small towns in Ontario are less likely to have full-time employment than urban nurses employed in larger hospitals. A compelling study found that "[a]s of July 2005, only nine per cent of small hospitals had met the 70 per cent full-time employment target using MOHLTC's [Ministry of Health and Long-Term Care] 2004-05 classification of full-time nurses... 15 per cent of small hospitals had fewer than 46 per cent of annual nursing hours worked by full-time nurses."⁵¹⁴ "16 per cent of rural hospital RNs and 17 per cent of rural hospital RPNs held two or more

nursing positions.”⁵¹⁵ In addition, the eclectic nature of nursing practice in small hospitals requires a unique preparation and support for new graduates. As they enter their chosen profession as novices, they are at risk of being overwhelmed by the breadth and depth of requirements in smaller centres where there are both greater expectations and often fewer supports. Recruitment and retention of nurses is a major issue in rural and Northern Ontario.

The shortage of primary care providers is equally concerning. In 2008, nearly one in 12 Ontario adults did not have a nurse practitioner, family physician⁵¹⁶ or other primary care provider. This is especially acute for the 30 per cent of Ontarians who live in northern, rural and under-serviced communities.⁵¹⁷

RNAO Recommendation:

- **Develop a health human resources strategy specifically for rural and northern communities that would address educational requirements, recruitment and retention, and the role of RNs in building a robust rural and northern health-care system.**
- **Expand the 1:1 tuition reimbursement to new nursing graduates who choose to relocate to northern, rural and underserved communities to include RN and RPN graduates from all regions of the province.**

E. BUILDING A NURSING CAREER IN ONTARIO

In *Creating Vibrant Communities*, RNAO recommends practical and concrete Made in Ontario solutions that will both strengthen the nursing workforce and say to the aspiring nurse, the nursing student, the recent graduate, the mid-career nurse and their later-career colleagues: “Build your Nursing Career in Ontario.”

Much progress has been made to recruit and retain RNs in Ontario. The public has gained access to 11,000 additional RNs since 2000, with the largest improvement happening since 2003.⁵¹⁸ Full-time RN employment increased from 50 per cent in 1998 to 65.6 per cent in 2009,⁵¹⁹ putting the 70 per cent goal within reach. New nursing graduates found full-time employment thanks to the Nursing Graduate Guarantee program, and the 80/20 initiative opened new horizons to keep experienced nurses in the workforce.

We must keep up the momentum. Concerns about a temporary budgetary shortfall must not derail the rebuilding of the profession. We must invest in more nursing graduates. Barriers to a nursing education must be overcome. With the tremendous success of the Nursing Graduate Guarantee in the recruitment and retention of nurses into the profession and integrating new graduates into the workplace,⁵²⁰ we need to ensure its continued benefit for all sectors and all parts of the province. A strategy must be developed to keep mid-career nurses fulfilled in the profession. Full-time, experienced RNs should have expanded opportunities to spend 20 per cent of their time in mentoring or other professional development activities through the innovative Late Career Initiative program. Commitment to hiring an additional 9,000 general class RNs and a further 1,400 NPs is crucial.

Commit to No International Recruitment

Individuals have the indisputable human right to migrate and live and work where they choose. As such, there should be no systemic barriers to nurses who have permanent status in Canada from practising their profession and serving the public, wherever they were educated.

However, the international recruitment of nurses that solicits emigration from one country, often a developing nation, to another, usually a wealthier country, raises a significant ethical concern. In the context of a global shortage of 4.3 million health workers, we are witnessing a growing disparity as poor nations with the fewest nurses and greatest burden of disease are losing them to wealthy countries with the most nurses.⁵²¹ A key push factor that has driven nurses from their home countries has been economic structural adjustment programs and fiscal restraint programs that have resulted in cuts to health services, increased casualization of the nursing workforce, and nursing unemployment.⁵²² Both industrialized and developing countries alike are faced with the paradox of nursing shortages existing alongside unemployed nurses.⁵²³

International recruitment as a quick fix for developed countries that have not addressed their own health human resources (HHR) needs has a negative impact on both the receiving and source countries. HHR policies in wealthy countries such as Canada that target HHR from less

affluent countries exacerbate domestically created HHR shortages, negatively impact population health, and destabilize health systems.^{524 525}

RNAO Recommendations:

- **Ensure that government and publicly funded health organizations do not engage in international recruitment of nurses and other health professionals, and do not see this as part of their health human resources strategy.**
- **Ensure that nurses and other health professionals who voluntarily and without pressure choose to make Ontario their new home face no systemic barriers to practise their profession.**
- **Establish permanent funding for existing upgrading and bridging programs for nurses who make Ontario their new home.**

Made In Ontario Solutions

From Student

Creating vibrant communities in challenging economic times requires investment in infrastructure. That means addressing long-neglected roads, bridges and housing, as well as rebuilding the infrastructure of health care and education. Investing in nursing education as part of a health human resource strategy is not only key to strengthening Medicare and ensuring people have access to the care they need, it is also good for the economy.

Significant numbers of new nursing graduates are required to meet the needs of a growing and aging population, and to replace the large number of nurses expected to retire in coming years. However, there are constraints to educating more nurses: adequate physical infrastructure; shortage of faculty; funding to support nursing education; and, access to practice education, including clinical placements and clinical simulation laboratories.

The Canadian Nurses Association has projected that increasing enrolment in RN entry-to-practice programs by 1,000 per year for three years would reduce the 15-year RN shortage gap by about 25 per cent from 60,000 to 45,000.⁵²⁶ The Canadian Association of Schools of Nursing estimates an annual need for 3,673 nurses with master's degrees and 650 nurses with doctoral degrees.⁵²⁷ This contrasts with the reality that in 2007 only 603 master's degrees were granted, and 44 PhDs – 16.4 per cent and 6.8 per cent of the required totals, respectively.⁵²⁸ A massive effort is required in order to have faculty to teach the needed increase in nursing students, especially as nursing faculty are nearing retirement in increasing numbers. In 2005, 43 per cent of nursing faculty were 50 years of age or older.⁵²⁹ Given that Ontario lags the rest of the country in the RN/population ratio, this province should be particularly focused on increasing its capacity to graduate more RNs.

In Ontario, the need for more faculty to teach growing numbers of nursing students reflects a province-wide problem where Ontario lags behind the rest of Canada with respect to faculty-to-student ratios.^{530 531} A 2005 study reported that 11,000 new university faculty and 7,000

new college faculty would be needed by the end of the decade.⁵³² However, the projected net increase in full-time faculty from fiscal year 2005-2006 to 2007-08 is 1,342.⁵³³ The need for increased faculty numbers is particularly urgent in nursing.

Another major obstacle to delivering more nursing education seats is the limited availability of clinical placements. Here, the faculty shortage makes staffing clinical placements more challenging. An education with a strong and varied clinical practice is essential. A coordinated system for clinical placements requires the capacity for inter-professional placements, deployment of students to support existing staff in emergency situations,⁵³⁴ and data analysis and reporting.

There are also constraints at the facility level, particularly during the consolidation year when staff members are required to provide the preceptorship. Increasing enrolment must be supported with enhanced physical infrastructure to ensure adequate physical space for additional students and faculty.⁵³⁵ Heavy workloads and the nursing shortage have reduced the numbers of staff RNs available to facilitate clinical placements. This requires innovative programs to free up resources. Ontario's Late Career Initiative, for example, funds facilities to allow senior nurses to devote 20 per cent of their time to preceptorship and other professional development activities. This mirrors RNAO's '80/20 program'.

Nurse practitioner advanced practice requires entry to practice at the graduate level to support complex critical thinking, enhanced leadership and development and application of research to enable visioning and innovation.⁵³⁶ Continued evolution of education for all nurse practitioners is necessary to ensure consistency with national core competencies for nurse practitioners and existing standards in other jurisdictions. A focus on NP graduate education will also support recruitment to the profession and enhance patient safety.

Increasing tuition is a significant barrier and major inequity for many aspiring nursing students. Many nursing students accumulate substantial debts while earning their RN credentials. This is a cost that many cannot afford, and which will deter some qualified applicants.

RNAO's Recommendations:

- **Increase the funding of first-year nursing programs to enable 500 admissions.**
- **Fund universities to increase their PhD entries by 10 per year, and their Masters entries by 100 per year.**
- **Create an endowment for three-year doctoral fellowships for nurses to enable at least 15 applicants per year to advance their research and accelerate completion of their dissertations, with priority given to nursing faculty.**
- **Provide funding to graduate 350 nurse practitioners per year.**
- **Make a nursing education accessible to all qualified Ontarians, including more generous loans and scholarships, and assistance for new grad transition, loan forgiveness and improved access for all marginalized and under-represented populations.**

- **Increase the Nursing Education Initiative (NEI) by \$500 for a total of \$2,000 per nurse per year.**

To New Graduate

More than 94 per cent of young nurses surveyed for RNAO's *The 70 Per Cent Solution* indicated a strong preference for full-time employment, while only 38 per cent had it.⁵³⁷ Another survey of nursing graduates found 79.3 per cent wanted to work full-time, but it could take them up to two years to find a full-time job.⁵³⁸ Full-time employment is essential for integrating newly acquired academic knowledge into actual practice knowledge and skills. New graduates with full-time employment, mentored by senior nurses, better serve the needs of the public.

On May 8, 2006, the government announced it would guarantee every nursing graduate in Ontario the offer of a full-time job in the province.⁵³⁹ In February 2007, the government announced \$89 million for the Nursing Graduate Guarantee (NGG) program.⁵⁴⁰ An evaluation following the 2008-2009 year extolled the success of the NGG initiative in integrating new graduates into the profession, extending orientation and mentoring, and generally promoting recruitment and retention among new nursing graduates during an unprecedented economic recession.⁵⁴¹ Overall, the full-time employment rate for new nursing graduates in 2008 was 82.6 per cent for RNs and 55.5 per cent for RPNs, an increase from 58.2 per cent for RNs and 26.4 per cent for RPNs in 2005 (combined permanent and temporary full-time).⁵⁴² Permanent full-time employment was highest in acute care hospitals, while long-term care homes had a high percentage of temporary full-time employment for new graduates.⁵⁴³

RNAO Recommendations:

- **Commit to continued funding of the highly successful Nursing Graduate Guarantee for all sectors and regions in Ontario, to ensure full-time employment for all new RN graduates who wish to work full time, and improve retention in the province.**
- **Expand the Nursing Graduate Guarantee to support transition and integration of new nurse practitioner graduates across all health-care sectors and specifically incorporate a mentorship/fellowship program for NPs.**

To Mid-Career

With the increasing nurse shortage, it is clear that the best recruitment strategy is staff retention.⁵⁴⁴

While much attention has been given to retaining nurses who are vulnerable to leaving the profession in the first months or years of nursing, there is increasing focus on those who may be considering their career options in the age range 35 to 54.

A recent study measuring job satisfaction among a sample of 56,253 registered nurses from 438 care facilities across the United States suggests that retention of mid-career nurses may be a bigger problem than recent graduates and late-career nurses, and recommends that health-

care organizations focus on increasing satisfaction of mid-career nurses as an effective strategy to address retention.⁵⁴⁵

Mid-career nurses constitute a diverse group. Most have 15 or more years of experience, but there are also many younger nurses who may be considering different challenges after as few as five to 10 years of practice. What they have in common is the valuable education, knowledge and experience that employers count on, patients require, and young nurses depend on for mentoring and support.⁵⁴⁶ Some are advanced practice nurses such as clinical nurse specialists. All are experienced clinical RNs.

They also find themselves at the stage in life when they face both the challenge and opportunity of reflecting on their careers. Some are feeling exhausted and discouraged and question their future, both personally and professionally. Many feel they have been carrying the load during a period of instability and change within the health-care system combined with increasing: complex clinical challenges. Many are seriously considering leaving their jobs and even the profession.

There are many factors that might drive an experienced and skilled nurse to consider a personal change: physical, emotional and intellectual demands; unsafe and even violent working conditions; lack of leadership support; underutilized skills; lack of support for re-entry to workforce after prolonged absence; and, increased acuity and complexity of patients. After working through cycles of lay-offs, reductions in nursing positions and disrespect, mid-career nurses can be left with decreased loyalty to their workplaces and the health-care system.

Retention strategies targeted at mid-career nurses must focus on their particular stage of personal and professional development and recognize their unique needs. There is no one-size-fits-all approach. If they are not helped to rediscover the significance of nursing in their lives and see opportunities for further advancement and fulfilment within the profession, many nurses will explore other options outside the profession or outside Ontario.⁵⁴⁷

RNAO Recommendations:

- **Develop a mid-career nursing strategy with opportunities for further professional and personal development, to retain mid-career nurses in the profession and the province.**

To Late Career

With the innovative Late Career Nurse Initiative (LCNI), full-time, part-time, experienced RNs, RPNs and NPs, aged 55 and over, who work in hospital and long-term care settings have the opportunity to spend 80 per cent of their time in direct patient care and 20 per cent of their time in mentoring or other professional development activities. This program opens up full-time positions for new graduates, provides clinical placement opportunities for nursing students and helps keep experienced nurses in the workforce. In trials to date, results have been very positive: 30.2 per cent of respondents in one study indicated that their retirement plans had changed as a result,⁵⁴⁸ while another study showed reduced overtime hours, low sick time, no rise in variable direct labour costs, and higher patient satisfaction.⁵⁴⁹ Those who indicated a

change in their retirement plans said that having a break from nightshifts and from the physical demands and stress of their regular work could allow them to continue working for longer.⁵⁵⁰

RNAO Recommendations:

- **Commit to expand the Late Career Nurse (80/20) Initiative (LCNI) to all nurses who are aged 55 years and over who work full and part time, in all sectors and regions in Ontario.**

F. EMBRACING OUR DEMOCRACY, STRENGTHENING OUR PUBLIC SERVICES

The global economy has been through a period of economic instability and job loss as severe as any since the Great Depression. Banks have been lending less, companies are producing less, and consumers are spending less. Polarization between the rich and poor is growing. As the middle class shrinks, the numbers of those at the lower end of the income scale grows. Even while the province, according to some indicators, is technically climbing out of recession, the unemployment rate continues to rise.

Government spending was essential to offset economic decline.⁵⁵¹ A consensus emerged among international bodies such as the International Monetary Fund (IMF), the United Nations, the G20, and the Organization for Economic Co-operation and Development (OECD) that a coordinated stimulus of two per cent of gross domestic product was needed to counter the effects of the global recession.⁵⁵² In Ontario's case, this meant a stimulus of about \$12 billion.

We are not yet out of the woods, although fears of a total collapse have receded. Governments necessarily accumulated large deficits while fighting the recession, and they are turning attention to reducing those deficits. However, employment has not returned, and inappropriate responses to deficits could risk the fragile recovery.

This period of ongoing economic uncertainty is exactly the time when bold leadership is needed to stimulate the economy by investing in Ontario's people and Ontario's future. Investing in infrastructure will create good jobs with decent wages, stimulate spending in local economies, and build capacity that will sustain vibrant communities. This includes continuing to address long-neglected infrastructure such as roads, bridges, and housing as well as strengthening the often-neglected infrastructure of health care, education, early learning and child care.

Increasing the minimum wage and substantially increasing social assistance will lift people out of poverty and allow people to spend more money locally. Repairing substandard public housing, retrofitting homes for energy efficiency, and building new affordable housing will create direct and spin-off jobs while providing a basic human right to shelter.

Ensure fiscal capacity through progressive and green taxes to invest in Public Services

A fire sale of valuable public assets such as Hydro One, Ontario Power Generation, Ontario Lottery and Gaming and the LCBO is not in the public interest. Nor is a resumption of tax cuts the way to go. Fiscal capacity must be maintained to deliver the services required in a modern, changing economy. Although much in the news, tax cuts have not demonstrated good value. A study of tax rebates given in May 2008 found that a dollar of tax cuts in the United States led to only 10 cents in economic stimulus as most of it went to debt repayment, savings, or

purchase of imports.⁵⁵³ “Inforemetrica Limited has calculated that \$1 billion of personal tax cuts increases GDP by \$720 million and creates 7,000 jobs. The same \$1 billion spent on infrastructure creates more than twice the number of jobs—16,000, about half in construction—and increases GDP by \$1.78 billion. Investing in health-related services boosts GDP by roughly the same amount and creates 18,000 jobs.”⁵⁵⁴

Income transfers to low-income Canadians would have a bigger multiplier effect than tax cuts as the IMF has calculated that “investing \$1 billion to boost the incomes of the poor—who spend everything they earn—would boost GDP by almost \$900 million and create 7,000 jobs.”⁵⁵⁵

Rather than choosing deficit-reduction over public services, the RNAO believes this is the time for government to step up with policies that support vibrant communities and all the social and environmental determinants of health. Progressive, fair taxes ensure we have sufficient resources for all Ontarians to live equally in health and dignity with access to a decent income, affordable, good quality housing, clean air and water, and public health and education.

Environmental taxes, such as carbon taxes, help both to achieve environmental objectives and strengthen public programs and services.

We urge all political parties to expand the use of green levies and taxes, which are much under-utilized in Canada by global standards. By taxing environmental “bads”, such as pollution and carbon emissions, we would make emitters face more of the environmental and social costs of their activities.

Polluters currently have little or no incentive to change their behaviour, and as a result, Canada has a deplorable record in such areas as emissions of greenhouse gases. Green taxes correct for market failure (pollution is being subsidized, which in turn harms human and environmental health).

Greater use of green taxes would enhance fiscal capacity and also allow for reduction of less efficient taxes, such as payroll taxes. Economist Nancy Olewiler, in an address to the Ontario Energy Association, estimated the revenue which Ontario could generate from applying carbon taxes along the lines planned for British Columbia at \$1.24 billion at \$10/tonne and \$2.39 billion at \$30/tonne.⁵⁵⁶

An adequate climate change program would generate much more revenue, because meeting the commonly agreed target of 25 per cent below 1990 levels by 2020 would require a phase-in starting at \$50/tonne and rising to \$200. Even the overly modest federal target (20 per cent below 2006 levels by 2020) would require \$40/tonne rising to \$100 by 2020.⁵⁵⁷

RNAO’s Recommendations:

- **Ensure the fiscal capacity to deliver all essential health, social, and environmental services by building a more progressive tax system and revenue sources that encourage environmental and societal responsibility.**

- **Reject a fire sale of publicly owned Crown Corporations such as Hydro One, Ontario Power Generation, Ontario Lottery and Gaming and the LCBO that would cut valuable sources of public revenue, severely restrict the government’s fiscal capacity and be contrary to the public interest.**
- **Phase in environmental levies, such as a carbon tax, to achieve environmental objectives and support the social programs and services most needed by at-risk populations.**

Trade Deals Not in Public Interest

Trade agreements could be tools to enhance people's well-being and raise environmental, social and labour standards. However in recent practice, governments including Ontario have negotiated trade agreements, such as the expansion of the Agreement on Internal Trade (AIT), the B.C.-Alberta Trade, Investment and Labour Mobility Agreement (TILMA), the Ontario-Quebec Trade and Cooperation Agreement (OQCTA) and the Canada-Economic Union Comprehensive Economic and Trade Agreement (CEUTA), in an undemocratic manner behind closed doors. These agreements tie the hands of present and future governments in ways that thwart the democratic aspirations of their people.

NAFTA (the North American Free Trade Agreement) and other agreements like it shift power to investors who can, under these agreements, sue the government when they think their profits are affected by actions of national and local governments. Already under NAFTA, Dow Chemical is suing Canada because the Quebec government decided to protect its children with a pesticide ban. Arizona investors are threatening a NAFTA challenge because they face barriers in establishing private, for profit health clinics in BC. There are dozens of similar lawsuits under the NAFTA across the U.S.-Canada border. We don’t need similar lawsuits across provincial borders.

RNAO’s Recommendations:

- **Stop all negotiations leading to comprehensive trade agreements unless:**
 - **All negotiations are carried out transparently and subject to public consultation, engagement and scrutiny;**
 - **Any agreement includes strong protections for health care, public education, the environment, human rights and labour standards in both existing and new policies and programs; and,**
 - **An agreement does not restrict the ability of governments – federal, provincial and municipal – to regulate or create, implement and sustain programs in the public interest.**
- **Specifically reject any comprehensive agreement with the European Union that would restrict Canada’s right to keep public control of vital services such as health care and water.**

- **Put ratification of the Ontario-Quebec Trade and Cooperation Agreement on hold pending full public consultation on the impact of the agreement on the provinces' capacity to address social, economic and environmental needs in the public interest.**
- **Oppose the strengthening of the pan-Canadian Agreement on Internal Trade that would further deregulate provincial policies and threaten public services.**

PLATFORM COSTS

	Annual cost \$s Millions			
	Year 1	Year 2	Year 3	Year 4
Strengthen Social Determinants, Equity and Healthy Communities				
Down payment to transform social assistance	732	747	762	777
Strengthen enforcement of Employment Standards Act	10.4	10.6	10.8	11.0
Fast-track provincial housing plan	1,313	1,339	1,366	1,393
Implement breastfeeding strategy	1.4	2.1	2.2	2.3
Implement Best Future in Mind (full-day pre-school learning)	427	723	1,020	1,020
Increase number of school nurses	9.1	18.6	28.5	38.8
Freeze post-secondary tuition	52	106	161	216
Raise funding for Ontario Human Rights Tribunal	10.0	10.2	10.4	10.6
Building Sustainable, Green Communities				
Implement promised rapid transit expansion	1,336	1,336	1,336	1,336
Toxics reduction	20.0	20.4	20.8	21.2
Implement cosmetic pesticide ban	10.0	10.2	10.4	10.6
Source water protection, including infrastructure renewal	1,200	1,200	1,200	1,200
Enhancing Medicare				
Equitable health care for rural and northern areas	443	452	461	470
Home care and aging at home	286	292	298	304
50 new NP-led clinics by 2015	19.5	39.8	59.3	79.6
Improving Access to Nursing Services				
Add 9,000 RN FTEs by 2015	103	271	439	607
Add 360 NP positions in each of next four years	34	70	107	146
70% full-time RNs by 2015	40	82	125	171
Equalize RN wage rates across sectors	241	246	251	256
Permanent funding for expanded practice nurses	10.9	13.3	15.9	18.5
Open under-serviced areas program to all new grads	0.7	1.5	2.2	3.0
Building a Nursing Career in Ontario				
Permanent funding for internationally educated nurses	6	6	7	7
Raise number of first-year nursing seats by 500	4.4	8.4	12.1	15.9
Add 10 more nursing PhD & 100 more Masters students/yr	2.0	4.2	5.4	5.8
Provide funding to graduate 350 NPs per year	6.2	12.7	16.1	16.5
Increase doctoral fellowships	0.375	0.750	1.125	1.125
Increase funding for Nursing Education Initiative	1.0	1.2	1.5	1.7
Continue funding Nursing Graduate Guarantee	94	96	97	99
Expand late career nurse initiative	74	75	77	78
Total	6,487	7,195	7,904	8,318
Revenue: Phase in \$10 to \$30/tonne carbon tax	1,290	1,740	2,189	2,639
Net	5,197	5,455	5,715	5,679

CONCLUSION

Creating Vibrant Communities means investing in our people, in our health, in strengthening our democracy and our public services.

Ontario's registered nurses look forward to working with members of all political parties to strengthen social determinants, equity and healthy communities, build sustainable green communities, enhance Medicare, improve access to nursing services, make our province the place of choice to build a nursing career, and embrace our democracy while strengthening our public services. We know this can be achieved with political will, strategic planning, and appropriate allocation of funding.

This is RNAO's challenge to the political parties. This is how, together, we can and must create vibrant communities for all Ontarians.

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