RNAO

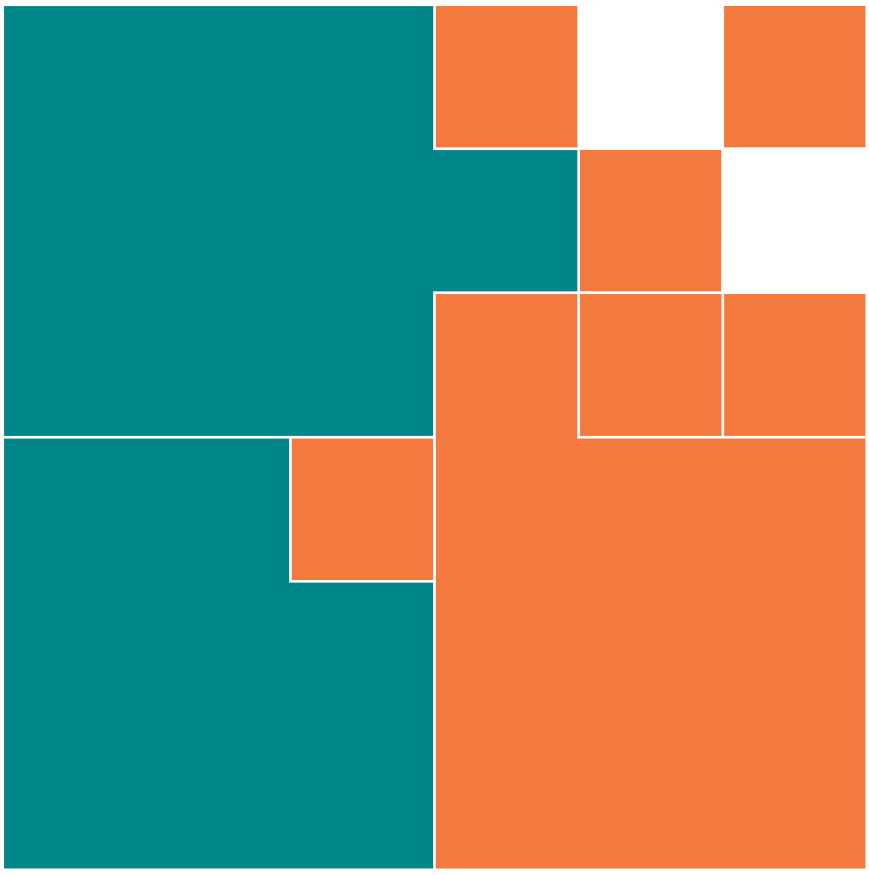
Registered Nurses' Association of Ontario

Association des infirmières et infirmiers autorisés de l'Ontario

ADVOCATING FOR Vibrant Communities

BRIEFING NOTES

2012



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March 1, 2012

To Cabinet Ministers and Members of Provincial Parliament,

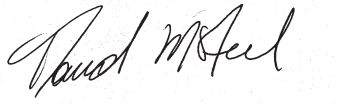
Thank you for taking the time to meet with us to celebrate nursing leadership in Ontario. On this 13th anniversary of RNAO's Queen's Park Day, we are coming to Queen's Park with 150 nursing leaders and nursing student leaders to urge MPPs from all political parties to adopt positions that improve access to nursing services in order to strengthen our publicly-funded, not-for-profit health-care system.

These are times of great challenges and opportunities in Ontario. In the midst of belt-tightening across the public sector, Ontarians understand the strong correlation between nurses, better health outcomes and reduced costs. Nurses are ideally positioned to play a leadership role in needed changes to our treasured health-care system.

This year we present you with a copy of *Advocating for Vibrant Communities,* a comprehensive package that outlines practical and concrete recommendations in the following key areas: strengthening our health care system; nursing human resources; social and environmental determinants of health; and mental health.

Ontario's nurses look forward to meeting and speaking with you about how advocating for vibrant communities will strengthen health, health care and nursing in your constituency.

Warmest regards and many thanks again for your participation in RNAO's 13th Queen's Park Day!



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RNAO's Queen's Park Day

MPP Participation Data, 2008-2012

Year	Total MPPs	MPPs by Party
2012	**71**	**Liberal = 30** **Conservative = 29** **NDP = 12**
2011	**54**	**Liberal = 36** **Conservative = 12** **NDP = 6**
2010	**55**	**Liberal = 37** **Conservative = 13** **NDP =6**
2009	**49**	**Liberal = 36** **Conservative = 6** **NDP =7**
2008	**27**	**Liberal = 14** **Conservative = 6** **NDP =7**

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Strengthening Health Care = Strengthening Nursing

QUESTIONS

1. PUBLIC HEALTH

a. Will you join the RNAO in advocating for the public health funding envelope to be protected if public health is integrated into other parts of the health system as recommended by the Drummond Commission?

b. Can we count on your support to fully utilize public health nurses in your community including in schools?

2. PRIMARY CARE

a. Do you agree that all Ontarians should have access to primary care delivered by inter-professional health teams?

b. Best value for Nurse Practitioner-Led Clinics: For best outcomes and cost-effectiveness, NP-Led Clinics must be fully staffed. Will you support ensuring that new investments are made in existing as well as new NP-Led Clinics, with a minimum of six NPs, two RNs and one RPN in addition to administrative staff within the funding envelope?

c. NP-Led Clinics: Will you support 50 additional NP-Led Clinics by 2015 (in addition to the 26 that are already announced or up and running), in order to enhance access to primary care in all communities?

d. Full use of RNs and RPNs: RNAO is leading a ground-breaking task force that is bringing together key stakeholders to review the role of family practice nurses (RNs and RPNs) in the delivery of primary care. Recommendations will aim at optimizing the utilization of the 2,873 RNs and 1,412 RPNs currently working in primary care by maximizing their scope of practice. Will you commit to review these recommendations and advance strategies that leverage family practice nurses' scope of practice to provide timely access to primary care for Ontarians?

e. Do you agree that primary care should be the next priority for implementation in the *Excellent Care for All Act, 2010*, thereby putting the focus on evidence-based practices and accountability for quality in primary care (currently the Act applies to the acute/hospital sector and can be extended by regulation)?

3. HOME/COMMUNITY CARE

a. Will your party support the Drummond Commission recommendations that home care and community services be adequately funded? Given the overwhelming evidence that shows care provided in not-for-profit health-care settings delivers better health outcomes for less money, will you agree that the not-for-profit sector be favoured in delivering these services?

b. Will your party support the immediate elimination of competitive bidding in home care to ensure service stability for clients?

c. Will your party support favouring publicly-funded and not-for-profit delivery wherever service expansion is needed?

d. Can we count on your support to strengthen the integration of care across the health care continuum through the primary care setting, while decreasing duplication of services between home care and Community Care Access Centres (CCACs)?

4. HOSPITALS/ACUTE CARE

a. As people move from inpatient hospital care to community care, publicly-funded and not-for-profit hospitals and clinics remain a vital resource for those who are most acutely ill or injured. RNs at the bedside will continue to work in collaboration with advanced practice nurses (nurse practitioners and clinical nurse specialists), along with inter-professional and support staff. Will you support the RNAO in advocating for nurses in all sectors to work to full scope, starting with RN prescribing, certain diagnostic tests and setting simple bone fractures or joint dislocations?

b. Will your party support policies that focus on continuity of care and caregiver through the delivery of total nursing care, where complex or unstable patients with unpredictable outcomes receive care from an RN and stable patients with predictable outcomes receive care from an RPN?

c. Will your party support the establishment of nurse-led units in hospitals to care for Alternate Level of Care (ALC) patients awaiting care in an alternate setting?

5. LONG-TERM CARE

a. Can we count on your support of the Drummond Commission recommendation that seniors and younger populations with special needs be provided with knowledgeable, integrated care across the continuum. In long-term care, will you support legislated standards guaranteeing funding of no less than an average of .59 RN hours per resident day, with greater acuity requiring more care?

b. In her 2008 report, Shirlee Sharkey pointed to the importance of an appropriate mix of care providers in long-term care homes. Will you support a staff mix in long-term care homes with NPs, RNs and RPNs working to their full scope? This means a staff mix of one NP per LTC Home, with no less than one NP per 150 residents, at least 20 per cent RNs, 25 per cent RPNs and 55 per cent personal support workers (PSWs), subject to increases in line with greater acuity. Two RNs working 24/7 per 100 beds has been established as a minimum.

6. NURSING EDUCATION

a. Given that nurses improve health outcomes and cut costs, as the Drummond Commission found, will you also support the Commission's call for significantly more nurses to be educated by our colleges and universities?

b. Of the 60,000 additional post-secondary student positions announced in the 2011 Ontario Budget, do you agree that at least 15 per cent or 9,000 should be dedicated to nursing programs for RNs as originally indicated by the government – especially given the serious projected shortage of RNs?

7. PUBLIC SPENDING CUTS

a. Adequate funding will be required for nurses to take on additional responsibilities in an improved health-care system. Yet the Drummond Commission also recommends a real per capita cut to overall program spending of 16.2 per cent over seven years which will imperil needed reforms. Even within health care, there would be a 5.8 per cent real per capita cut. Do you agree that cuts of this magnitude to overall social programs will reduce the ability to keep people healthy and will cost government more in the long run?

8. EVIDENCE-BASED BEST PRACTICES

a. The *Excellent Care For All Act* focuses on evidence-based practices and accountability for quality in Ontario's health-care system. Implementation of this legislation comes at a time when the provincial and territorial Health Ministers are participating in a working group to promote expanded scope of practice and the development and adoption of clinical best practice guidelines. Ontario's nurses have set the gold standard in the development and implementation of evidence-based clinical best practice guidelines. Will you support the establishment of nursing quality indicators for reporting and evaluation data base (NQuIRE) -- a central database that will cement Ontario's reputation as a national and international leader in evidence-based best practices?

BACKGROUND

A. Drummond Commission

While the overall effect of the 362 recommendations of the Drummond Commission[1] was an alarming and "unprecedented" proposed cut to program spending, amounting to 16.2 per cent for every Ontarian from 2010-2011 to 2017-2018, the Commission took a very different approach to nursing. In fact, the Commission sees nurses as playing a central role in the health-care system and being key to achieving better health outcomes and cost savings.

Recommendation 5-18, for example, states: "There should be a net shift in responsibilities from physicians to nurses and others in health teams" and then goes on to suggest that physicians should not be paid for interventions like vaccinations that could be done by nurses. Models such as family health teams, and presumably NP-Led clinics and community health centres, are supported where nurses can practice to full scope and have a physician accessible for consultation as needed.

Recommendation 5-19 calls for a system-wide approach to expanding the scope of practice of health professionals with nurses and physicians developing joint strategies. That many of the controlled acts authorized to physicians are also authorized to nurse practitioners is acknowledged by recommendation 5-20. Then recommendation 5-21 assigns responsibility to colleges and universities to "recognize the increased demand for nurses," "train more nurses" and make it a priority to address "a desperate need to increase supply and improve retention" of nurses.[2]

As the Drummond Commission acknowledged, Ontario has a "desperate need to increase supply and retention" of nurses. Over 14,000 more RNs are needed to attain the RN/population ratio in the rest of Canada.

Scope of practice for RNs and CNSs must expand in all sectors, starting with nurse prescribing, simple diagnostic tests and setting simple bone fractures or joint dislocations.

Nurses as primary care providers must be integrated with all other members of inter-professional teams at the local level through strengthened Local Health Integration Networks (LHINs).

B. Health Accord and Premiers' Committee

- Strengthening our publicly-funded, not-for-profit health-care system requires federal leadership. Yet the federal government has abdicated its responsibility to enforce the *Canada Health Act* and oversee the development of needed national programs such as pharmacare and home care.

- However, there is hope in the establishment of the Premiers' Health Care Innovation Working Group. Co-chaired by Premier Brad Wall of Saskatchewan and Robert Ghiz of Prince Edward Island, the Working Group includes all provincial and territorial health ministers and is mandated to drive a collaborative process for "transformation

and innovation to help ensure the sustainable delivery of health care services." Specifically, the Working Group will consult with health care providers to focus on expanding scope of practice, addressing health human resource challenges and accelerating the development and adoption of clinical best practice guidelines. Progress in these three areas is expected by July.

- With its leadership role developing clinical best practice guidelines in Ontario, across Canada and internationally, and its groundbreaking work enhancing the scope of practice of all nurses, the RNAO is superbly positioned to contribute ideas and expertise to the Premiers' initiative.

C. Full Utilization of All Nurses

In August, 2011, landmark legislation was proclaimed that enables Ontario's nurse practitioners to maximize their potential within the acute care system. Legislation and complementary regulations in the *Public Hospitals Act* support NPs to autonomously treat and discharge hospital inpatients. As of July 1, 2012, NPs will also be authorized to admit patients into hospital.

Other groundbreaking enhancements to NPs, RNs and RPNs scope of practice in Ontario include:

- Nurse practitioners can autonomously prescribe medications appropriate to patient care, rather than from a pre-determined list
- A restrictive list of laboratory tests that NPs are authorized to prescribe has been removed
- NPs are authorized to set and cast fractures of bones and dislocations of joints.
- NPs are enabled to dispense, compound and sell medications in certain situations
- RNs and RPNs will be able to receive patient care orders from NPs

Enabling NPs to provide these services not only improves hospital quality measures, patient safety, cost-effectiveness and patient flow, it also nurtures an equitable, collaborative professional paradigm that promotes excellent value within the not-for-profit system.

In November, 2011, the RNAO announced the creation of a task force to recommend ways to maximize utilization of primary care/family practice nurses. There are currently 4,285 primary care nurses in Ontario, of whom 2,873 are RNs and 1,412 are registered practical nurses. To bring about needed improvements in Ontario's primary care system, all health care professionals must be utilized to their maximum scope of practice. For example, primary care nurses are ideally positioned to coordinate care at home, conduct "house calls," and assume a navigating role. By leveraging their central role, primary care nurses can help build a primary health-care system that promotes health equity and addresses root causes of health disparities, including addressing the social and environmental determinants of health.

Since 2002, some primary care RNs in the United Kingdom have been functioning in an expanded role as independent nurse prescribers. Increasing access to needed medications and

maximizing the skills of all health professionals are two reasons the British government championed this expanded role. Independent nurse prescribers are "first level" registered nurses who have completed a specialized certification training course. They are responsible and accountable for patient assessments and clinical management, including prescribing. In some jurisdictions, the nurse prescriber must work in partnership with a mentor for a specified period of time before working autonomously in the role. Independent nurse prescribers do not work from a formulary list of permitted medications but rather are authorized to prescribe any medication appropriate for patient care within their competence, knowledge and skill. In an evaluation published in 2010, nurse prescribing was found to be safe and clinically appropriate and widely accepted by patients.[3]

The goal of 70 per cent full-time employment for all nurses in all sectors in Ontario must be achieved. This goal was almost attained by January 1, 2011 when 67.9 per cent of RNs in Ontario were already working full-time.

Knowledge exchange initiatives should continue to empower nurse executives to collaborate and integrate care across all health-care sectors and with sectors outside of health care that influence the health of individuals and populations.

NQuIRE should continue to be established in all world-wide best practice spotlight organizations collecting data on nursing-sensitive indicators that have been achieved through the implementation of nursing best practice guidelines.

D. Public Health

Public health nurses should help to politically mobilize their communities to improve health and decrease health inequities by challenging environmental and social policies that are expected to have a detrimental impact on health outcomes. Public Health Nurse leadership is being implemented with one chief nursing officer (CNO) designated in each public health unit by January 2013; each of whom is master-prepared. Improved quality and organizational effectiveness is realized through the establishment and strengthening of the Nurse-executive governance and leadership role and responsibilities of the CNO.

CNOs should be actively engaged in developing collaborative initiatives with various sectors, in particular primary health care.

The Drummond Commission has recommended integrating Ontario's public health programming with other areas of the health-care system. Enhanced integration has the potential to benefit Ontarians, however, it is important that the public health funding envelope be protected. Historically, approximately two per cent of Ontario's overall health care budget has been allocated to the delivery of public health programming. Currently, Ontario's Public Health Units receive 25 per cent of their base funding from the local municipality and the remainder from the province. If the government chooses to fully upload public health services to the province, it must maintain provincial funding and account for the 25 per cent of funding previously provided by the municipality.

E. Primary Care

Nurse Practitioner-led clinics in Ontario, such as the Sudbury District Nurse Practitioner Clinic, have resulted in improved access to primary care and quality of life for hundreds of patients and their families.[4] [5] Following the success of the Sudbury clinic after its opening in 2007, the government committed to twenty-five additional NP-Led Clinics across the province. These have been announced in three successive waves and 21 of the 26 have opened their doors, with the remainder to follow shortly.

Dozens of other communities are just waiting for the green light to move forward with their own NP-Led Clinics. Opening an additional 50 NP-Led Clinics by 2015 is an essential, practical and cost-effective way to give thousands of Ontarians needed access to primary care. At the same time, it is crucial that established clinics have adequate resources and staffing to be sustainable. NP-Led Clinics must have adequate administrative support and a minimum of six NPs working collaboratively within an inter-professional team.

Established NP-Led Clinics, such as the Lakehead NP-Led Clinic in Thunder Bay, have achieved their defined patient quota and already possess the capital infrastructure capacity to expand the number of Thunder Bay residents with access to primary care. However, in order for an expansion to occur, additional human resource investments must be made so that additional NPs, RNs, RPNs and administrative support staff can be hired by the clinics.

Ontario has a total of 4,285 family practice nurses (2,873 RNs and 1,412 RPNs). To bring about transformational change to our primary care system, the doors must be opened to utilize health care professionals to their full scope of practice and in a range of roles that optimize the nurses' impact on the health outcomes of individuals, families and community. RNAO is coordinating the ground-breaking Primary Care/Family Practice Nurse Task Force that is bringing together key stakeholders in family practice/primary care nursing to review and revise, as necessary the role of RNs and RPNs in primary care. The end goal of this task force is to adjust roles as needed to facilitate timely quality primary care and optimize client and community outcomes.

Wellness, health promotion and primary care are cornerstone principles of health care integration.[6] Family practice nurses in primary care are well situated to lead integration of health-care services across the lifespan. This leadership will eliminate the duplication of services being provided between CCACs and home care. A number of strategies have been implemented abroad to support integration within primary care and between primary care and other settings.[7] Ontario can learn from these strategies to grow a robust primary care system based on principles of integration and continuity of care.

F. Home/Community Care

On January 30, 2012, Health and Long-Term Care Minister Deb Matthews released Ontario's Action Plan for Health Care that included a focus on supporting seniors to stay healthy and live at home longer, thereby reducing strain on hospitals and long-term care homes.[8] Two weeks later, the Drummond Commission released its 362 recommendations to reduce the record deficit. While the overall effect of the Drummond recommendations was an alarming and "unprecedented" cut to program spending, amounting to 16.2 per cent for every Ontarian from

2010-2011 to 2017-2018,[9] the Commission took a very different approach to home care and community care.

In addition to prescribing adequate funding to support home care, particularly at the community level, the Drummond Commission called for:

- Matching seniors to the services they need from the earliest available care provider;
- Improved coordination of care through the use of referral management tools for long-term care, home care and community services;
- Primary care providers to make care for the elderly a priority, including early identification of seniors at risk of frailty and proactive management of their multiple challenges;
- Supporting the continuum of community care through additional and sustained resources to integrate, coordinate and enhance traditional sectors and assisted living arrangements while bridging gaps through new models of care;
- Providing seniors and younger populations with special needs, particularly behavioural challenges, with knowledgeable, integrated care across the continuum, wherever they seek treatment, with equitable and timely transition to the right provider for the right service.
- Enhancing programs aimed at restoring and reactivating elderly patients' level of functioning, and creating opportunities for them to be transferred home with appropriate ongoing supports.[10]

In diverting patients and clients not needing acute care from hospitals to more appropriate forms of care that are less expensive, the Drummond Commission would open the door to those services being provided by private, for-profit entities.[11] As the RNAO pointed out upon release of the report, the Drummond Commission "overstepped its mandate by making policy recommendations that steer the province to health care privatization."[12] Referring to the overwhelming evidence, the RNAO stated that "this market approach to health care goes against the research that shows care provided in not-for-profit health-care settings delivers better health outcomes for less money."[13] [14] [15] [16] [17] [18] [19] [20] [21] [22] [23] [24] [25] [26] [27] [28] It is not surprising because the profit incentive harnesses human ingenuity in perverse ways that are hard to catch in health care: cherry-picking of lower-cost/higher-reward patients and services, cutting corners in low-visibility costs, creative bidding, etc. And of course, for-profit agencies face additional costs in marketing, and investor relations.

While the Drummond report is on the right track calling for more home care and community services, the RNAO strongly urges that the not-for-profit sector be favoured in delivering these services.

With a competitive bidding model still in place, home care remains at risk of unnecessary costs associated with the bidding process and profits paid to for-profit shareholders. 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.[29] 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 addition to the above recommendations, there is another role for government to enhance quality and efficiency in home care services. It can support implementation of relevant best practice guidelines in home care (such as wound care). A wide range of best practice guidelines are available through the RNAO website.[30]

G. Educating More Nurses

Given the central role assigned to nurses by the Drummond Commission to improve health outcomes and cut costs, it is not surprising that the Commission called for significantly more nurses to be educated by our colleges and universities.

So long as there is the commitment to provide nursing education seats, it will not be difficult to fill them. Demand for those seats is consistently higher than the ability to enroll well qualified applicants. Data is available for fall 2011 from the Ontario Universities Application Centre (OUAC) that captures all universities and some colleges in collaborative programs. Only 13.4 per cent of applications end in confirmations in nursing, in contrast to 17.7 per cent for all OUAC programs. Only 23.7 per cent of applicants whose first choice was nursing were confirmed (vs. 38 per cent for all OUAC applications). This suggests that applications to nursing are much less likely to result in seats than applications to other programs. It also suggests that the availability of seats (and other infrastructure such as physical plant, faculty and clinical placements) is exceeded by the high demand for nursing education. Given the high grades of entering students (e.g., over 99 per cent of all first year students in the large Ryerson University nursing program entered with averages over 80 per cent) there will be many more qualified applicants who were not accepted into the program. RNAO was encouraged by the announcement in the 2011 Ontario Budget that an additional 60,000 post-secondary student positions would be funded by 2015-16, of which 15 per cent, or 9,000 positions, would be dedicated to nursing programs for RNs. More investment in nursing education is urgently needed.

H. Gold Standard in Evidence-Based Clinical Best Practice Guidelines: Nursing Quality Indicators for Reporting and Evaluation (NQuIRE)

As the next important step in its cutting edge work developing and implementing clinical best practice guidelines and dove-tailing with the Premiers' Health Care Innovation Working Group, the RNAO has created the **N**ursing **Qu**ality **I**ndicators for **R**eporting and **E**valuation (NQuIRE).

NQuIRE is the only international quality improvement initiative that will systematically measure the clinical outcomes of nursing best practices. It is an unprecedented opportunity to articulate the quality of nursing care through the identification of nursing-sensitive indicators reflecting the structure, process, and outcomes of nursing care arising from RNAO's clinical Best Practice Guidelines. Such data will inform where and how evidence-based nursing best practices are providing the best patient outcomes at the best value.

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Health Care is a Public Good, Not a Commodity
Safeguarding and Strengthening Not-For-Profit, Publicly-Financed and Publicly-Delivered Health-Care Services

QUESTIONS

1. There is overwhelming evidence that not-for-profit financing and delivery of health services provides increased access, higher quality, and lower cost compared with for-profit models. In the context of persistent and ongoing efforts to erode medicare for private profit, will your party commit to safeguarding and strengthening not-for-profit, publicly-financed and publicly-delivered health-care services?

2. As health professionals who have a legal and ethical responsibility to protect the public, we have been concerned by the treatment of whistle-blowers who have been speaking out for the common good. A recent example involved executives of the provincial air ambulance service, ORNGE, who betrayed the public interest once a for-profit element was introduced. Until the employees of ORNGE were reassured by Minister Matthews that their jobs were safe, interim CEO Ron McKerlie warned 400 employees that "they may go to jail if they keep talking." How will your party implement whistle-blower protection against reprisals when in good faith Ontarians bring forward issues that threaten public safety or the common good?

RNAO POSITION

RNAO believes that health is a resource for everyday living and health care a universal human right.[31] RNAO advocates for strengthening our not-for profit publicly-funded and publicly-delivered health-care system while firmly rejecting efforts to commercialize or privatize health care as a commodity like any other. Consistent with these values and the evidence outlined in *Creating Vibrant Communities RNAO's Challenge to Ontario's Political Parties 2011 Provincial Election*,[32] RNAO specifically recommends:

- Establish an immediate and indefinite province-wide moratorium on private-finance, for-profit alternative financing and procurement (AFP) hospital projects. Instead of public-private partnerships or AFPs, ensure that all hospitals and community health facilities are publicly operated and financed.
- Enforce the *Commitment to the Future of Medicare Act* to prevent private for-profit clinics from delivering medically necessary health-care services in Ontario.

- Abandon competitive bidding as a method of allocating funding for home care and other essential health services.
- Expand the publicly-funded, not-for-profit health-care system to include a comprehensive national home care strategy and national pharmacare program.
- Oppose trade agreements that seek to undermine the ability of governments to implement or regulate programs in the public interest such as medicare.

RNAO has been calling for whistle-blower protection for those who work within and those who use the health-care system since 1998.[33]

BACKGROUND

In a November 2011 speech, Roy Romanow, Commissioner on the Future of Health Care in Canada, describes feeling "a palpable momentum toward individualism, decentralization, and privatization."[34] Despite "every indicator points to the fact that the public health system delivers better outcomes at lower costs,"[35] Romanow warns of those who see health care as a commodity and believe "that markets should determine who gets care, when and how."[36]

Since coming to power in 2006, Prime Minister Stephen Harper has failed to enforce the *Canada Health Act* by allowing jurisdictions to experiment with two-tiered services, delisting, user fees, and private for-profit medicine. This erosion of public health care was exacerbated by Federal Finance Minister Flaherty's unilateral funding announcement in December 2011 that when the Health Accord expires in 2014, funding transfers to jurisdictions will arrive without national standards and adequate consideration of health inequities.[37] Romanow said "he is worried the Harper government has adopted a deliberate strategy to leave health care to the provinces—possibly to foster the development of more private, for-profit medical companies."[38] Political scientist Tom Flanagan, has praised Harper for "moving 'incrementally' towards a more classic form of federalism, where aberrations such as national medicare would not exist."[39] Toronto Star newspaper columnist Thomas Walkom has predicted that Harper will not attack the popular medicare program directly. "But what we can expect is a hands-off approach from Ottawa, which, when coupled with federal transfer cutbacks, will encourage cash-strapped provinces to search for more privately funded alternatives—from user fees to private-pay clinics."[40]

Speaking of cash-strapped provinces, on February 15, 2012, the Commission on the Reform of Ontario's Public Services or the Drummond Commission, released its 362 recommendations to reduce Ontario's deficit.[41] The overall effect of the Drummond recommendations, if implemented, will be an alarming and "unprecedented" cut to program spending, amounting to 16.2 per cent for every Ontarian from 2010-2011 to 2017-2018.[42] Walkom is among those [43] [44] who argue that the real danger is not so much Ontario's debt but "the danger of overreacting to that debt."[45] In addition to the hardships arising from spending cuts that will disproportionately impact the poor and middle class, Walkom calculates that withdrawing billions of dollars from the economy "will end up throwing roughly 250,000 additional Ontarians out of work by 2018," which translates into an unemployment rate of about 11 per cent.[46]

Adding to the disease burden caused by the social determinants of health arising from increased poverty and rising unemployment, the recommendations of the Drummond Commission will decrease access to health services by how they frame and open the door to those services being provided by private, for-profit entities.[47]As the RNAO pointed out upon release of the report, the Drummond Commission "overstepped its mandate by making policy recommendations that steer the province to health care privatization."[48] Referring to the overwhelming evidence, the RNAO stated that "this market approach to health care goes against the research that shows care provided in not-for-profit health-care settings delivers better health outcomes for less money." [49] [50] [51] [52] [53] [54] [55] [56] [57] [58] [59] [60] [61]

Chapter 5 of the Drummond Report frames the discussion of health care as both "the source of the most intense and emotional public policy debate" and as a system whose sustainability is very much in doubt.[62] This enables the Drummond Report to justify privatization while simultaneously painting those who insist on the evidence as somehow less than reasonable:

> There should not be an a priori or ideological bias toward public-or-private service delivery. Both options should be fully tested to see which provides the best service. This should not be defined simply with respect to cost, but be quality-adjusted. As long as government remains the payer for all covered services, it should allow for a role to be played by both the public and private sectors. After all, family physicians are for the most part private-sector operators paid by OHIP for their services. And we seem to have no trouble with the idea that private companies now provide publicly funded laboratory work for health care providers.[63]

Moving beyond the idea of private laboratories to the actual evidence, for profit-laboratory services cost at least 25 per cent more than their non-profit counterparts.[64] It is estimated that using a fully integrated non-profit laboratory system to deliver all services would save the Canadian health system at least $250 million in 2010.[65] Although the idea of alternative financing and procurement (AFPs) might be alluring, the Auditor General of Ontario found that the Brampton Hospital cost considerately more than if it had been built by traditional not-for-profit procurement. The cost difference was $194 million in 2003 dollars, not including an additional $200 million difference because of the higher financing costs of the AFP and a further $63 million in additional modifications. Not only was it more expensive, but it opened with 479 beds instead of the 608 beds originally planned and it took longer to build than expected.[66]

In a May 2010 TD Economics report, Don Drummond and Derek Burleton warn that "the status quo is unsustainable." They "challenge the government to open the door more widely for private sector involvement, not only to improve efficiencies, but also to capitalize on the huge economic potential in building a vibrant health care sector in Ontario."[67] This "huge economic potential" for profit is at the heart of the "inequality agenda"[68] or the "redistributive agenda" that necessitates "the phantom crisis of medicare sustainability."[69]

Health Economist Robert Evans provides strong evidence that market approaches to health care reform have a "redistributive agenda" that is both more costly for health care systems as a whole and privileges those who are healthy and wealthy.[70] "Any shift from public to private financing, by whatever means, will necessarily transfer costs from those with higher to those with lower

incomes, and from the healthy to the ill."[71] Private insurance[72] [73] and medical savings accounts[74] [75] are two examples of non-public financing common in the United States that would increase inequities in health outcomes, access and quality of health care while costing more. Or, to put it more starkly, Canada's medicare is in danger of being a casualty in the class war as the "one per cent don't like medicare" as Evans provocatively argues:

> "There's class warfare, all right, but it's my class, the rich class, that's making war, and we're winning." (Warren Buffett, five years ago.) Last year's Occupy Wall Street movement suggested that people are finally catching on. Note, *making* war: Buffett meant that there was deliberate intent and agency behind the huge transfer of wealth, since 1980, from the 99 per cent to the 1 per cent. Nor is the war metaphorical. There are real casualties, even if no body bags. Sadly, much Canadian commentary on inequality is pitiably naïve or deliberately obfuscatory. The one per cent have captured national governments. The astronomical cost of American elections excludes the 99 per cent. In Canada, parliamentary government permits one man to rule as a de facto dictator. The 1 per cent don't like medicare."[76]

RNAO has been calling for whistle-blower protection for those who work within and those who use the health-care system since 1998.[77] A recent *Toronto Star* investigation revealed that the former CEO of ORNGE, Dr. Chris Mazza, used publicly-funded air ambulance expertise and assets for his own business interests.[78] The Ontario Provincial Police have been asked to investigate a $6.7 million payment from an Italian helicopter firm as well as payments of $1.2 million to Mazza in loans, in addition to the $1.4 million paid to him annually.[79] In 2007, Keith Walmsley, a certified general account and senior business analyst at ORNGE, was let go before the end of his three-month probation when he brought accountability concerns forward. In 2008, Walmsley gave evidence to Ministry of Finance investigators of Mazza and other executives "paying themselves whopping bonuses and had set up a spider web of for-profit companies."[80] Other ORNGE employees spoke to the media after "failed attempts to sound the alarm for two years" by complaining to the health ministry, finance ministry, provincial auditor-general, ministers, and opposition critics.[81] Interim ORNGE CEO Ron McKerlie warned 400 employees at a town-hall meeting that "if you leak information you can be held criminally liable for obstructing a criminal investigation…You can go to jail."[82] Minister Matthews subsequently gave the assurance that no employees will lose their job for blowing the whistle and McKerlie said that he was developing a "whistle-blower policy" to protect employees.[83]

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

Commitment to Bring Ontario's RN to Population Ratio in line with the rest of the Country

QUESTIONS

1. Do you agree with the Drummond Commission finding that there is a severe shortage of nurses in Ontario? Can we count on your Party's support to bring Ontario's RN to population ratio in line with the rest of the country by adopting RNAO's call to increase Ontario's RN workforce by an additional 9,000 RN FTEs by 2015, in addition to the previous commitment to hire 9,000 nurses by 2011?

2. Can we count on your party's support to raise the full-time share of RN employment to 70 per cent full-time employment in all sectors for RNs and RPNs by 2015?

BACKGROUND

Building Nursing Employment

As the Drummond Commission recognized, there is a severe shortage of nurses in Ontario: "There is a desperate need to increase supply and improve retention"[84]

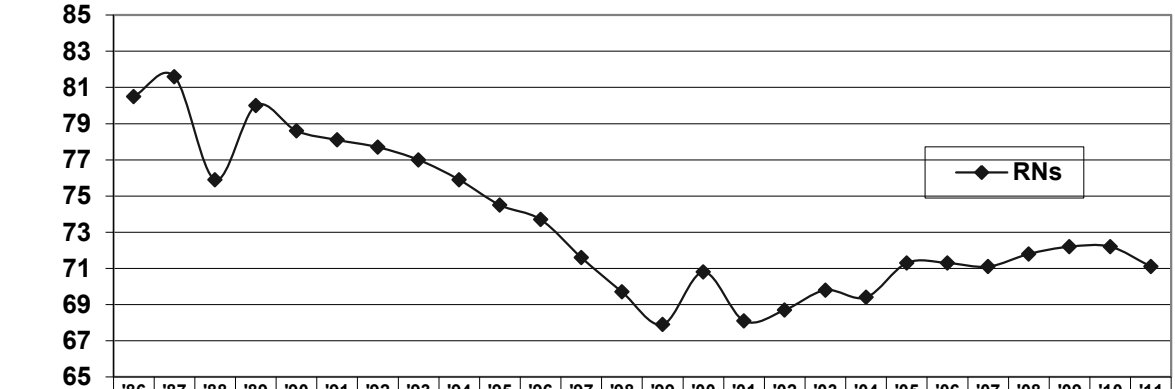
There are several pressures on the nursing workforce. First, many are approaching retirement age. Latest data show fully 30 per cent of RNs in the general class were over the age of 54, which is close to a typical RN retirement age. Further recruitment and retention efforts will be needed to ensure sufficient replacements for the many RNs who will retire over the next ten years and meet the need for additional RNs. Second, workloads for many are higher these days, and that contributes to burnout and early departure from the workforce.

RN/Population Ratio

Statistics back up this impression. In order to catch up with the rest of Canada in RN/population ratio, Ontario would have to add 14,383 more RNs to its workforce, an increase of 15.1 per cent. The plunging RN/population ratio provides a direct measure of access to nursing services. As the ratio falls, the number of people each RN must care for

increases. Figure 1 below shows the striking pattern from 1986 to 2010: the nursing workforce first plummeted from over 80 per 10,000 people to 68 in 1999 and again in 2001. After that, it trended up, reaching 72 by 2008. The sharp drop was caused by a declining nursing workforce and a rising population. The reversal was due to growth in RN employment that exceeded population growth. The bulk of the gain under the current government occurred during the first year of its first mandate, but the general trend remained upwards until the drop in 2011.

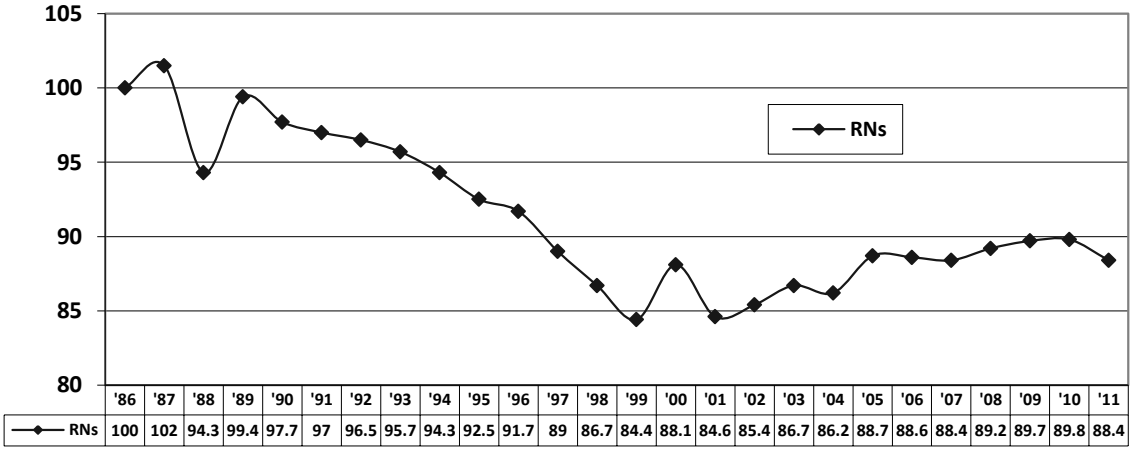
1. Ontario Trend in RNs/10,000 Population (General Class plus Nurse Practitioners)



	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11
RNs	80.5	81.6	75.9	80	78.6	78.1	77.7	77	75.9	74.5	73.7	71.6	69.7	67.9	70.8	68.1	68.7	69.8	69.4	71.3	71.3	71.1	71.8	72.2	72.2	71.1

The index of the RN/population ratio in Figure 2 provides a vivid statistical picture to explain the sharp rise in workloads reported by many RNs. In percentage terms, the ratio deteriorated to 16 per cent below 1986 levels in 1999 and 15 per cent below in 2001. It recovered to about 10 per cent below by 2009, but deteriorated to 12 per cent below in 2011. We have not recovered to ratios that prevailed in the 1980s, but the reversal is important, and the improvement is significant. The deterioration in the RN/population ratio in the last two years follows the hit nursing took in spending restraints announced in October 2008 as part of the government's attempt to deal with a recession-driven deficit.[85] RNAO continues to hear concerns about workloads, and the data show that ratios are considerably less favourable than they were in the late 1980s, when the provincial client base was younger and its health-care needs were lower.

2. Index of Ontario RN-to-Population Ratio: 1986 = 100 (General Class plus Nurse Practitioners)

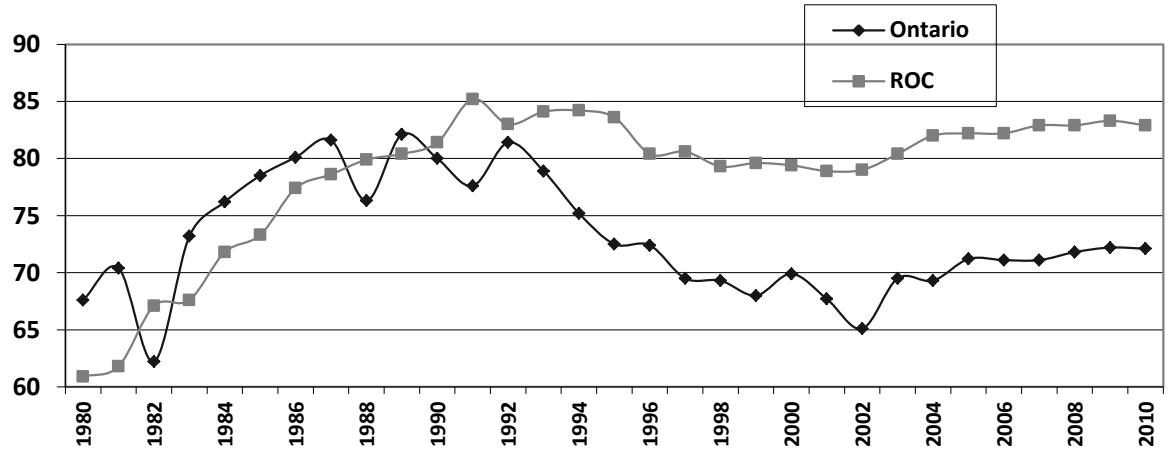


	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11
RNs	100	102	94.3	99.4	97.7	97	96.5	95.7	94.3	92.5	91.7	89	86.7	84.4	88.1	84.6	85.4	86.7	86.2	88.7	88.6	88.4	89.2	89.7	89.8	88.4

Trend in RN Employment (General Class plus Nurse Practitioners) per 10,000 Population: Ontario vs. Rest of Canada

Even though Ontario's RN-to-population ratio has improved in recent years, the province consistently ranks below the rest of Canada (ROC). Only British Columbia has the distinction of having a lower RN-to-population ratio than Ontario. As of 2010, Ontario had 72.1 RNs per 10,000 people, compared to 82.9 for the rest of the country.[86] This inevitably has significant workload implications. As noted above, in order for Ontario to catch up with the rest of Canada, it would have to add 14,383 more RNs to its workforce, an increase of 15.1 per cent. In terms of direct care alone, 8,607 RNs would have to be added to catch up to the rest of the country (for data on access to direct RN care, see Figure 4).

3. RNs per 10,000 Population: Ontario vs. Rest of Canada (General Class plus Nurse Practitioners)



4. Interprovincial Comparison of RN Workforce per 10,000 Population Against Ontario (General Class plus Nurse Practitioners)			
	All RNs		**Direct Care RNs**
Jurisdiction	**1994**	**2010**	**2010**
Newfoundland	90.1	118.0	103.8
Prince Edward Island	87.1	103.5	90.1
New Brunswick	101.4	107.8	96.9
Nova Scotia	98.8	97.3	85.1
Manitoba	89.8	94.1	77.7
Saskatchewan	84.1	91.2	80.8
Québec	85.1	83.9	71.8
Canada excluding Ontario	**84.2**	**82.9**	**71.2**
Alberta	80.7	77.1	69.8
Ontario	**75.2**	**72.1**	**64.7**
British Columbia	75.0	68.2	55.2

Nurse Practitioner Employment Ratios

Figure 5 shows the number of working NPs per 100,000 population for 2005 to 2010. In 2010, Ontario had 59.6 per cent of all the NPs in Canada, and we know that the number of NPs continues to grow quickly in Ontario. It is not surprising that Ontario has substantially more NPs per 100,000 population (11.2) than Canada as a whole (5.9; excluding Ontario, the ratio would be 4.8). However two provinces have higher ratios: Newfoundland (18.8), and Saskatchewan (11.7). Note that Newfoundland also has the highest RN-to-population ratio of the provinces as well. Nunavut/Northwest Territories have a much higher ratio still: 72.8. We are unable to calculate ratios for some of the provinces due to data suppression for privacy reasons.

5. Interprovincial Comparison of NPs/100,000 Population

	2005	2006	2007	2008	2009	2010
Newfoundland	12.84	17.44	18.95	19.55	18.47	18.83
P.E.I.	*	*	*	*	*	*
Nova Scotia	3.95	6.50	7.69	8.54	9.06	11.14
New Brunswick	2.53	3.22	3.89	6.56	7.34	9.18
Québec	*	0.22	0.22	0.37	0.49	0.81
Ontario	4.70	5.05	5.71	6.74	8.60	11.22
Manitoba	*	*	*	*	*	*
Saskatchewan	7.47	8.87	9.70	9.67	10.78	11.67
Alberta	3.96	4.56	5.01	5.84	6.81	7.07
British Columbia	*	*	1.16	2.01	2.67	2.85
Yukon	*	*	*	*	*	*
N.W.T./Nunavut	26.12	21.62	56.14	69.02	60.83	72.75
Canada	2.92	3.47	4.08	4.88	5.90	7.29

* indicates small cell size or data suppressed to meet CIHI privacy standards

Net Gains/Losses in Nursing Employment

In terms of overall nursing numbers, there is also reason for concern. The 1990s saw stagnation in the growth of the RN workforce, with falling employment in the latter 1990s. At the same time, the population of Ontario continued to grow rapidly and age, so the need for nursing services was growing at the same time as RNs were being laid off. The 1999 Nursing Task Force report outlined these problems, their implications for the profession and for client outcomes. Concerted efforts by successive governments since that time have reversed the downward trend in nursing employment.

During the McGuinty government's first mandate (October 2003 to October 2007), it promised to create 8,000 nursing positions, and in the corresponding CNO data period (2004-2008), 9,669 nursing positions were created. Thus, we can say that the government met its commitment. In its second mandate, the government promised to create 9,000 additional nursing positions. Because CNO data is about a year old when released, we do not yet know the final story on nursing employment in the second mandate. We do know the government was lagging in its promise due to spending cuts announced in October 2008. Three quarters of the way through the mandate, the numbers show that there was only a net gain of 6,308 positions, which is less than three quarters of the way to 9,000 positions. More alarmingly, RN employment actually dropped in the last year. RNs in the general class lost 501 positions while NPs gained 180, for a net loss of 321 RN positions in the period January 2010 to January 2011.

6. Net Changes in Ontario Nursing Employment, 2004-2011

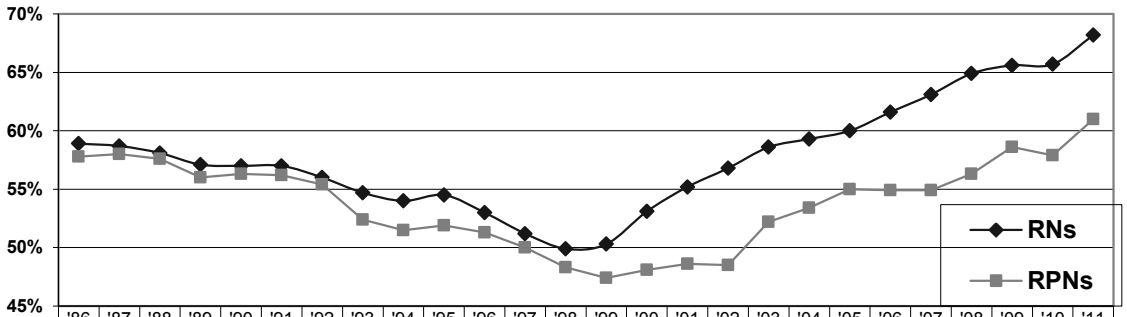
	Nursing Employment			Net Gains in Nursing Employment		
	2004	**2008**	**2011**	**2004-08**	**2008-11**	**2004-11**
RN(GC)s	85,638	91,965	93,415	6,327	1,450	7,777
NPs	530	868	1,666	338	798	1,136
RPNs	24,428	27,432	31,492	3,004	4,060	7,064
All Nurses	110,596	120,265	126,573	9,669	6,308	15,977

Given the serious shortfall on RN positions we are asking the government to make up any shortfall as soon as possible. Furthermore, in view of the continuing gap with the rest of the country, we are asking all parties to commit to making up more of the gap in the next four years through the net creation of 9,000 more RN FTEs.

Working Status: Ontario

The measured share of full-time employment for RNs in the general class plus nurse practitioners rose from 59.3 per cent to 68.2 per cent between 2004 and 2011. The trend has been very positive since 1998, when the share of full-time employment for RNs in the general class was below 50 per cent. RPN employment followed a similar pattern, bottoming out in 1999 at 47.4 per cent full-time, and hit a new high of 61.0 per cent in 2011. Ontario is well on the way to achieving the objective of 70 per cent full-time for RNs and RPNs, as stated in RNAO's platform[87] and as committed to by the McGuinty government.

7. Full-time Share of Employment for Ontario RNs (General Class plus Nurse Practitioners) vs. RPNs

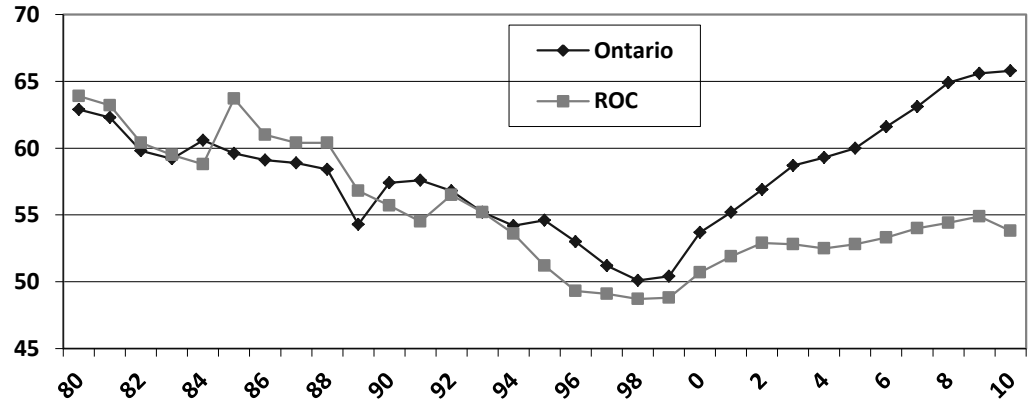


	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11
RNs	59%	59%	58%	57%	57%	57%	56%	55%	54%	55%	53%	51%	50%	50%	53%	55%	57%	59%	59%	60%	62%	63%	65%	66%	66%	68%
RPNs	58%	58%	58%	56%	56%	56%	55%	52%	52%	52%	51%	50%	48%	47%	48%	49%	49%	52%	53%	55%	55%	55%	56%	59%	58%	61%

Working Status: Ontario vs. the Rest of Canada (RNs (General Class plus Nurse Practitioners))

As with nurse-to-population ratios, Ontario and the rest of Canada experienced similar patterns with respect to shares of full-time employment over time (see Figure 8 below). They both started well above 60 per cent in 1980, and followed a general trend downwards over time, bottoming out at or below 50 per cent by 1999. After that, both trended upwards, with Ontario rising much more quickly than the rest of the country. As of 2010, Ontario RNs were 65.8 per cent full-time, whereas in the rest of Canada, they were 53.8 per cent. The ratio in the rest of the country deteriorated in 2010, so Ontario and the rest of the country are diverging. It should be noted that Ontario's much higher full-time share means that its RN/population ratio understates its comparative access to RNs relative to the rest of the country. An estimate of RN full-time equivalents per 10,000 population would put Ontario in eighth place in Canada, ahead of Alberta.

8. Per Cent of RN (General Class plus Nurse Practitioners) that is Full-time: Ontario vs. Rest of Canada



There is considerable variation across the country in terms of shares of RN employment that is full-time. It ranges from 40.4 per cent in Alberta to 74.7 per cent in Newfoundland. Joining Ontario in the 60 per cent range were Nova Scotia, New Brunswick and Saskatchewan. Three western provinces had less than 50 per cent full time: Alberta, Manitoba (46.5 per cent) and BC (49.9 per cent). The rest of the provinces and territories all fall in the 50 per cent range. Newfoundland demonstrates that a goal of 70 per cent full-time employment is very achievable. Newfoundland also has the highest RN/population ratio, which suggests that its residents unequivocally have more access to RN services.

9. Per cent Shares of RN (General Class plus Nurse Practitioners) Employment that is Full-time, 2010	
Province/Territory	**Full-time Share**
Newfoundland	74.7%
Prince Edward Island	50.5%
Nova Scotia	65.4%
New Brunswick	64.5%
Québec	56.9%
Ontario	65.8%
Manitoba	46.5%
Saskatchewan	60.3%
Alberta	40.4%
British Columbia	49.9%
Yukon	56.4%
N.W.T./Nunavut	58.0%
Canada	53.8%

Number of nurses registered to practise in Ontario as of March 1, 2012 (January 4, 2011 and change in brackets):

- RNs in general class: 112,739 (114,676; - 1,937)
- Nurse Practitioners: 2,056 (1,825; + 231)
- All RNs (= RN(GC)s + NPs) 114,795 (116,501; - 1,706)
- RPNs 39,578 (38,086; + 1,492)
- All Nurses (= All RNs + RPNs) 154,373 (154,587; - 214)

Number of nurses working in nursing in Ontario in 2011 (2010 and change in brackets):

- RNs in general class: 93,415 (93,916; - 501)
- Nurse Practitioners 1,666 (1,486; + 180)
- All RNs 95,081 (95,402; - 321)
- RPNs 31,492 (30,442; + 1,050)
- All nurses 126,573 (125,844; + 729)

RN (General Class) Employment by Sector in 2011

By numbers of positions, hospitals remain the dominant employers of RN (GC)s. Please note that these are counts of positions, which are more numerous than RNs, due to many RNs having multiple employers.

Employment Sectors for RN (GC)s		
	#	**%**
Hospital	64,380	60.0
Community	19,322	18.0
Long-Term Care	9,876	9.2
Other	9,744	9.1
Not Specified	4,025	3.7
Total	107,347	100.0

Age of Nurses (2011, 2002 in brackets):

RN (general class): 46.7 (44.8)
Nurse Practitioner: 45.8 (43.5)
RPN: 44.1 (44.2)

The share of RNs (general class) under 30 and over 55 is rising. The rise in the share under 30 indicates that the effort to recruit and educate new RNs is already yielding tangible gains. The dramatic decrease in the share of RNs (general class) ages 30 to 49 points to the need to develop a mid-career nursing strategy to retain mid-career nurses. The rise in the share over 55 indicates that further recruitment and retention efforts are needed to ensure sufficient replacements for the many RNs who will retire over the next ten years and meet the need for additional RNs.

11. Trends in Distribution of Age Groups among RNs (General Class)

	1992		**1999**		**2010**		**2011**	
Age Group	#	%	**#**	**%**	**#**	**%**	**#**	**%**
18 - 24	1,801	2.2	810	1.0	1,674	1.8	1626	1.7
25 - 29	10,246	12.5	5,548	7.1	7,481	8.0	7,582	8.1
30 - 34	11,129	13.6	8,809	11.3	8,159	8.8	8,182	8.8
35 - 39	14,086	17.2	12,002	15.4	10,354	11.0	9,818	10.5
40 - 44	14,427	17.6	12,379	15.9	11,630	12.4	11,446	12.3
45 - 49	12,480	15.2	14,823	19.1	14,196	15.1	14,032	15.0
50 - 54	8,771	10.7	11,902	15.3	13,164	14.0	12,960	13.9
55 - 59	5,512	6.7	7,905	10.2	14,240	15.2	14,052	15.0
60 - 64	2,835	3.5	3,019	3.9	8,746	9.3	9,075	9.7
65+	806	1.0	597	0.8	4,266	4.5	4,642	5.0
Not Specified	12	0.0	1	0.0	6	0.0		
Total:	**82,105**	**100.0**	**77,795**	**100.0**	**93,916**	**100.0**	**93,415**	**100.0**

Gender of Nurses in 2011

The gender ratio has been fairly stable over time, and heavily balanced toward females, with a very slight trend towards more males.

- RN (GC)s: 94.7 per cent female (96.3 per cent in 2002)
- NPs: 95.2 per cent female (95.4 per cent in 2002)
- RPNs: 93 per cent female (94 per cent in 2002)

RN (general class) Employment by Region

Employment shares between regions show modest shifts in employment shares. 2011 counts are not comparable to those in previous years because they are for total positions, not for numbers of RNs as in previous years: see endnote.

12. LHIN Employment Regions 2005 to 2010

LHIN Region	2005		2010		2011[88]	
	#	%	#	%	#	%
Erie St. Clair	4,252	4.8	4,419	4.7	4,941	4.6
South East	4,379	4.9	4,408	4.7	4,904	4.6
Champlain	9,637	10.8	10,448	11.1	11,722	10.9
North Simcoe Muskoka	2,971	3.3	3,131	3.3	3,619	3.4
North East	4,968	5.6	5,202	5.5	5,882	5.5
North West	2,344	2.6	2,449	2.6	2,863	2.7
South West	8,361	9.4	8,848	9.4	9,777	9.1
Waterloo Wellington	3,884	4.4	4,092	4.4	4,761	4.4
Hamilton Niagara Haldimand Brant	10,330	11.6	10,383	11.1	11,651	10.9
Central West	2,506	2.8	2,641	2.8	3,383	3.2
Mississauga Halton	5,104	5.7	5,615	6.0	6,910	6.4
Toronto Central	14,840	16.7	16,214	17.3	18,537	17.3
Central	6,596	7.4	7,523	8.0	9,048	8.4
Central East	7,704	8.7	7,745	8.3	9,053	8.4
Not Specified	1,178	1.3	798	0.9	296	0.3
Total	**89,054**	**100**	**93,916**	**100**	**107,347**	**100**

A Note on the Data

This backgrounder provides an overview of Ontario's registered nurse (RN) workforce, which is broken into RNs in the general class (RN(GC)s) and RNs in the extended class (nurse practitioners or "NPs"). Unless otherwise specified, "RN" refers to RN in the general class. RPNs refer to registered practical nurses. Employment figures are snapshots taken at registration renewal time, which takes place over several months

around January 1st of each given year. Please note that cross-Canada comparisons are done using data from the Canadian Institute for Health Information (CIHI), which give slightly different figures for Ontario than CNO data. The data in this backgrounder are the latest available as of March 10, 2012.

The Ontario nursing data come from the College of Nurses of Ontario (CNO). The national RN data for interprovincial comparisons come from the Canadian Institute for Health Information (CIHI) RN database. The population data used to help generate the RN/population ratio come from the CIHI National Health Expenditure data set. The calculations, analyses, conclusions, opinions and statements expressed herein are those of RNAO, and are not necessarily those of CNO or CIHI.

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

Ontario's Most Vulnerable Need Income Security for Health and Human Dignity

QUESTIONS

1. Social assistance rates for beneficiaries of the Ontario Disability Support Program and especially for Ontario Works, at $599 per month for a single person, are dangerously low. Will your party commit to ensuring that social assistance rates are increased to reflect the actual cost of living?

2. Many Ontarians cannot escape poverty as they wait for years on waiting lists for affordable housing. Will your party commit to building affordable housing across the province? As Canada is the only major country in the world without a national housing plan, will your party keep up the pressure on the federal government for a National Affordable Housing Strategy?

3. Good quality jobs are often a pathway out of poverty. Will your party commit to increasing the minimum wage to bring workers out of poverty? Will your party strengthen enforcement of employment standards to protect workers against wage theft?

RNAO POSITION

Ontario's nurses are guided by the vision of a poverty-free province where all Ontarians have the opportunity to achieve their full potential. The evidence is clear that those who live in poverty and are socially excluded experience a greater burden of disease and die earlier than those who have better access to economic, social, and political resources. Transforming the social assistance system, sustaining good quality employment, and increasing access to affordable housing are three interrelated actions that are needed to improve income security for health and human dignity.[89]

BACKGROUND

In 2010, 402,000 Ontarians per month needed to turn to food banks, which was a sharp increase from 374,000 in 2009.[90] There has been an unprecedented increase in food bank use in Ontario by 28 per cent since the recession hit in 2008.[91] Two-thirds of the households that access food banks are paying market rent.[92] In 2010, single adults comprise the largest proportion of the population served by food banks at 38 per cent,

followed by single parent families at 30 per cent. Most households using food banks depended on social assistance (including 45 per cent on Ontario Works (OW) and 23 per cent on Ontario Disability Support Program (ODSP)), 11 per cent have employment income, and five per cent are pensioners.[93] People in Ontario are going hungry[94] because of the high cost of housing, low social assistance rates, especially for single adults, and the growth in precarious minimum wage jobs that do not lift people out of poverty.[95]

In December 2008, the provincial government launched Ontario's first ever Poverty Reduction Strategy, with the goal of reducing the number of children living in poverty by 25 per cent over five years. The child poverty rate in Ontario decreased from 15.2 per cent in 2008 to 14.6 per cent in 2009, thereby lifting 20,000 children out of poverty.[96] [97] This four per cent reduction which came during the worst of Canada's recession may be contrasted with Alberta's child poverty soaring by 25 per cent in the same period without equivalent policy action.[98] While the rewards of investing in a poverty reduction strategy aimed at children became evident, there was almost a ten per cent increase in the poverty rate for all Ontarians aged 18 to 64 years or 102,000 more people in this age bracket living in poverty in 2009 compared with 2008.[99]

Social assistance incomes have the same purchasing power today as they did in 1967.[100] A single person on OW receives $599 per month.[101] Without the 21.6 per cent cut in 1995 imposed by then Premier Mike Harris' Progressive Conservatives, the inflation adjusted single rate would have been $932 per month--$333 more than it is today.[102] During its initial consultations, the Commission for the Review of Social Assistance in Ontario "heard from many people that the benefit structure should more closely reflect the cost of living, including the cost of nutritious food, secure housing and community participation."[103] According to Ottawa Public Health, for example, a single person in that city can expect to pay an average monthly rent of $715 for a bachelor apartment and $254 per food for nutritious food. Including tax credits with OW, Ottawa Public Health estimates that individual would be short $334 per month.[104] Over a year, OW plus federal and provincial tax credits, comes to $7,952, which is only 42 per cent of the Low Income Cut-Off (LICO) of $18,759. An individual receiving ODSP plus federal and provincial tax credits is better off at 72 per of the LICO[105] at $13,600 per year.[106]

In January 2011, 152,077 households were on waiting lists for financially assisted housing across Ontario. The waiting list grew by 7.4 per cent between 2010 and 2011 representing an increase of 10,442 households.[107] These numbers may be significantly underestimated, as many do not even apply for assisted housing due to the long wait time.[108] Like other years, the Peel Region continues to have the longest wait time in Ontario, in 2011 up to 15 years.[109] One fifth of all households living in rental housing in 2005 were paying 50 per cent of their income on rent. These households "may have to forego other necessities including food, and are considered at risk of homelessness."[110] The *Strong Communities Through Affordable Housing Act* was passed on April 19, 2011. Housing advocates welcomed it as "erecting the scaffolding necessary to create a truly comprehensive long-term affordable housing plan for Ontario, but noted that the new commitment does not provide the necessary funding and tools to allow the work to

proceed."[111] On June 24, 2011, Ontario's Long Term Infrastructure Plan was released. "The Ministry of Infrastructure is currently providing $89 million in funding for affordable housing projects valued at $267 million, but there are no specific affordable housing projects under the Long Term Infrastructure Plan."[112]

After a nine year minimum wage freeze between 1995 and 2004,[113] the minimum wage in Ontario has increased each year from $6.85 per hour in 2003 to the current rate of $10.25 per hour that took effect in 2010.[114] Although it is technically true that "in 2011, Ontario's minimum wage is the highest among all the provinces,"[115] the territory of Nunavut's minimum wage in 2011 is higher at $11.00 per hour.[116] Since the last increase in 2010, the minimum wage has been frozen while the cost of rent, food, and transportation continues to rise. A recently released Metcalf Foundation report found 113,000 working-poor individuals in the Toronto Region in 2005, which is a 42 per cent increase since 2000.[117] Immigrants to Canada are over-represented among both the working poor and non-working poor categories.[118]

Going forward, the McGuinty government has promised to take "advice on the minimum wage from a committee representing both business and workers."[119] This committee was scheduled to be appointed in the fall of 2011 in order to provide advice on the minimum wage in advance of the 2012 budget.[120] As of February 21, 2012 the terms of reference, process for selecting committee members, and timelines have not yet been announced. As no one should work full-time and yet still live in poverty, it is vital that this committee be convened soon with fair representation from labour, including those who can speak to precarious employment, business, community stakeholders, and progressive as well as traditional economic experts.

One measurement of poverty is when an annual income drops below the Low Income Measure (LIM), or 50 per cent of the median income, after taxes. By that measure in Ontario, a single person with an after-tax income of $19,600 or less in 2011 would be considered poor.[121] A recent Learning Enrichment Foundation study found that there was a significant difference in improved quality of life between people whose incomes were less than $30,000 and those whose annual income were between $30,000 to $40,000 annually.[122] In other words, "it would take an additional $10,000 to $20,000 annually to boost a single person from grinding poverty to a life with a sense of well-being."[123] This is consistent with a 2008 report that estimated a living wage for Toronto (for a family of four with two children and both parents working) would be $16.60 per hour or about $33,000 per year per adult.[124]

What is needed to live with a sense of well-being may be contrasted with a Workers' Action Centre survey of 520 people which found 64 per cent of them made $12.50 or less and 22 per cent earned less than the minimum wage of $10.25 per hour.[125] The survey found 33 per cent of the workers reported being owed wages by their employer. Of these, 77 per cent were not successful in obtaining the wages owning to them.[126] There are currently only 20 Employment Standards officers to inspect 370,000 workplaces across

Ontario.[127] As the problem of 'wage theft' remains endemic, it is crucial that the government make permanent a two-year, $6 million Ministry of Labour initiative launched in 2010 for Employment Standards enforcement set to expire in 2012.[128]

The human and economic costs of ignoring poverty are profound. The National Council of Welfare reports that the poverty gap in Canada in 2007—the money it would have taken to bring everyone over the poverty line—was $12.3 billion. Even using the most cautious estimates, the total cost of poverty that year was double or more.[129] Just in Ontario, the total economic costs of poverty (both private and social) have been estimated to be $32.2 to $38.3 billion (2007 dollars) or 5.5 to 6.6 per cent of Ontario's GDP.[130] A growing body of evidence and experience shows that investing to reduce poverty will benefit everyone.[131] "The greater the inequalities, the greater the stress on people all along the income spectrum, and the worse the outcomes are for a society overall, not just for those at the bottom of the income ladder."[132]

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

Invest in Mental Health and Addiction Services for a Healthier Ontario

QUESTIONS:

1. Will your party support urgent investments in mental health and addiction services to improve equitable access for all Ontarians across the province?

2. Will your party respond to the urgent requests by the Chiefs of the Nishnawbe Aski Nation (NAN) for the province to address the imminent "public health catastrophe" of mass involuntary opioid withdrawal for thousands of people in NAN Territory?

RNAO POSITION

RNAO supports the vision of Ontario's Comprehensive Mental Health and Addiction Strategy of "an Ontario where every person enjoys good mental health and well-being throughout their lifetime, and where all Ontarians with mental illness or addictions can recover and participate in welcoming, supporting communities."[133] While RNAO understands that the *Open Minds, Healthy Minds* strategy "will start with children and youth" in the first three years,[134] RNAO continues to advocate for "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.[135]

RNAO remains committed to the following principles arising from a human rights perspective on health and health care: equity; dignity; accountability, transparency, democracy; upstream, visionary policies; and fairness and respect for our First Peoples.[136] The current public health challenge in NAN Territory reinforces RNAO's platform statement: "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-determination and equitable access to resources, jobs, health care, clean water, good schools and safe housing."[137]

BACKGROUND

According to Health Canada, one in five Ontarians will experience a mental illness or addiction at some point within their lifetime.[138] Although the tracking of suicide is poor and likely underreported, there were at least 1,000 people in Ontario who committed suicide in 2007.[139] In total, including lost productivity, law enforcement, disability claims, drug costs, and employee assistance claims, mental health and addictions cost Ontario at least $39 billion each year.[140] Investment in a client-centred long-term strategy is the only humane and cost-effective solution. We know that every dollar spent on mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs.[141]

At least 20 reports documenting the need for mental health system reform in Ontario have been written in the last 25 years,[142] including most recently the interim and final reports of the Minister's Advisory Group on the 10-Year Mental Health and Addiction Strategy[143][144] and the Legislative Assembly of Ontario's Select Committee on Mental Health and Addictions.[145][146] In June 2011, the Ministry of Health and Long-Term Care released *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* that takes a "long-term view" to transformation by starting in the first three years with a focus on children and youth.[147] Noting that "seventy per cent of mental health problems first appear in childhood and adolescence," *Ontario's Action Plan for Health Care*, made specific mention of "getting mental health nurses into our schools."[148] RNAO is supportive of this initiative and looks forward to learning more details about its implementation.

At the same time, RNAO is also in agreement with the Ontario Mental Health and Addictions Alliance's advocacy for investment "to ensure equitable access to a core basket of services across Ontario to meet population needs and to reduce regional service gaps in the continuum of care."[149] There is dramatically uneven access to services across the province as per capita funding for community mental health ranges from $18.54 to $124.78.[150] The average wait by LHIN over 2010-2011 for mental health case management varied from 3.8 days to 63.2 days, with a provincial average of 34.3 days. The average wait by LHIN for residential addiction treatment ranged from a low of 15.6 days to a high of 286.6 days, with a provincial average of 47.6 days. The wait for supportive housing ranged from an average low of 41.1 days in one LHIN to a high of 1060.4 days in another LHIN, with a provincial average of 267.3 days.[151] As this Alliance aptly summarizes: "finding help for the most expensive, most disabling problem in Canada should not depend on your persistence or your postal code." [152]

The Nishnawbe Aski Nation (NAN) Chiefs-in–Assembly declared a Prescription Drug Abuse State of Emergency in November 2009 (Resolution 09/92).[153] The Eabametoong First Nation community of 1,200 people[154] declared a state of emergency in October 2010 as a result of "extreme social disruption, after the community experienced three murders, 73 drug charges, 61 assaults, and 47 arson cases (35 structural fires)."[155] Despite extensive acknowledgement of these unique challenges[156] [157] [158] and compelling

testimony by elected representatives on the suffering they have witnessed in their ridings,[159] [160] NAN Resolution 11/59 of November 24, 2011 states "there has been a lack of response by both levels of government to the epidemic of Opioid addiction in our territory."[161]

RNAO had the privilege of being invited to attend the NAN Think Tank on Prescription Drug Abuse in March 2011 and learned of the almost 200 people who were doing well within six NAN community-based Suboxone treatment programs. Despite the cost-effectiveness and value of this program, access to Suboxone is limited due to federal constraints on access to this medication and a directive to prevent nurses from administering Suboxone to new clients. In January 2012, RNAO sent a letter of support to both federal and provincial Ministers of Health urging a swift response to requests from NAN leaders for assistance with this public health emergency.[162]

This public health emergency is now in danger of turning into a "public health catastrophe."[163] There is widespread addiction to OxyContin among NAN First Nations members and it will not be manufactured in Canada after February 29, 2012.[164] OxyContin will be replaced by OxyNeo, a formulation designed to reduce misuse. In the United States when this change to OxyNeo was made, heroin slowly became the drug of choice over eight months among opiate users.[165] In the context of thousands of people in remote northern Ontario communities currently being addicted to OxyContin, NAN leaders are understandably worried about people going into involuntary withdrawal with few options for appropriate health care or drug treatment.

The scope of this health and social problem is staggering. On February 6, 2012 it was reported that at least 2,000 people have an opioid addiction in Matawa First Nation communities.[166] In January 2012, Chief Matthew Keewaykapow of Cat Lake First Nation declared a state of emergency "due to widespread opioid addiction reaching 70 per cent of his community members, ranging in age as young as eleven years to over sixty years."[167] At least 9,000 community members in Sioux Lookout Zone alone will be impacted, out of the total population of 25,000.[168] A senior scientist at the Centre for Addictions and Mental Health, Dr. Benedikt Fischer, warns: "In the absence of any regular treatment, a public health catastrophe is imminent, as there are thousands of prescription opioid addicted individuals with rapidly shrinking supplies—likely leading to massive increases in black market prices, use of other drugs, needle use/sharing and subsequent infectious disease transmission, overdoses and crime."[169]

RNAO continues to urge federal and provincial Ministries of Health to listen to the voices of Nishnawbe Aski Nation and act immediately to prevent a public health catastrophe.

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

Commit to Protect Health by Immediately Terminating All Coal Burning at Ontario's Power Plants and Cancel Plans to Build New Nuclear Plants.

QUESTIONS

1. Will your party commit to protecting health by immediately closing the remaining coal-fired generators, while keeping them on standby reserve to be operated only in event of an emergency?

2. Will your party commit to protecting health by cancelling plans for the construction of expensive and risky new nuclear plants and phasing out Ontario's dependence on nuclear power?

RNAO POSITION

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

- *Reduced consumption through conservation and energy efficiency*
- *Immediate closure of all remaining coal plants, keeping them on emergency stand-by until permanent closure in 2014 and only operating them if there is no other option to keep the lights on*
- *Cancellation of plans for construction of new risky and expensive nuclear power plants*
- *Strategic use of natural gas to meet peak needs until renewable power is on-line and ensure all new natural gas-supplied electricity is highly efficient combined heat and power (CHP)*
- *Increased reliance on renewable energy such as community-controlled, appropriately located and scaled water, wind, solar and bio-energy. All new developments must be subject to robust environmental assessments.*

BACKGROUND

1. DIRTY COAL

In 2007, the Ontario government enacted a regulation requiring all remaining coal-fired electricity generation in the province to end by December 31, 2014.[170] During the 2011 provincial election, all the major political parties agreed that the time has come to protect the health of Ontarians by phasing out coal-fired electricity generation.[171]

Many groups, including the RNAO, the Canadian Association of Physicians for the Environment (CAPE), the Lung Association, Asthma Society and the Ontario Clean Air Alliance (OCAA) are advocating to end the burning of coal immediately and not wait until 2014. Coal plants can be placed on standby reserve and only operated when there is an emergency or if there is no other option to keep the lights on.[172]

Coal plants release harmful particulate matter, lead and mercury into the air we breathe and are responsible for thousands of tonnes of climate change-causing greenhouse gases. Pollution from generating electricity using coal is considered to have contributed to over 300 deaths in Ontario in 2010, 440 hospital admissions, 522 emergency room visits and 158,000 minor illnesses such as asthma attacks.[173] In fact, the end of coal would represent the equivalent of taking seven million cars off the road.[174] [175]

While evidence of the health dangers of coal is overwhelming, the economic costs, particularly in wake of the Drummond Commission and record deficits, are unsustainable. Ministry of Energy numbers put Ontario's health and environmental costs of coal at three billion dollars annually.[176] According to the Ontario Clean Air Alliance, the Ontario Electricity Financial Corporation, an agency of the provincial government, has paid $865 million to Ontario Power Generation since January 2009 to compensate for the operating losses of its four coal plants.[177]

With the closure of two coal units at Nanticoke in December, 2011, a total of ten coal units have already closed in Ontario, representing a reduction of coal-fired generation by more than 70 per cent from 2003 levels.[178] Two additional units in Thunder Bay will be converted to gas and potentially biomass, the Atikokan unit will be converted to biomass by 2013 and, finally, the remaining units at Nanticoke and Lambton will be permanently closed by the end of 2014 according to the government's plan. A decision is expected to be made in 2012 as to whether some or all of the remaining coal units at Nanticoke and Lambton will be converted to natural gas during a transitional period. That would help save jobs in those communities and also reduce reliance on such risky sources of generation as nuclear in ensuring overall system reliability while waiting for cleaner, renewable energy sources to come on-line.[179]

As for whether some coal-generated electricity is needed between now and the end of 2014 to prepare for the peak periods in winter and summer, an analysis by the Ontario Clean Air Alliance, finds that Ontario's coal-free generation capacity is currently about

29 per cent higher than the forecasted peak demand during the summer of 2012 and 35 per cent greater than the peak demand that is forecast in 2014.[180] Even if it is found necessary to keep some of the coal capacity on "standby reserve" until the permanent closure of the coal plants in 2014, the OCAA argues that there is no reason for the coal plants to be operated at even a minimal level in the interim pending an emergency or a need to support grid stability.[181]

Ontarians understand and support the need to phase out the province's reliance on coal-fired electricity According to a poll conducted by Strategic Communications Inc. in November, 2010, two-thirds of Ontarians support closing the province's coal plants and 75 per cent recognize that coal is more harmful than wind power as a source of electricity.[182]

2. NEW NUCLEAR TOO RISKY AND EXPENSIVE

Nuclear power may not emit air pollutants during "production"[183] of electricity, but in fact nuclear power is neither emissions-free nor clean. There is no safe level of radiation exposure – any amount of exposure to ionizing radiation is too much and is harmful.[184] Japan's Fukushima nuclear disaster is a reminder of the danger even in the most technically advanced economies.

Further, the health risks associated with nuclear power arise at all stages of the nuclear fuel chain, from uranium mining and refining, to the fission process in nuclear reactors and radioactive releases into the air and water, to the legacy of radioactive waste that we leave for our grandchildren and future generations.[185]

As RNAO noted in a submission on the acceptable level of the radionuclide tritium in Ontario's drinking water, "Ontario's and Canada's heavy water nuclear reactors have been known to release large amounts of tritium due to their design. Depending upon the comparator, heavy water reactors have been estimated to release from over 20 times to over 100 times as much tritium per unit of energy produced (compared to pressurized water reactors and boiling water reactors respectively).[186] By one estimate, major Canadian nuclear facilities release amounts of tritium equaling about ten per cent of natural production of tritium in the Northern hemisphere.[187] The majority of the releases come from Ontario reactors, and the impact is greatest near nuclear facilities."

While there are relatively few Canadian studies on the deleterious effects of low levels of radiation on health, there is evidence linking increased prevalence of leukemia in children and living near nuclear facilities. Higher rates of congenital abnormalities have also been documented. A 2008 German study showed a statistically significant relationship between risk of leukemia and living within ten kilometres of a nuclear plant with consistent results across all 16 nuclear power plants in Germany.[188]

Ontario now has safe and clean alternatives to the unacceptable health risks of nuclear power. It is time to invoke the precautionary principle and reject plans to build new nuclear power plants in the province.

There are other reasons to end new nuclear construction projects in Ontario. Nuclear power is prohibitively expensive. This is crucially important in an era when the government is scrambling to cut its huge deficit, and when its own Drummond Commission called for real per capita cuts in spending amounting to a massive 16.2 per cent of program spending.[189]

While the government itself is budgeting $33 billion for its nuclear plans, which alone would elbow out other more cost-efficient investments, the track record of nuclear projects is not impressive. Every nuclear project in Ontario has gone considerably over-budget, on average about 2.5 times.[190] Ontarians concerned about their rising hydro bills are still paying for the huge cost overruns from reactors built decades ago. Compare nuclear plants, where there is no protection for consumers, with renewable energy where Ontario's feed-in tariff guarantees that only the cost of electricity generated is passed along to Ontarians and the cost of overruns and unforeseen liabilities is borne by the developer.[191]

3. CONSERVATION AND CLEAN ENERGY – BETTER OPTIONS

It is clear that conservation has not been the priority it should be. In 2010, the Ontario Power Authority (OPA) reported reducing demand by 430 MW, yet contracted for 13,409 MW of electricity supply. Calculations by the Ontario Clean Air Alliance illustrate that the OPA's payments for energy efficiency are 78 to 89 per cent lower than the cost of new nuclear power supply.[192] If Ontario is serious about building a "culture of conservation,"[193] the playing field must be much more level.

As the Ontario Clean Air Alliance points out, Ontario's demand for electricity has dropped by seven per cent since 2006, but our usage of electricity per person continues to be 35 per cent higher than our neighbours in New York.[194] Clearly there is much room for improvement. Rather than basing its electricity plan on massive increases to supply (63 per cent higher generation in 2030 than in 2010), the government must focus on greatly enhancing conservation efforts to cut waste and improve energy efficiency.

Combined heat and power is cleaner and safer than most other sources and should play a more prominent role in the overall diversity of power sources in Ontario.[195] By simultaneously producing heat and electricity from the same molecules of natural gas, CHP provides energy efficiency of 80 to 90 per cent. Many hospitals (for example London Health Sciences Centre, Sudbury Regional Hospital, Kingston General Hospital) and other facilities, such as the University of Toronto and Pearson International Airport already employ combined heat and power.[196]

Ontario is proposing a target of 10,700 MW by 2018 from wind, solar and bio renewable energy. This would include continuing such clean energy programs as the Feed-In Tariff (FIT) and microFIT that encourage businesses to build and supply clean energy and homeowners to produce clean energy and connect to the grid. Under the long-term energy plan, renewable sources would provide Ontario with 15 per cent of its electricity supply by 2030, compared to about three per cent today.[197]

Following the 2011 provincial election when green energy and the Feed-In Tariff in particular were major political issues, the newly appointed Minister of Energy, Chris Bentley, announced a review of the FIT program. While the Feed-In Tariff was intended to be reviewed every two years in any event, the announcement triggered uncertainty in the sector and it remains to be seen whether rapid growth in renewable energy in Ontario will continue at the same pace.[198]

Of the renewable options, wind is touted as having huge potential to deliver clean, plentiful and affordable power. In Canada, it is estimated that wind will meet at least 20 per cent of the country's power needs by 2025, up from the current 1.1 per cent.[199] [200] As of late 2010, there were a total of 690 wind turbines in Ontario.[201] Both wind and solar energy developments can be expected to come under greater public scrutiny to ensure they are properly sited and scaled as the industry continues to grow.

Opponents of wind turbines are demanding a moratorium on all further development pending a full health study of their health impacts, and to restore community control over local wind initiatives.[202] At this time, the predominance of expert opinion, though, is that a general moratorium or "time out" is not necessary or supported by the evidence. Ontario's Chief Medical Officer of Health acknowledges that some people living near wind turbines may report symptoms such as headaches and sleep disturbance, but in a comprehensive review of existing scientific evidence, Dr. Arlene King found no causal link between wind turbine noise and adverse health effects at common residential setbacks.[203]

That is not to say that changes are unnecessary. Government and renewable energy companies must do more to fully engage communities as partners in future developments.[204] [205] As with any development project that potentially impacts communities and the environment, environmental assessments must be robust with timely and proper consultation with local communities. Communities must be full partners in ensuring siting and setback decisions meet local needs.[206] Dr. Arlene King, Ontario Chief Medical Officer of Health suggests that community engagement at the very outset of planning for wind turbines and indeed any renewable energy development is important and may help address health concerns.[207] Such a process will help to mitigate potential risks to health such as sound, low frequency sound, ice formation and shadow flicker.

The health effects of wind turbines have been extensively studied, and further studies are ongoing. The RNAO looks forward to reviewing and evaluating new information on both wind and other energy sources such as solar as it becomes available.

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