Discussion of Current Issues

In this section, we provide information on current health-care issues.

Current Issues

Every day, we are confronted with important policy issues in our practice, in our children's schools, and in our communities. To effectively take action on an issue, we often need to have background information that will support our positions.

This is where the Policy Department can help you. We have included information on five current issues in health-care to assist you in your efforts:

- For-profit vs. not-for-profit delivery
- Local Health Integration Networks
- Public-private partnerships (P3s)
- 70% full-time employment for RNs
- Homelessness

The information is provided in different formats to give you an idea of the different ways in which issues can be approached and discussed.

Check out our website at www.rnao.org for up-to-date information on these and other issues.

FACT SHEET: FOR-PROFIT VS. NOT-FOR-PROFIT HEALTH CARE

In June 2005, the Supreme Court Chaoulli decision heated up the debate on two-tier health-care across the country. While this decision only applied to the provision of private insurance in Quebec, it has rekindled the debate about whether private health-care is cheaper, better, or faster.

Is for-profit delivery faster?

- Countries with parallel private hospital systems have larger and longer public wait lists than countries with a single-payer system [1].
- The more care provided in the private sector in a given region, the longer the wait times for public hospital patients [2].
- Parallel private systems "cherry pick" patients who are healthier, younger or have conditions that are cheaper to treat.
- Parallel private systems don't increase the number of health care practitioners; rather, practitioners are split into two systems, creating an incentive for doctors to lengthen waiting lists in the public system [3].

Is for-profit delivery better?

- Studies show that the quality of care in for-profit institutions is lower [4] [5] [6] [7].
- Systematic review and meta-analysis of all available peer-reviewed literature on for-profit vs. not-for-profit health care delivery found higher patient mortality rates in for-profit as compared to non-profit centres [8] [9].

Is for-profit delivery cheaper?

- *Higher administrative costs:* In 1999, administrative costs in the US were $1,059 per capita as compared to $307 per capita in Canada. Overhead costs for Canada's medicare system were 1.3 percent as compared to 13.2 per cent for Canadian private insurers [10].
- *More expensive services:* A systematic review and meta-analysis of all available peer-reviewed literature in the Canadian Medical Association Journal concluded that for-profit hospitals charge a significant 19 percent more than not-for-profit hospitals [11].
- *More expensive financing model:* P3s are more expensive because of higher borrowing costs for the private sector, transactions costs, and the added costs associated with profits [12].
- An estimate of the increased interest costs associated with the Brampton Hospital alone is $175 million, or the cost of more than 2,000 FTEs.

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BRIEFING NOTE: LOCAL HEALTH INTEGRATION NETWORKS (LHINS)

The implementation of Local Health Integration Networks is a key part of the Ontario government's health-care transformation agenda. LHINs will become accountable for and have the authority to make planning and funding decisions for local health services.

In November 2005, the provincial government introduced Bill 36, the Local Health System Integration Act. The legislation will go through the Committee process, and plans to be passed in 2006.

BACKGROUND

How will LHINs operate?

- Ontario has been divided into fourteen LHINs, each with specific geographic boundaries. Each LHIN will be led by a nine-person Board, including a CEO.
- Each LHIN will be funded by the provincial government, governed by a board of directors appointed by the provincial government, and bound by a memorandum of understanding and a performance agreement with the Ministry of Health and Long Term Care.

What will LHINs be responsible for?

- Hospitals (including divested psychiatric hospitals)
- Community Care Access Centres
- Community Support Service Agencies
- Mental Health and Addictions Agencies
- Community Health Centres
- Long-Term Care Homes

LHINs will not oversee:

- Physicians
- Ambulance Services (emergency and non-emergency)
- Laboratories
- Provincial drug programs
- Public health

What is the government's timeline for LHIN implementation?

The government plans that each LHIN would be responsible by 2007/08 for:

- Local health system planning in accordance with MOHLTC strategic directions
- Local health system integration and service coordination (including integration with other LHINs)
- Accountability and performance management (including accountability agreements with health service providers funded by LHINs)
- Local community engagement
- Evaluation and reporting
- Funding

- Providing funds to health service providers within the scope of LHINs and within the available LHIN funding envelope
- Providing advice on capital needs to MOHLTC

KEY ISSUES/CONCERNS WITH PROPOSED LEGISLATION

We have two major concerns with the proposed legislation: it will facilitate the expansion of for-profit providers in the health care system; and, that it could result in the expansion of the competitive bidding process as a method of allocating health funding.

Increased For-Profit Delivery

- There are no provisions in the Bill which would require or even encourage LHINs, the Minister, or Cabinet to preserve or expand public, not-for-profit delivery of health care services.
- The Bill provides the Minister, on the advice of LHINs, with powers to order not-for-profit providers to:
    - cease operating; to dissolve or wind up operations;
    - amalgamate with other not-for-profit providers;
    - transfer all or substantially all its operations to another not-for-profit provider.

The Bill does not provide the Minister with similar powers with respect to for-providers; this imbalance could facilitate the expansion of the for-profit sector.

We are profoundly concerned because the bill allows LHINs to make decisions that will facilitate or require health service providers to contract out any and all services (s26(1)(4)) and allows Cabinet to order contracting out of "non-clinical" hospital services (s. 33(1)).

This bill would provide LHINs with the legislative authority to contract out everything from nursing to housekeeping services.

Competitive Bidding

Extending competitive bidding as a method of allocating funding to a broad range of health service providers would be expensive, inefficient, and lead to deteriorating health outcomes. Government officials have stated that there is no intention to extend competitive bidding beyond home care sector. However, any legislation passed will continue beyond the current government and Minister. As a result, that intention must be enshrined in the proposed legislation.

Suggested Amendments

We are asking for the following amendments:

- A prohibition on LHINs using competitive bidding as a method for allocating funding to health service providers.

- A requirement that any integration decisions that provide for a transfer of services must, in the first instance, be to not-for-profit providers. Only if not-for-profit providers are unwilling to accept the transfer of health services, should transfers to for-profit providers occur.

- Integration between a for-profit provider and a not-for-profit provider should only be allowed if the resulting health service provider operates on a not-for-profit basis.

- The Bill provide the Minister with the same powers over for-profit and not-for-profit providers.

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BRIEFING NOTE: PUBLIC-PRIVATE PARTNERSHIPS (P3S)

In the lead up to the 2003 election, Premier McGuinty promised to bring the Royal Ottawa Hospital and William Osler Health Centre in Brampton into the public system as quickly as possible. Shortly after the government was elected, it announced that the projects in Brampton & Ottawa would go ahead. The contracts were modified only to provide for public ownership.

Subsequently, the government announced a program of alternative financing and procurement (AFPs) for hospitals and other public infrastructure. Its position is that AFPs are not P3s because they will remain publicly owned and controlled. However, they will be privately financed, and the government has not committed to public operation. Many of the problems associated with P3s arise from private financing and operations.

The government says this method of financing will offer the following benefits:

- Accelerated investments in infrastructure
- Transferring the risk of cost overruns and missed deadlines to the private sector
- Enhanced expertise, skills and dependability
- Earlier construction starts on more projects
- More effective project management and monitoring
- Transparency and fairness in processes
- On-time, on-budget project delivery

Does the evidence support the government's claims?

- Studies show that costs tend to be much higher, and frequently, the quality of the service is reported to be poor [1] [2] [3] [4] [5]. Moreover, auditors general are concerned about P3's lack of transparency.
- The evidence also shows that risk transfer is both unclear and comes at a high cost (about a 30% increase) [6].
- The study that the government uses to support its contention that cost over-runs are less likely in P3s has limited applicability, as it compared P3 project constructions costs with public sector ones over 2 different time periods [7].

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Recent information about the British experience with P3s (PFIs) provides further cause for concern about the costs and longer-term impact of these kinds of agreements on hospitals. The Queen Elizabeth, a P3 hospital in London, became technically insolvent late last year. A report by Price Waterhouse Cooper stated that problems were particularly severe at this hospital

because of the high costs associated with its P3 agreement. The hospital estimated that this method of financing increased costs by £9m a year, or 150%, compared to the costs to an equivalent hospital built with money borrowed from the government.[16] The report states that without the added costs associated with the P3 financing, the hospital would be more efficient than others of similar size and nature.

The Economist newspaper stated that the extensive use of private finance to fund new hospitals is bad policy, and it stated that the right lesson from the Queen Elizabeth hospital is to suspend further PFI commitments [17].

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BRIEFING NOTE: 70% FULL-TIME EMPLOYMENT

Following their 2003 provincial election victory, the Liberal government introduced a Nursing Strategy for Ontario to address key areas of instability in the nursing workforce. The Strategy aims to increase the number of full-time positions for registered nurses to 70 per cent; hire 8,000 new nurses; improve retention and recruitment of all nurses; and improve work environments for nurses and other health professionals.

We support the efforts that the government has made so far, and we ask them to continue their progress by revitalizing their commitment in five key areas:

- Funding to ensure that no RNs are laid off as a result of hospital balanced budget plans;
- Increased targeted, conditional funding to health care organizations in all sectors to increase the share of RNs working full-time;
- Additional targeted funding to ensure that all newly graduating RNs can attain full-time employment;
- Tuition reimbursement for new graduating nurses willing to relocate to underserved northern and rural communities (1:1 and up to a total of four years BScN education);
- Ongoing targeted funding toward the 80/20 strategy (80% clinical work and 20% mentorship and educational activities). This funding will allow experienced RNs to mentor new graduates to ease their transition into the workforce and support retention of both new graduates and experienced RNs.

Full-Time Employment

- 70 per cent full-time employment for RNs is essential to improving patient outcomes; ensuring system cost-effectiveness; improving recruitment and retention; and ensuring sustainability of the nursing profession.
- RNAO strongly supports the government's conditional, targeted funding of $50 million to hospitals to increase their full-time nursing workforce. However, we are concerned that this amount is insufficient to reach the goal of 70 per cent full-time employment for RNs. $50 million per year amounts to less than two per cent of hospital nursing salaries and benefits.[1]
- While the hospital sector has received targeted funding for full-time positions, other sectors, such as home care and long-term care, have not.

Recruitment and Retention

- 53% of RNs employed in Ontario are over the age of 45 – more than half of the nursing workforce. [2] This means that more than 45,000 expert RNs will be eligible to retire in the next ten years. This impending shortage and loss of nursing expertise and experience will have negative implications for quality patient care and the next generation of nurses.
- The Late Career Initiative was initiated in 2004-05, and provided one-time funding of $28 million in 2005-06 for nurses in hospitals and long-term care facilities. This funding allows nurses over the age of 55 to spend part of their working hours in 'less physically demanding' roles, such as patient teaching or staff mentoring.

- 95% of young nurses surveyed for RNAO's 70 Per Cent Solution indicated a strong preference for full-time employment, yet were the least likely age group to have it (only 38%). [3] Similarly, a 2004 survey by the Nursing Health Services Research Unit showed that while 79% of nursing graduates wanted full-time employment, only 37% were able to attain it. As a result, graduates have had to consider other options: more than 50% of graduates in southwest Ontario were considering employment in the United States**.**[4]
- The New Graduate Initiative provided 1,000 graduates with six months extended orientation to gain full-time experience in 2004-05.

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POLICY STATEMENT: HOMELESSNESS

Everyone in Ontario has a right to adequate shelter. Article 25.1 of the United Nations' *Universal Declaration of Human Rights* (1948) states that:

> *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control"*

Adequate shelter is a basic prerequisite of health. Without it, there are far reaching implications on other determinants of health. The Registered Nurses Association of Ontario (RNAO) believes that nurses have a professional and moral responsibility to speak out against homelessness to ensure and protect the overall health of Ontarians.

There are different ways in which homelessness occurs. These include:

Absolute Homelessness: Individuals sleeping outside or using public or private shelters

Concealed Homelessness: Individuals who are provisionally lodging with friends or family

Risk of Homelessness: Individuals struggling to meet core housing needs of which affordability, suitability and adequacy norms are all elements

The 1993 cancellation of Canada's national housing program, the 22% reduction of welfare rates in Ontario, the 1998 cancellation of the Ontario Rental Housing Protection Act and the continuing loss of private rental (between 1996 to 2001: 44,780 units lost)[1] and social housing (between 1995 to 2003: 82,900 units lost) have had an enormous impact.[2] These stark realities have prompted Toronto, Ottawa and Durham Region municipal councils to declare homelessness a national disaster.

Homelessness is not just a "big city" problem; it is an issue throughout all Ontario communities. Approximately 1.5 million Ontarians spend more than 30% of their total household income on rent.[3] By January 2004, Ontario had 158,456 households (approximately 300,000 individuals) on waiting lists for social housing of which 46.5% were families. [4] In Ontario approximately 390,000 children live in poverty.[5]

The reality of homelessness is complex. Multiple interconnected and interrelated determinants come together setting the stage for homelessness. Determinants include supply of affordable housing (gentrification), falling incomes (poverty), unemployment, social factors (which include substance abuse, lack of supports and services, prison release and mental illness), education, domestic violence and vulnerable groups (encompassing sex, race, socioeconomic status, disability and sexual orientation).

- Shelter use is on the rise, increasing by 51% for single parent families between 1990 and 2002.[6]

- Aboriginal peoples are over-represented in Canada's homeless population by a factor of 10.
- In 2002, 22% of all shelter users were youth between the ages of 15 to 24.[7]
- One in five cases of Toronto children taken into CAS care was directly related to housing issues during 2000 – a 60% increase from 1992.[8]

Homelessness precipitates an exponential increase in negative health consequences affecting individuals, families and communities. Mortality, violence, mental illness and morbidity rates all elevate. [9]

- 18 to 24 year old Toronto homeless men are over eight times more likely to die than their housed counterparts[10]
- 18 to 45 year old Toronto homeless women are ten times more likely to die than their housed counterparts[11]
- Thirty-three percent of homeless individuals have a severe mental illness [12] with homelessness itself, a source of some mental illnesses (i.e. depression)
- Tuberculosis is 20 to 300 times more likely to develop in a homeless individual [13] with more than half being primary TB cases. [14]
- Homelessness is associated with a higher risk and prevalence of HIV, hepatitis C, gonorrhea and *Chlamydia*[15]
- Asthma, emphysema/chronic bronchitis and epilepsy rates in homeless individuals are respectively 3, 5 and 6 times that of the general population.[16]
- The incidence of bed bugs within Toronto shelters has risen since 2001 despite control measures increasing the risk of skin infections, sleeplessness and a source of considerable psychological distress. [17]
- Preventable skin and foot problems such as scabies, cellulitis, tinea pedis and trenchfoot are frequently seen amongst homeless individuals.[18]

Managing and preventing these negative health consequences requires proper nutrition, acquisition of medication, storage of medication, adequate rest, hygiene and safety. These all pose serious challenges for homeless individuals.

Unfortunately, the relationship between the determinants and the outcomes of homelessness exist within a spiraling cycle where each subsequent event reinforces the former. Circumstances may have induced homelessness but the ensuing challenges and outcomes render the climb out extremely difficult. In addition, discrimination, stigma, powerlessness and social disaffiliation shape the lived experience of homeless individuals and families.[19]

Nurses must be aware of homelessness and basic housing needs in each facet of their practice. This should include all three dimensions of housing which include: house (physical structure), home (social and psychological characteristics) and neighbourhood (physical location and available services).[20] Part of this process will require education and a reflective review of our own beliefs and practices surrounding homelessness.

Nurses also have a responsibility to educate the public and advocate on behalf of homeless individuals – for health. Since many determinants of homelessness are of a systemic nature, advocacy needs to extend to governments as well.

Ontario needs realistic and concerted efforts by all levels of government to reverse the trend of increasing homelessness and ultimately eliminate homelessness altogether. As a result, RNAO calls on governments to:

- Increase the per diem rates to municipalities for homeless shelters to cover the actual cost of operating shelter beds, services and adequate infection/infestation control measures
- Increase funding for affordable social housing, implementing an interim plan to shelter the increasing numbers of homeless until the promised housing is available
- Adopt the recommendation of the Coroner's Jury at the Kimberly Rogers inquest to base social assistance rates on actual living costs
- Support the *One Percent Solution* which calls on governments to spend an additional 1% of their budget on housing

Homelessness is every Ontarians' issue. Homelessness is every nurse's issue. We can no longer speak out for health without speaking out against homelessness.

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