Submission to the Ministry of Health on Bill 60, Your Health Act, 2023

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The Registered Nurses' Association of Ontario (RNAO) represents more than 50,000 registered nurses (RN), nurse practitioners (NP) and nursing students across the province. For nearly a century, the association has advocated for changes that improve people's health. RNAO welcomes the opportunity to present the views of nurses on Bill 60, Your Health Act, 2023.

Introduction

RNAO's vision is of an Ontario that creates the conditions for health and wellness for everyone, that addresses the many determinants of health. This means a system that is:

- **accessible,** with interprofessional care teams anchored in the communities where people live, work and play
- **person-centred,** where a person and their support system are viewed as a whole and empowered to be genuine partners for their own health
- **equitable,** where deliberate efforts are made to decrease gaps in health outcomes, services and experiences
- **integrated,** where care is coordinated so that transitions from sector to sector and service to service are all seamless
- **publicly-funded and not-for-profit,** so that it is sustainable, efficient and equitable and everyone – no matter their means – receives the care they require

Bill 60 threatens this vision by attacking the foundations of universal health-care delivery in our province. In laying the framework for a parallel for-profit delivery system, its provisions will vitiate the already-beleaguered health human resources within the public system and undermine existing self-regulation of health professionals, including nurses.

More generally, we are deeply concerned that profitizing health-care delivery in our province has been put forward in far-reaching draft legislation that leaves substantive content largely to regulation – and possibly policy – with less than five weeks between bill introduction and termination of limited public input. Major changes impacting our public health-care system – a system so highly valued and so integral to Ontario's and Canada's social and political fabric – warrant far fuller transparency and meaningful opportunity for comment. This is especially true given the open-ended powers the bill would give to ministers, cabinet and, most problematically, unelected "directors."

We urge the government to withdraw the bill for the reasons that follow.

A. The bill ignores the evidence that expanding delivery of health care to the for-profit sector will result in poorer outcomes at higher cost.

The issue

Bill 60 proposes to greatly expand for-profit provision of health care through exploiting public concerns about patient wait times. If proclaimed, Bill 60 will result in a massive transfer of health-care services and resources, including health human resources, to the for-profit sector through broadly-defined

"integrated community health services centres". The evidence shows that this will result in poorer health outcomes at higher cost to the system.

The complete lack of detail in the bill about these centres also causes concerns about longer-term plans for profitization of health-care services beyond the limited scope alluded to by government officials in their announcements. It suggests that in the future these centres will not be limited to what the government has termed "routine" procedures. Nothing in the bill limits the type of surgery that could be moved to for-profit sector delivery, nor precludes the extension of these for-profit centres into other health system sectors, including primary care.[1] Nor does the bill limit the type or "class" of health facility, leaving this to regulation.

Discussion

Bill 60 proposes to greatly expand for-profit provision of health care in Ontario by shifting a presently-undefined range of procedures and services from public hospitals, and potentially other health care settings, to new facilities called "integrated community health services centres". Although details about the plan to establish these new entities are notably lacking in the bill, it is clear to RNAO that not-for-profit health-care services will transfer overwhelmingly to the for-profit sector – more than 97 per cent of Ontario's existing independent health facilities are for-profit agencies[2] and we expect this trend to continue. Abundant evidence shows that diverting public services to for-profit agencies will have major adverse effects on patient safety, access and cost of care.[3]

Patient safety

The bill broadly defines "integrated community health service centre" as including "a health facility, including a community surgical and diagnostic centre, or a class of health facilities, that is prescribed" (that is, later defined in regulations at the sole discretion of the cabinet).[4] The lack of constraint on services to be delivered through what will become a for-profit health-care system parallel to our publicly-funded health system raises two immediate concerns. First, nothing in the bill restricts shifting more complex and less "routine" surgeries than those alluded to by the government – that is, hip and knee replacements and cataract surgeries – out of the public hospital system. Second, the bill does not disclose nor limit the full range of services that could be potentially conducted by these centres. Without these constraints in place, the bill poses an enormous threat to our not-for-profit health system and, importantly, patient safety.

Indeed, there is abundant evidence in multiple studies about the poor track record of for-profit health-care entities in delivering safe, effective care.[5] [6] [7] [8] For example, England's experiment with outsourcing health services to private for-profit providers resulted in an increase in treatable mortality rates of 0.38 per cent for every percentage point increase in outsourcing.[9] The profit motive has been shown to spark ingenuity in perverse ways in the context of health care, such as cutting corners in areas where the risk of detection is low, "upselling" by offering unnecessary services to patients for a fee, and encouraging creative billing for services already covered by public insurance.[10] Indeed, the situation of upselling and extra billing is already rife in private clinics across Canada.[11] [12] [13] Nor is it reassuring that Bill 60 expressly allows for selling uninsured services.[14]

The profit motive also interferes with the objective assessment of the interests of patients and the risks to them. How the profit motive might affect the practices of for-profit facilities will depend on which incentives are embedded in the potential profit sources – as yet, not prescribed or outlined in regulations. For example, facilities could refuse to provide services with any foreseeable risk of complication, burdening the public hospital system with costs and complications and creating further delays for patients. Or, facilities could take risks – including, for example, providing invasive surgeries and therapies where less profitable non-invasive responses would suffice – in order to receive the profit associated with the provision of the service, secure in the knowledge that any complications can be quickly transferred back to hospitals. Whatever the incentives embedded in the fee structures yet to be prescribed, these incentives will shape assessments of risk and compete with the interest of evidence-based care and safety.

Against these heightened risks, patients must hope that the oversight and accountability for quality of care will be stronger than they are in public hospitals. That is entirely speculative and most likely disingenuous, because inspections of these new facilities would not be conducted by the ministry as is currently the rule. Any oversight mechanisms are entirely at cabinet's discretion to be decided at some uncertain time after passing of this proposed legislation.[15] Appointment of third-party inspection bodies would also be left to the discretion of cabinet, the minister or unelected "directors".[16] [17]

Access

As noted above, diverting the delivery of publicly-funded health-care services to the for-profit sphere provides incentives and opportunities to introduce additional fees and charges for some services traditionally covered by our public health-care scheme irrespective of protections written into the bill. These could operate as insurmountable barriers to many Ontarians, resulting in a full-blown two-tier system, with higher-income Canadians able to buy their way to the front of the queue.[18]

This blatantly undermines the primary objective of the Canada Health Act "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[19] Further, to the extent that for-profit provision raises expenditures as addressed in the next section, the total volume of services for any given expenditure will drop, meaning overall access to health-care services would be worse than if the funding had stayed in the public sector. That is, the higher the cost of providing a specific service, the fewer of those services can be provided.

Cost

It makes little economic sense to create or augment a parallel system that duplicates and competes with services already supplied in the public health system. RNAO anticipates a net increase in health system costs to result from any move to profitized delivery of health care. First, this would duplicate infrastructure that is already available for use. Ontario's auditor general and the Financial Accountability Office have both noted that even as wait times are excessive for some procedures, hospital facilities

such as operating rooms are going unused much of the time, often for want of staffing – particularly nurses.[20] [21] It is wasteful to throw money at for-profit surgical facilities when that capacity already exists in the public sector.

Second, it would duplicate the administrative system already serving the public sector by creating a parallel, competing bureaucracy to oversee the "integrated community health services centres" system. Although details about this new regulatory scheme are almost completely lacking, this would doubtless entail considerable negotiation, documentation, oversight and expense. Worse still, there could be insufficient oversight, as Ontario's auditor general noted was the case in their report on outpatient surgeries.[22] The report flagged deficient monitoring of: unreasonable surgery volumes and billings, additional fees charged to patients for publicly funded services, and misleading information given to patients. The auditor general noted also that these deficiencies and the underuse of hospital operating rooms had been highlighted in numerous previous value-for-money audits,[23] so this is a long-standing problem. It does not speak of a government commitment to oversight and monitoring of for-profit clinics.

As recognized in the bill which allows for various types of costs[24], the new "integrated community health services centres" would be obliged to negotiate high payments to cover infrastructure expenses, fees related to licensing, and other costs – and to mitigate any risk related to uncertainty of patient volumes. It is highly unlikely that investor-driven for-profit health providers would go to the trouble and expense of entering into these agreements and licences without the prospect of substantial revenues and profits. This is evidenced by Ontario's paying for-profit centres at least 25 per cent more for cataract surgeries than hospitals are paid,[25] even though hospital capacity could be boosted to perform more cataract surgeries.[26] Any health care services that are outsourced ought to be transparently costed to demonstrate cost savings, but such transparency can be obstructed in Canada by confidentiality agreements.[27] In this regard, RNAO notes that the bill expressly makes all information in license applications confidential.[28]

Summary

The evidence, economic logic and lack of restrictions in Bill 60 on the types of health services it applies to point to higher costs and higher patient risk should the bill be proclaimed. It is not reassuring that the bill omits any requirement that applications to become a "integrated community health service centre" demonstrate cost savings or quality improvements. With a given budget, there is less health care provided due to higher costs, which reduces access. There is the inevitability of more two-tier health care, as the opportunities to jump the queue expand, and as resources, including scarce health human resources, transition away from more accessible providers like hospitals – meaning that people with low incomes will have less access.

It is difficult to see how a parallel for-profit health care delivery system will be anything but utterly destabilizing for the current health system. It will compete for resources and funding and cherry pick the profitable procedures, leaving the most costly and complex procedures to be borne by the public hospitals and the not-for-profit sector. Furthermore, the government also plans to ensure that the for-profit clinics have physicians with admitting privileges in hospitals, so that patients who experience complications may be quickly transferred to hospitals.[29] This is another incentive to stint on quality care, as consequences of inadequate care are borne by the public hospital. Tragically, at the same time as

hospitals are stripped of more and more resources, they will end up caring for sicker and more complex patients, creating – by design – a vicious cycle of public discontent.

More generally, this gigantic expansion of the for-profit sector will transform the body politic of Ontario health care, reducing transparency and oversight and multiplying the risk of self-dealing and corruption. It will also create a second power base that has a strong interest in regulatory capture and in distortion of policy-making in the province. If you put a pot of money on the ground, people will take it, and those best organized to do so will end up with the lion's share.

None of this is needed. Our publicly-funded system already has infrastructure to address the surgical needs of Ontarians. A more cost-effective approach would make full use of existing capacity rather than creating a parallel system at great cost. For example, we presently have publicly-funded operating rooms standing idle on evenings and weekends. To meet the goals of filling the gaps, shortening wait times and equitable access for all Ontarians, RNAO recommends policies and programs to retain and recruit health human resources (HHR) -- something completely lacking in Bill 60.

B. The bill will make Ontario's longstanding nursing shortage even worse.

The issue

The creation of a parallel for-profit health delivery system in Ontario will further destabilize the already understaffed and highly-stressed public sector health workforce through the poaching of nurses and other health professionals into for-profit work settings. Any protections in the bill purporting to address the sustainability of the public sector workforce lack credibility. Moreover, the bill fails to address the current gaps in nursing HHR exacerbated by the COVID-19 pandemic and the real income losses imposed on nurses by Bill 124.

Discussion

Ontario is experiencing a full-blown nursing staffing crisis based on historically low RN-to-population ratios exacerbated by the impact of the pandemic and government policy undermining the worth of nurses and their contribution to an effective health system. This has most recently been highlighted in a report by the Financial Accountability Office of Ontario (FAO), which noted elevated nursing vacancy rates.[30] The report conservatively estimated a need for a 26 per cent increase in nurses just to meet program commitments in hospitals, home care and long-term care and to return to pre-pandemic vacancy rates.[31] It noted that Ontario would not be able to meet those commitments without filling the nursing and personal support worker shortfalls. The FAO conservatively targets maintaining existing or "normal" service levels (that is, same staffing per bed), so its staffing shortfall estimates are accordingly conservative. Indeed, the FAO attributed long wait times and closures in emergency departments (ED) to existing staffing shortages – particularly of nurses and physicians[32] – so, solving the ED problem would require more additional staff than the conservative shortfall estimate would suggest. The FAO's projection for the number of nurses and personal support workers required to be hired does not reflect an assessment about the quality of services that should be provided by these programs.[33]

The FAO also noted that the province's wage restraint policies resulted in Ontario nurses having the lowest wage rates in Canada, which is a retention and recruitment problem.[34] And, in another recent report, the FAO noted that high nursing vacancy rates were causing hospitals to cut back services.[35]

RNAO has repeatedly advised this and previous governments to invest in and improve nursing human health resources (HHR) in Ontario.[36] As recently as February 2023, RNAO made several recommendations to this government about HHR[37],shared at the end of this submission.

Although Bill 60 and its promotional material offer reassurances[38] about protections against destabilization of the health-care workforce, they are not persuasive. The bill provides no mechanisms to address the current and profound level of staffing shortages in the public sector that are the cause of the surgical and diagnostic backlogs that, nominally at least, give rise to this bill.

Although the bill does allude to the "availability of sustainable health human resources" as one or many considerations in the licensing process for new integrated community health services centres,[39] no criteria are available for review to assess how licensing determinations would be made with this in mind. Absent regulations available for review, it is not possible to assess whether the government even contemplates imposing conditions to safeguard HHR in the public health system, let alone how such conditions would work in the real competitive world.

Stability of the HHR workforce is the major binding constraint on health care delivery, and **all** health policy should include a lens for its adequacy and stability. RNAO is troubled by the lack of specificity in the bill as presented for public consultation on this front, especially given the evidence and feedback on HHR we and many others have provided this government on behalf of nurses and other health professionals. We are also mindful that any HHR policies ultimately created by Bill 60 and its regulations will not be restricted to the acute care sector, and may well conflict with policies existing in other sectors such as long-term care. Absent a comprehensive and credible HHR retention and recruitment strategy, the likeliest outcome is confusion and further destabilization of the HHR workforce in our province.

C. The bill will undermine the public protection function of Ontario's existing health professionals regulatory colleges.

The issue

Schedule 2 of Bill 60 substantially undermines the regulatory regime in Ontario that governs the registration of health professionals and protection of the public. The disruption of the health professions regulatory framework[40] created by the proposed amendments to several health professions acts will impact professional practice and patient safety as well as the role of regulatory colleges.

Discussion

Bill 60's amendments to health-related legislation to enable nurses from other jurisdictions to practice in Ontario without first registering with the College of Nurses (CNO) would have far-reaching effects on health profession regulation, health-care organizations and the public. Included in these effects is that the CNO would have no regulatory oversight over nurses licenced in different jurisdictions. This would make Ontario's sole regulator of nurses powerless to deal with any complaints about professional practice of these non-registrants.[41] Bill 60 amends the current definitions of all categories of nurse, physician and other health professionals. The revised definitions include a member of the respective college or another "person prescribed by the regulations," undermining Ontario's system of title protection for health professionals. Other health professionals – notably x-ray technologists and laboratory technologists – are also included in this erosion of health professions regulation.

Disruptions to regulatory framework

Our Canadian health system is recognized for safe patient care ensured through a strong health professional regulatory framework that protects titles earned by regulated health professionals and defines and regulates their scope of practice. In Ontario, this means that being licensed to use the titles "nurse", "registered nurse" (RN), "registered practical nurse" (RPN), "nurse practitioner" (NP), and "physician" are restricted to those who have studied in approved educational programs, passed licensing examinations based on clear standards of practice and role expectations, and continually demonstrate professional development and quality improvement.

This means for example in Ontario a nurse licensed by the CNO can call themselves by a protected title, adhere to an authorized scope of practice, follow a professional code of ethics, and are subject to discipline for breach of these requirements – also the case for physicians and the other 26 regulated health professions in Ontario. In turn, employers and managers, other health professionals, and, importantly, the public know what to expect from specific regulated health professionals. For example, they have a level of trust when someone holds themselves out as a registered nurse, that the person is qualified to carry out this role.

With Bill 60's proposed amendments to the Nursing Act and the Medicine Act among others, cabinet can make regulations exempting as yet undefined "persons" from title restrictions as identified above and from holding themselves out as a person qualified to practice in Ontario in one of the restricted roles. Further, these proposed amendments threaten existing scope of practice and role expectations by allowing for the addition of new categories of health professionals under the current protected titles, and potentially incorporating new roles and responsibilities for these additional health workers. This circumvents existing regulatory schemes and presents obvious threats to public perceptions of quality and safety of care, and could undermine public trust in Ontario's health system. For example, these amendments open the door to virtually anyone calling themselves a "nurse" and purporting to practice "nursing" in Ontario, based on the whim of those authorizing and promulgating the regulations – creating the potential to seriously erode public safety and trust in their care provider.

These threats are compounded by proposed amendments to the Fixing Long-Term Care Act, 2021[42] that allow "prescribed persons" to meet the definitions of different classes of nurses and physicians, and remove any form of title protection for safe practice raising similar perils to those identified above. The

fact that these amendments are targeted to the long-term care sector, where public trust related to safe resident care has been severely damaged, renders them even more alarming. To ensure public protection, every health-care sector requires qualified health professionals who meet pre-determined training requirements and standards of competence. This is precisely why we have a rigorous health professions regulatory system which should not be by-passed by operation of unrelated legislation or regulations.

Concerns about insurance and public protection

Through Ontario's regulated health professions framework that outlines controlled acts and scope of practice requirements in relevant legislation and regulation, three categories or classes of nurse have been established – RPN, RN and NP. This helps inform and guide patients, other health professionals and employers on role expectations and limitations. Employers base nursing staffing models on patient needs and role expectations of the three categories of nurse stipulated in the existing regulatory frameworks, which outline who is sanctioned to practice in one of the regulated nurse categories, their standards of education and practice, licensing requirements and their scope of practice.

With these proposed amendments, health professionals such as nurses could find themselves working alongside a "person" authorized – based on some loose discretionary regulatory powers of cabinet – to work as a "registered nurse" or a "physician" but who may lack the qualifications needed to carry out the expected roles and responsibilities. Such situations are fraught with high risk for nurses, health organizations and patients. Nurses and nurse managers delegating or assigning work to such "persons" or directed in tasks by physicians are exposed to complaints or lawsuits alleging professional misconduct and malpractice.

Liability claims against organizations by patients subject to malpractice and medical error are at risk of increasing markedly in this environment fraught with credential fraud and role confusion. Equally concerning is the risk to for-profit and not-for-profit health-care organizations who inadvertently hire "persons" without undertaking special credibility checks related to academic credentials, licensure and references. Robust liability insurance coverage which enhances protection of the public in such cases and offers sound safeguards for health professionals at risk of malpractice claims should be a clear – and clearly delineated – requirement for any new entities authorized to conduct surgeries or provide other services under Bill 60.

While all nurses and other health professionals covered by the Regulated Health Professions Act are required to carry professional liability protection, this will need to be augmented by insurance covering added situations related to the fallout from the "as of right" regulatory amendments in the bill. Such health-care provider insurance protection must be a critical requirement for licensure of an independent community health and surgical centre. RNAO is concerned about this gap in the bill as presented for comment.

Confusion about health professional roles through proposed fast-tracking

Introducing legislation to fast-track the ability of nurses from across Canada to practice in our province is not the solution to the nursing HHR problem which has contributed to our health crisis. Aside from the regulatory instability and confusion resulting from this misguided recruitment process, it is akin to

poaching from other Canadian jurisdictions. RNAO strongly opposes the recruitment of nurses from other jurisdictions nationally or internationally – in particular from developing countries and also from poorer Canadian jurisdictions. We do support registration of internationally educated nurses already living in Canada.

With its proposed regulatory amendments, Bill 60 exacerbates the risk of inadequate public protection for patients, given the variation in current entry to practice standards for RNs across Canada, with some RNs prepared in three-year diploma programs and others in four-year degree programs with different practice expectations. This role and regulatory confusion will not alleviate Ontario's nursing and health-care crisis.

RNAO notes that Ontario, with its nursing workforce shortage of 24,000 RNs[43] and a vacancy rate of over 10,000 RNs,[44] drew just over 500 new registrants from other provinces and territories in 2021,[45] making it clear the province's health-care landscape is not attractive. Moreover, the scope of our current nursing HHR shortage does not result from a lack of nurses licenced to practice in Ontario – approximately 18,000 Ontario nurse registrants are currently working outside the province, employed in non-nursing positions or not employed.[46] As RNAO recommends further in this submission, investments in nursing HHR to offer better pay and working conditions to the many nurses already licensed to practice in Ontario are key. Yet, Bill 60 does not speak to this issue.

While RNAO has long called for country-wide registration parity in nursing, it must be achieved through a pan-Canadian collaborative approach where all provinces and territories agree to make changes without disrupting health professional regulatory frameworks or jeopardizing patient safety. Instead, the "as of right" rules enshrined in Bill 60 open the door to a unilateral strategy likely to result in confusion. By all means, the College of Nurses of Ontario ought to be supported to process nursing applicants in a safe and expeditious way, but circumventing self-regulation is a risky and counter-productive approach.

D. The bill is too far-reaching in scope and confers too much discretionary power on undefined "directors".

The issue

As already noted, Bill 60 would make sweeping changes to the Ontario health system, greatly accelerating profitization of care and the advent of a two-tier health care system. The bill contains no limitation on the kinds of services that could be shifted to for-profit providers, and virtually no limitation on which private entities could start to offer health services. It also undermines the complex system of health human resources regulation long in place in our province, risking public safety and public confidence in nurses and other health professionals.

Discussion

Of profound concern to RNAO is the heightened powers conferred on the minister, cabinet and (as yet unspecified or undefined) "directors" to prescribe by regulation the key details related to the future provision of health services in Ontario. The bill itself contains no seeming limits on the outsourcing of publicly-funded health services to the private sector. No piece of legislation should accord this level of discretionary power to any of those bodies. Particularly worrisome is the level of discretion given to unelected directors – shadow figures outside the electoral process – through unshared (as yet) regulations.

RNAO believes that the government owes all Ontarians far more detail regarding any legislation making such profound changes to provision of health services in our province. The issues and spending priorities covered by the bill are far too important to every single person in Ontario to be presented without full information and context. Unlike other sectors that necessitate massive public expenditures in the public good – for example, the justice system, income maintenance, transit – every single person in Ontario is bound to intersect with the health system at some point, and likely multiple points, in their lifespan.

Ontarians deserve full transparency so that they can better assess, understand and comment on drastic changes which will impact their access to health services, and which may conflict with other overarching legislation like the Canada Health Act. Powers given by the bill must be commensurate with the task at hand and subject to transparent review.

Recommendations

1. Withdraw Bill 60 in its entirety.
2. Clear the backlog of surgeries, treatments and procedures in a safe and timely way by making available operating rooms, step-down units and diagnostic facilities and equipment in public hospitals twenty-four hours per day, seven days per week.
3. Mandate any and all existing and new independent health facilities to provide professional liability insurance protection to their entire staff.
4. Make available to the public hospital system all staff needed to make these facilities and services functional and safe.
5. Develop a comprehensive nursing HR program with ambitious retention and recruitment elements, including:
    a. Withdraw the appeal of Bill 124 and negotiate compensation to make nurses whole after the imposition of the Bill.
    b. Increase compensation for Ontario nurses working in all roles, domains, and sectors so it is competitive with compensation in other jurisdictions including the US.
    c. Address pay disparities among nurses working in different sectors, including primary care, home care and long-term care by harmonizing their compensation upwards.
    d. Increase enrolments, and corresponding funding, in four-year baccalaureate (Bachelor of Science in Nursing or BScN) programs, second entry/compressed programs and RPN-to-RN bridging programs by 10 per cent per year for five years.
    e. Continue to expedite applications and develop and fund pathways for registration of internationally educated nurses who are waiting to be registered to practice in Ontario.

f. Establish a “Return to Nursing Now” program to attract College of Nurses of Ontario registrants back into Ontario’s nursing workforce.
g. Expand the Nursing Graduate Guarantee to ensure access to all new nursing registrants; reinstate the Late Career Nurse Initiative to return recently-retired nurses to the workforce as mentors and preceptors.
h. Ensure safe and healthy workloads for nurses by increasing nurse staffing and supports across all sectors.
i. Implement evidence-based recommendations to retain and recruit nurses by providing full-time employment, mentorship and professional development, occupational health and safety measures and enforcement, as well as safe workloads.
j. Expand extern programs throughout Ontario to benefit both students and health organizations.
k. Fund innovative nursing education-practice partnerships across all health sectors to enable effective preceptor arrangements for nursing students at all levels of education.
l. Increase the supply of NPs by increasing the funding and capacity for student-NP seats and associated program costs. This should include enabling more NPs to be prepared at the PhD/DNP/DN levels for faculty support.
m. Support a 50 per cent increase in the number of NPs by 2030 as set out in RNAO’s 2021 NP Task Force report, *Vision for Tomorrow*.[47]
n. Expand NP scope of practice and innovative models of care, including more NP-led clinics.

Conclusion

Ontario is experiencing an unprecedented nursing and health-care crisis. In response – as demonstrated by Bill 60 – the government continues to ignore the critical role a healthy, robust nursing workforce plays in a highly-effective health system.

The bill gives rise to several other concerns for RNAO – and for all Ontarians. The proposed expansion of health-care delivery to the for-profit sector will result in a full-blown two tier health system in our province. It will not resolve the surgical backlog, as suggested by the government, unless they expend more money than would otherwise be required to keep the services within the hospital system.

Instead, Bill 60, if proclaimed, will lead to poorer health outcomes, higher costs, and less overall access to health-care services for those most in need. The bill will deepen the nursing crisis by draining staff into the for-profit sphere, while leaving the most complex procedures to the public sector. The bill will undermine the longstanding health professions regulatory framework established to protect the public, resulting in lack of proper oversight over health professionals who would be working but not licensed in Ontario. And, the bill will delegate essential components about the delivery of health-care services in Ontario to unnamed and unelected officials, without the public accountability that comes with elected positions.

Access to a universal and equitable health-care system – access that all Ontarians need and deserve – must not be profitized in our province or our country. Bill 60 must be withdrawn in its entirety.

[1] Legislative Assembly of Ontario. (2023). *Bill 60, Your Health Act, 2023* (Bill 60), section 1. https://www.ola.org/en/legislative-business/bills/parliament-43/session-1/bill-60.

[2] Ontario Government. Feb. 21, 2023. News release "Ontario Reducing Wait Times for Publicly Funded Surgeries and Diagnostics". https://news.ontario.ca/en/release/1002732/ontario-reducing-wait-times-for-publicly-funded-surgeries-and-diagnostics. Moreover, more than 97 per cent of existing independent health facilities currently existing in Ontario are for-profit sites: see generally Auditor General of Ontario. (2014). *2014 Annual Report. Independent Health Facilities.* Page 481. https://www.auditor.on.ca/en/content/annualreports/arbyyear/ar2014.html or https://www.auditor.on.ca/en/content/annualreports/arreports/en14/406en14.pdf.

[3] Registered Nurses' Association of Ontario (RNAO). (2014). *Visionary Leadership: Charting a Course for the Health System and Nursing in Ontario – Strenghtening our publicly funded, not-for-profit health care system.* Page 5. https://rnao.ca/sites/rnao-ca/files/vision-docs/RNAO-Vision-Strengthening-Public-Healthcare.pdf

[4] Op. Cit note 1, section 1(1), "integrated community health services centre" at (b).

[5] Braun, R.T., Jung, H., Casalino, L.P. Myslinski, Z. and Unruh, M.A. (2021). Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents. *Journal of the American Medical Association*. Vol. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786442.

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[9] Goodair, B. and Reeves, A. (2022). Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013–20: an observational study of NHS privatization. *The Lancet.* July. Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013-20: an observational study of NHS privatisation - PubMed (nih.gov) https://doi.org/10.1016/S2468-2667(22)00133-5.

[10] RNAO. (2014). Op. Cit. Page 5.

[11] Tomlinson, K. (2017). Some doctors are charging both government and patients privately in illegal double-dipping practice. *Globe and Mail.* June 10. https://www.theglobeandmail.com/news/investigations/doctors-extra-billing-private-clinics-investigation/article35260558/.

[12] Ontario Health Coalition. (2023). *Patients Who Have Been Extra-Billed Thousands of Dollars in Ontario Private Clinics Join Advocates to Call Out Ford Government's False Claims.* Feb. 27. https://www.ontariohealthcoalition.ca/index.php/release-briefing-note-patients-who-have-been-extra-billed-thousands-of-dollars-in-ontario-private-clinics-join-advocates-to-call-out-ford-governments-false-claims/.

[13] Ontario Health Coalition. (2017). *Private Clinics and the Threat to Public Medicare in Canada: Results of Surveys with Private Clinics and Patients.* June 10. https://www.ontariohealthcoalition.ca/wp-content/uploads/final-report-1.pdf.

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