Ontario Pre-Budget 2014: Finding the Right Balance

Submission to the Standing Committee on Finance and Economic Affairs

The Registered Nurses' Association of Ontario (RNAO)

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1) Ensure the fiscal capacity to deliver all essential health, health care, social, and environmental services by building a more progressive tax system.

2) Increase revenue sources that encourage environmental and societal responsibility. Begin by phasing in environmental levies, such as a carbon tax, to help pay for the damage polluters cause and to support the social programs and services most needed by at-risk populations.

3) Work with the federal government to research the scope of tax evasion losses, and then put in resources to recover the lost revenues.

Social Determinants of Health

1) Immediately increase the minimum wage to $14 per hour, and automatically index it to the rate of inflation thereafter in order to bring workers 10 per cent above the Low Income Measure of poverty.

2) Improve access to affordable housing and stimulate job creation in the process.

3) Transform the social assistance system to reflect the actual cost of living.

Environment

1) Set ambitious toxics reduction targets. Ensure people have the right-to-know about the existence of toxics in the environment, in their homes, in their workplaces, and in consumer products.

2) Minimize the energy footprint by: focusing first on conservation and energy efficiency, relying minimally on existing coal plants until they are closed, increasing reliance on renewable energy, and strategically using natural gas and hydroelectricity imports from Quebec to meet any energy shortfall.

3) Create new dedicated revenue sources to pay for a substantial expansion of transit and active transportation**.**

Medicare: Fiscal Issues

1) Work with the other provinces to bring the federal government back to the table to negotiate a 2014 *Health Accord* to replace the expiring 2004 accord. Part of that negotiation would include preservation of the Health Council of Canada.

2) Expanding our publicly funded, not-for-profit health-care system to all medically necessary areas, starting with universal home care, universal pharmacare and dental care for people living with low income.

3) Focus on well-researched and demonstrated policies and evidence-based clinical practices to optimize the health of people, families, communities, and our health system.

4) Given the federal threat to close the door on supervised injection services, we urge Premier Kathleen Wynne to demonstrate leadership and immediately fund services in Toronto and Ottawa.

5) Reject efforts to commercialize or privatize health-care delivery. Place a moratorium on new P3 negotiations and contracts. Prohibit medical tourism, and do not allow Canadians or foreigners to buy their way to the front of a queue for insured health-care services**.**

Medicare: System Improvements

To ensure co-ordination between the various elements of our health system, we must secure system integration and decrease duplication. To achieve this, we ask that government:

1) Support Local Health Integration Networks to achieve regional health system planning, integration and accountability for all health sectors, using an evidence-based and person-centred approach rooted within a population health, primary health-care framework.

2) Commit to providing all Ontarians with access to integrated interprofessional primary care by 2020 in nurse practitioner-led clinics (NPLC), community health centres (CHC), Aboriginal Health Access Centres (AHAC) and family health teams (FHT), and fund them to work to full capacity.

3) Improve navigation across our complex system by partnering with patients to co-ordinate their care through primary care.

4) Transition the 3,500 case managers and care co-ordinators from Community Care Access Centres into primary care through a carefully crafted labour management strategy that retains their salary and benefits.

Nursing Care

1) Narrow the gap of about 17,600 RN positions as quickly as possible. Ensure that staffing mix decisions are based on client need.

2) To protect the safety of our seniors and to ensure their timely access to quality care, phase in new minimum staffing standards in long-term care, starting with a minimum of one nurse practitioner per 120 residents.

3) Ensure 70 per cent of all nurses work full-time so patients have continuity in their care and care provider.

4) Maximize and expand the role of RNs to deliver a broader range of care, such as ordering lab tests and prescribing medications.

5) Secure fair and competitive wages for nurses and nurse practitioners working in all sectors of health care. RNs face substantially lower compensation in primary care and home care, while Ontario NPs receive substantially lower compensation than NPs in jurisdictions like Alberta.

RNAO Pre-Budget Submission 2014: Finding the Right Balance

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RNs) in all settings and roles across Ontario. It is the strong, credible voice leading the nursing profession to influence and promote healthy public policy. RNAO understands that budgets profoundly affect people's health and nursing services. For this, we welcome this opportunity to participate in the pre-budget consultation, and to convey the view and recommendations of Ontario's registered nurses.

Time to Broaden the Focus of the Budget Process

As with our last submission, RNAO continues to call for balance in the budget process. We are concerned with a strong, untimely tilt to austerity that would not serve Ontarians well at this time. Ontario is into its sixth consecutive year of weak employment. Unemployment soared to 9.0 per cent in 2009 as a result of the 2008-09 recession. It has remained painfully high, while gradually dropping. Unemployment was forecasted to drop to 7.5 per cent in 2013, but it spiked to 7.9 per cent in December,[1] with youth unemployment at 16.7 per cent.[2] Forecasters had projected unemployment to decline to 6.9 per cent by 2015, but that may now be in doubt. Even 6.9 per cent would still be well above the pre-recession levels of 6.4 to 6.5 per cent prevailing before the recession,[3] [4] a target that Economic Development Minister Eric Hoskins would like to achieve.[5] This extended bout of high unemployment represents a major loss in productive capacity. More importantly, it causes a great deal of human suffering, ill health and permanent loss of human capital. This should be a key focus of governments at the federal and provincial levels.

Instead, there remain calls to rein in public expenditures, which threaten public services and cost jobs. Yet by Canadian standards, Ontario's program expenditures are low, consuming 16.6 per cent of GDP as of 2012-13. Only two (high income) provinces have lower ratios: Saskatchewan and Alberta.[6] The current spending is not high by historic Ontario standards either: the 16.6 per cent is roughly in the middle of the range of 13.6 per cent to 18.9 per cent over the past 30 years. To be sure, provincial and federal governments' deficits ballooned in the desperate but successful battle to stave off a major economic collapse. Ontario went from three annual surpluses to a small deficit (1.1 per cent of GDP) in 2008-09, to a large deficit in 2009-10 (3.2 per cent of GDP). Since that time, the deficit declined steadily to 1.4 per cent of GDP in 2012-13. The government cautiously projects a 1.7 per cent deficit in the coming fiscal year,[7] but such projections invariably overstate the actual deficit. The Ontario deficit is projected to virtually

disappear by 2017-18. Pundits from all sides called on government to step in where the financial system had failed. But the job of recovering from the recession is far from finished. We do not believe that the need to reduce the deficit outweighs the urgency to maintain a level of services consistent with a health society, including healthy levels of employment.

There is no question that fiscal deficits and debts must be taken seriously. Over the business cycle, there must be a reasonable balance between revenues and expenses. But deficits must be understood as constraints and not as principal objectives. The objective is to harness physical, human and natural resources in a way that builds a healthy, dynamic, sustainable, inclusive society. Runaway fiscal debts and deficits could limit capacity to pay for needed services in the future. But growing social, infrastructure and environmental deficits have immediate and long-term consequences that are not top-of-mind in budget discourse, and that must change. We can deal with the manageable fiscal deficit on a schedule that doesn't harm the economy while getting the right mix of expenditures and revenues.

The problem is: if priority is placed on balancing the budget and doing so by austerity, everything else takes a back seat. This approach, Ontario's RNs say, has failed elsewhere in the world, and is bad for Ontarians.

Now is a perfect time to catch up on infrastructure deficits, because of the low interest rates and because there are many resources idled by the stagnant economy that there is limited risk of rampant inflation.

Nurses understand the toll that a recession can take, as they see the victims and nurse the many who fall ill, every day on the front lines, in hospitals and community clinics, in homes and in our streets and shelters. Nurses see the thousands of laid off women and men for whom a pink slip represents not only the loss of their livelihoods, but also their private health benefits. We also see those in dire distress because losing their jobs has resulted in losing their homes, reliance on food banks, a sense of shame and social exclusion. This leads to higher rates of illness. Nurses know that communities and individuals can help out. However, we all know that only governments can, and must, take the lead – through policy and budgetary decisions – of fighting the downturn, facilitating recovery, and protecting the most vulnerable if we truly care for a just and fair society. RNs and the public know that government has taken major steps to blunt the worst effects of the recession, and they understand that these steps necessarily entailed large temporary budget deficits. But, they become alarmed when a focus on the deficit threatens the recovery and places essential social programs at risk.

A. Fiscal Capacity

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

During the mid-1990s and early 2000s, the Government of Ontario cut revenues and expenditures severely. Government revenues as a share of GDP fell from 17.6 per cent in 1995-96 to 15.1 per cent in 2003-04. Over the same period, program expenditures were cut from 18.1 per cent to 14.3 per cent of GDP.[8] This created a severe social deficit and limited the ability to deal with it due to lower tax rates. Subsequently, the government restored much of the program spending and brought in more revenue with the introduction of a health tax. With economic recovery, rising revenues pushed the government into a modest surplus. However, the brutal 2008 recession called for major spending to help head off economic collapse. Program spending jumped from 15.8 per cent of GDP in 2008-09 to 18.0 per cent the following year.[9] The deficit spending strategy in Ontario and across the country did succeed in averting a much worse economic decline. A negative side effect was very large deficits at a time when the economy remains fragile.

Ontario must, of course, take its debt and deficit seriously. Taking them seriously means thinking carefully about when and how to reduce them. The province must resist the temptation to punish the economy further with untimely spending cuts. Ill-advised austerity policies in Europe plunged country after country into severe recession and social strife. That doesn't need to happen in Ontario, nor in Canada. The government deficit in Ontario has dropped from 3.1 per cent of GDP to 1.4 per cent in 2012-13. Ontario's deficit is significant but manageable. Thanks to continuing low interest rates, now is a good time to invest in rebuilding the economy. In spite of the growing debt, interest charges on the debt have remained at a fairly flat 1.5 to 1.6 per cent of GDP in recent years.[10] Enhanced revenue measures, such as reducing tax avoidance, more green taxes, prices on carbon and surcharges on those better able to pay, will help to reduce the deficit and restore Ontario's fiscal capacity. New revenue measures are required to address growing needs in a number of areas, including transit (as gridlock imposes a worsening toll on the environment) productivity and health. Green taxes have the advantage of discouraging harmful behaviour. These taxes are more efficient, and could help replace less efficient taxes. On these grounds, the Task Force on Competitiveness has called for the implementation of an Ontario carbon tax.[11] It is not responsible to consider tax cuts unless alternative revenue sources are in place. The benefits of tax cuts are elusive, as any private spending stimulus may be more than offset by corresponding government

spending cuts. As the Task Force on Competitiveness admitted, substantial federal and Ontario tax cuts were accompanied by falling investment rates per worker.[12]

Recommendations:

1) **Ensure the fiscal capacity to deliver all essential health, health care, social, and environmental services by building a more progressive tax system.**

2) **Increase revenue sources that encourage environmental and societal responsibility. Begin by phasing in environmental levies, such as a carbon tax, to help pay for the damage polluters cause and to support the social programs and services most needed by at-risk populations.**

3) **Work with the federal government to research the scope of tax evasion losses, and then put in resources to recover the lost revenues.**

B. Social Determinants of Health

It's hard to imagine that a low-income neighbourhood in Ontario has something in common with Nepal. And yet both share an unsettling statistic. In a part of Hamilton, the average age at death is 65.5 years, tied with Nepal. Perhaps even more surprising is that a few kilometers away in a more affluent neighbourhood within that same Ontario community, the average life expectancy is 86.3 years, which is five years higher than Canada's average life expectancy. This 21-year difference in life expectancy is not due to random chance, but because of the growing gulf between rich and poor. This avoidable and early loss of life is not imaginary, but the day-to-day reality of members of our society living in parts of Hamilton.[13]

Minimum Wage Rates. Ontarians who live in poverty because of precarious low-wage employment and those who struggle because of dangerously low social assistance rates are the very Ontarians who are dying years and decades too soon. The evidence is conclusive: people who live in poverty and are socially excluded experience a greater burden of disease and die earlier than those with better access to economic, social, and political resources.[14] Poverty is not restricted to certain areas of particular cities, but is pervasive across the province: one in 10 Ontarians (1.3 million) are living in poverty every day. Good quality jobs are often a pathway out of poverty, yet the provincial minimum wage has not been increased since March 2010,[15] meaning the purchasing power of the minimum wage has fallen by over 6 per cent. The current minimum wage of $10.25 per hour still leaves workers 10 per cent below the poverty line.[16]

Things were even worse. The minimum wage was frozen at $6.85 per hour from 1995 to 2004, corresponding to a 17 per cent cut in purchasing power. After that, important increases brought it to $10.25. The table below shows the recent progression in minimum wage rates in Ontario.

Ontario Minimum Wage	
Date of Change	**Rate**
01-Jan-95	$6.85
01-Feb-04	$7.15
01-Feb-05	$7.45
01-Feb-06	$7.75
01-Feb-07	$8.00
31-Mar-08	$8.75
31-Mar-09	$9.50
31-Mar-10	$10.25

Alarmingly, the improvements to minimum wage froze in 2010. It is not reasonable to expect people to live below the poverty line while working. Advocates for low-income workers, RNAO included, have taken up the call to set the minimum wage 10 per cent above the Low Income Measure, or $14/hour, and to raise the minimum wage annually after that at the rate of inflation.[17] [18]

Taking Action on Poverty. We know public policy can make a difference in people's day-to-day lives and improve health outcomes. Ontario has taken some steps with its first *Poverty Reduction Strategy* released in December 2008. Early investments in increasing the Ontario Child Benefit helped reduce the child poverty rate from 15.2 per cent to 13.8 per cent in 2011despite the global economic recession.[19] [20] [21] However, we have a long way to go just to get back to the 9.9 per cent child poverty rate of 1989.[22]

In May 2009, all three parties voted unanimously to pass Ontario's *Poverty Reduction Act*, which commits successive governments to remain focused on the fight against poverty.[23] Ontario raised the minimum wage in increments from $6.85 to $10.25, which was a significant boon to the working poor, but still leaves the minimum wage workers below the poverty line. RNAO supports the community campaign to increase the minimum wage to $14, which would be 10 per cent above the poverty line. It is crucial that we all work together to eliminate poverty so that all Ontarians can live in health and dignity. And any policy that raises incomes of poor people benefits the local economy because that increase will translate into decreased illness rates and related health-care spending, as well as increases in consumer spending.

Detailed spending recommendations on housing and social assistance include:

Affordable Housing

1) Make the $42 million in "transition funding" permanent for critically important housing and homelessness funds administered by municipalities under the Community Homelessness Prevention Initiative. This will not replace the devastating loss of the Community Start-Up and Maintenance Benefit, but will help prevent some low-income Ontarians from losing their housing.

2) Ontario needs to continue to advocate to the federal government for a National Housing Strategy. In response to the federal government's 2013 budget commitment to match housing funding for provinces and territories, the provincial government should allocate $90 million.

3) To address the backlog of existing affordable housing units in need of repair and to create new affordable housing stock, ensure that the affordable housing loan fund at Infrastructure Ontario remains capitalized at $500 million.

Social Assistance

1) Include the cost of shelter, energy, and nutritious food, based on the Ministry of Health and Long-Term Care's Nutritious Food Basket survey and then index to inflation. As a down-payment towards adequacy, start immediately with a $100 per month increase for single people on Ontario Works, whose rates are dangerously low.

2) Implement increases to the Ontario Child Benefit (OCB) to $1310/child/year in July 2014, fully indexed to inflation, and increase the OCB by $100 annually until the end of the next *Poverty Reduction Strategy* in 2018. Stop clawing back OCB increases from families on Ontario Works and the Ontario Disability Assistance Program.

Recommendations:

1) **Immediately increase the minimum wage to $14, and automatically index it to the rate of inflation thereafter, in order to bring workers 10 per cent above the Low Income Measure of poverty.**

2) **Improve access to affordable housing and stimulate job creation[24] [25] [26]in the process through steps that include:**

a. **Making permanent the currently temporary $42 million funding for the municipal Community Homelessness Prevention Initiative.**
b. **Allocating $90 million to housing funding, to be matched under the federal government's 2013 budget commitment.**
c. **Continuing to capitalize the affordable housing loan fund at $500 million.**

3) **Transform the social assistance system to reflect the actual cost of living,[27] [28] [29] including the cost of shelter, energy and nutritious food.**
   a. **As a first step, increase monthly payments to people on Ontario Works by $100.**
   b. **Increase Ontario Child Benefit payments to $1310/year in July 2014, fully inflation indexed, and increase annually by $100/year. Stop clawbacks of OCB increases.**

C. Environmental

Nurses know environmental determinants of health play a huge role in each community's overall health and wellbeing, as evidenced in Ontario[30] [31] [32] [33] and around the world.[34] [35] [36] [37] Environmental degradation and climate change are not vague future threats, but actual realities that are impacting Ontarians' health. Access to clean air, a safe environment, and reliable and sustainable forms of electricity help preserve our planet and secure the future for our children. That's why RNAO continues to focus on strengthening two key environmental determinants of health: supporting the use of green energy and reducing all exposure to toxics, including those from the environment, in homes, in workplaces and in consumer products. RNAO is also actively engaged in promotion of public support of transit and active transportation.[38]

Green energy. RNAO strongly supports an electricity system that is safe, reliable, equitable and environmentally sustainable; one that supports community sustaining green jobs, and one that does not pollute the air or leave a legacy of toxic waste and bankrupt Ontario residents and businesses.[39] Healthy public policy demands aggressive conservation and energy efficiency targets as well as phasing out Ontario's dependence on dirty coal and other fossil fuels. Ontario has made excellent progress on coal, and now is the time to complete the job. RNAO's vision of a clean, healthy energy future is balanced and comprehensive. It includes:

- Closing immediately all remaining coal plants, keeping them on emergency stand-by until permanent closure in 2014 and only operating them if there is no other option to keep the lights on;
- Reducing consumption through conservation and energy efficiency;

- Cancelling plans for construction of new risky and expensive nuclear power plants; strategic use of natural gas to meet peak needs until renewable power is online while ensuring all new natural gas-supplied electricity is not from shale gas extraction ("fracking") and uses highly efficient combined heat and power (CHP).
- Solid targets and implementation plans for increasing reliance on renewable energy such as community controlled, appropriately located and scaled water, wind, solar and bio-energy; subject to comprehensive environmental assessments.
- Phasing in a tax on carbon, which would act as a tool to build fiscal capacity, as well as a signal to users to economize on carbon use.

Toxics. New toxics are being discovered and released on a regular basis, and the public is often unaware of their presence or effects. Concern has been growing about a worrisome class of toxics called endocrine disruptors. These particular toxics can cause serious health effects, even in very low concentrations and particularly in young children.[40] [41] [42] The range of effects are not fully understood, but based on what is known, RNAO calls for extreme caution and tougher protection from the government on toxics by:

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

Transit and Active Transportation. Automobiles are a major source of pollution, particularly in urban environments. When added to congestion costs, the bill comes to billions of dollars. For example, in the Greater Toronto and Hamilton Area (GTHA), the cost in 2006 alone was estimated at $3.3 billion to commuters and $2.7 billion in lost economic opportunities.[43] For many in urban areas, there are limited alternatives to automobile use: public transit may be inadequate and opportunities for active transportation like biking and walking may be limited and unsafe. Cities like Toronto can grind to a virtual halt in rush hour. Approximately $50 billion over 25 years (or about $2 billion per year) is needed for transit infrastructure for the GTHA alone.[44] The Ann Golden Panel has pointed the way with its recommendations.[45]

Recommendations:

1) **Set ambitious toxics reduction targets. Ensure people have the right-to-know about the existence of toxics in the environment, in their homes, in their workplaces, and in consumer products.**

2) **Minimize the energy footprint by: focusing first on conservation and energy efficiency, relying minimally on existing coal plants until they are closed, increasing reliance on renewable energy, and strategically using natural gas and hydroelectricity imports from Quebec to meet any energy shortfall.**

3) **Create new dedicated revenue sources to pay for a substantial expansion of transit and active transportation.**

D. Medicare

Expanding Medicare. The Canada Health Act (CHA) is a valued tool to deliver health care to all Canadians in an equitable way. It guarantees universal access to hospital and medical care via first-dollar coverage. Unfortunately, omitted are key health-care services, including home care, pharmacare, long-term care, physiotherapy, and denticare. The omissions lead to very uneven access to the uncovered services across the country. They also result in inefficient overuse of covered services and underuse of uncovered services. The time to expand medicare through parallel legislation to the CHA is long past. In 1997, the National Forum on Health called for protection of the single-payer model and *"*expanding publicly funded services to include all medically necessary services and, in the first instance, home care and drugs."[46] In 2002, the Romanow Commission recommended expansion of home health care for mental health, post-acute care and palliative care.[47] It also recommended coverage for catastrophic drug expenses.[48] The Kirby Report called for a national post-acute home care program, catastrophic drug coverage and a national drug formulary.[49] RNAO has long advocated for expansion of medicare "to all uncovered areas, including home care, pharmacare, long-term care, rehabilitation services, public health and truly comprehensive primary health care."[50] It shares the National Forum's belief that we could start with pharmacare and home care. Let's begin now.

Pharmacare. Canadians are covered by a patchwork of partial pharmacare coverage.[51] A commentary written for the conservative C.D. Howe Institute neatly summarizes the case for pharmacare in Canada:[52] [53] it would deliver equitable access to medicines; it would better financially protect the ill; and it would result in a net saving of money. The savings

come from reduced administrative, marketing and regulatory costs (due to being a single-payer system), from integration of decisions on pharmaceutical care into overall health care (e.g., health-care providers have more incentive to rationally optimize between medical and pharmaceutical care), from pooling of risk over larger populations, from value-for-money testing, and from use of purchasing power to reduce drug prices. A 2010 study quantified the potential savings of a comprehensive first-dollar pharmacare programs for Canadians at up to $10.7 billion annually (or 42.8 per cent of total spending on pharmaceuticals).[54] RNAO,[55] Canadian Federation of Nurses Unions[56 57]; Canadian Medical Association,[58] Standing Senate Committee on Social Affairs, Science and Technology,[59] Canadian Health Coalition,[60] Canadian Association of Retired Persons,[61 62] and Canadian Doctors for Medicare[63] have called for a national pharmacare program. The public is game: a May 22, 2013 poll by EKOS found 78 percent of Canadian respondents supported a universal public drug plan for all necessary prescription drugs.[64] The poll also found strong support (82 per cent) for bulk purchasing of drugs and strong negotiations to lower drug prices.

It would be better if pharmacare was implemented nation-wide, but as the C.D. Howe article points out, in the current policy environment, one or more provinces must lead the way. Ontario would serve its citizens and all Canadians well if it were to play that role. Currently, the Ontario Drug Benefit Program covers senior citizens and those receiving social assistance, while the Trillium Drug Program subsidizes those whose costs are high relative to their income.[65 66] The Ontario government has indicated an interest in a full provincial pharmacare program, but it requires a push.[67] RNAO will continue to mobilize for a national pharmacare program.

Home care. Expansion of medicare to include home care would yield similar types of benefits to those related to a national pharmacare program. As noted above, the National Health Forum, the Romanow Report and the Kirby Report called for various forms of national home care programs, and home care expansion was one of the mandates of the 2004 *Health Accord*, which committed provinces to cover two weeks of home care for the acute, mental health and palliative areas.[68] RNAO, the Canadian College of Family Physicians,[69] and the Canadian Healthcare Association[70] have called for a national home care program. The result would be: much broader and more equitable access to home care services; reduction in the need for more costly long-term care and acute care; better outcomes; and greater client satisfaction.

Dental care. RNAO appreciates the December 2013 announcement of an integrated low-income dental program for children and youth that will increase access to vital dental care by raising the income eligibility criteria.[71] Building on this important advancement that will improve public health, it is critical that access to free dental coverage be available for all Ontarians living with low income, not just those receiving social assistance. We

support the recommendations of Ontario's Chief Medical Officer of Health to address oral health inequities in the province[72] and the need to align dental care with the rest of the health care system.[73] [74]

Supervised injection services. RNAO is proud of its role in defending harm reduction in supervised injection services at the Supreme Court.[75] These services save lives. According to the Toronto and Ottawa Supervised Consumption Assessment (TOSCA) Study, Toronto would benefit from three supervised injection services (SIS) and Ottawa would benefit from two SISs.[76] Vancouver's Insite prevents 35 new HIV cases and three deaths per year on average, providing a societal benefit of about $6 million per year, and a benefit cost ratio of 5:1.[77] Based on this evidence, RNAO has urged the Ontario government to fund supervised injection services into existing provincially funded clinical health services, which is the model recommended by the TOSCA Study.[78]

Making Medicare More Efficient. Expanding Medicare by creating national pharmacare and homecare programs would improve outcomes and make more rational use of resources, instead of overusing covered services and underusing uncovered services. That would help make medicare more efficient. But that is not enough. Transparency and accountability are important in all public activities, including health care, to ensure that services are efficiently and effectively delivered. The loss of the Health Council of Canada weakens transparency and accountability at the national level. Health Quality Ontario[79] and the provincial Auditor General[80] do provide accountability for health at the provincial level for Ontario, and the same accountability is required nationally.

We now consider the impact on outcomes and efficiency of private payment and for-profit delivery.

Threats to Medicare

Private Payment. Private payment restricts access to health-care services, based on income, meaning that lower income people without insurance get delayed, reduced or no access to health care. Private payment results in higher costs due to limited buying power, higher administrative costs, and skewed usage to insured versus uninsured services. The American health-care system is an example. As of 2012, 15.4 per cent of Americans had neither public nor private health insurance.[81] In part due to its multi-payer nature, U.S. health expenditures exceed those of the rest of the OECD, but health outcomes are comparatively poor.[82]

An area of growing concern for RNAO is medical tourism: the sale of health care at a profit to well-heeled people who travel abroad to access health services more quickly or

more cheaply. RNAO is aware of at least three Toronto hospitals that have provided health services to non-urgent paying patients from abroad. [83] Given the existence of waiting lists, this queue-jumping can only lengthen the delay facing others patiently waiting their turn.

While equity and efficiency support a single-payer system, there is money to be made through private payment for health care, and that creates powerful interests to lobby against the common good. The scope of private services available is broad, as can be seen from www.findprivateservices.ca. Private providers sell CHA-insured services to Canadians, as Dr. Brian Day has been doing very publicly with his two for-profit clinics. This creates a two-tier system, with higher-income Canadians able to buy their way to the front of the queue. Dr. Day's clinics have already been ordered to cease extra-billing for services covered under British Columbia's Medicare system.[84] Dr. Day is also challenging the single-payer Medicare system in B.C. in the Supreme Court of British Columbia (opposed by interveners like the Council of Canadians). The case was scheduled to go to court January 15, 2014.[85] [86] This follows on the heels of the 2005 Chaoulli Supreme Court decision that invalidated Quebec's ban on private insurance to cover publicly insured procedures.[87] The Day case could go all the way to the Supreme Court of Canada, potentially undermining the CHA and Medicare's universality.

For-Profit Delivery. Delivery of services is another area of privatization. Services are generally delivered privately, either by not-for-profit or by for-profit agencies. For example, in Ontario, most hospitals are private, not-for-profit bodies. In the home care and long-term care sectors, services are delivered by a combination of for-profit and not-for-profit bodies. The profit incentive turns out to be perverse in health care, because it harnesses human ingenuity in ways that inflate costs and deliver worse outcomes. Health care is particularly vulnerable because it is very difficult to assess and monitor quality of care; the incentive to cut corners is very powerful, and the penalty for not cheating may be loss of market share. A review of four decades of experience with privatization in the United States with a combination of public funding and private health-care management and delivery found that "for-profit health institutions provide inferior care at inflated prices."[88] For-profit provision leads to cherry-picking of profitable services and clients, leaving the public sector to deal with high-cost clients. [89] [90] An abundance of literature points to poorer outcomes from for-profit health care[91] [92] [93] [94] [95] [96] [97] [98] [99] and at higher cost. [100]

Public-private partnerships (also known as P3s or Alternative Financing and Procurement[101]) are a variation on for-profit provision, in the case of infrastructure. They generally involve the private sector organizing the financing, design, and construction of infrastructure. Controversially, they tend to involve very complicated and long-term contracts that also include private operation and maintenance of the facility after it has

been built. P3s tend to be more expensive because private borrowing costs are higher than public borrowing costs, because of the high negotiation costs of these complex deals, and because the representatives of the public sector are ill-equipped to negotiate such complex contracts. The public ends up absorbing higher costs and lower quality of services as a result.[102 103 104 105 106 107 108 109 110]

Potential Loss of the *Health Accord*

In an alarming development, the federal government has walked away from renegotiating the 2004 10-year *Health Accord*. This was a federal-provincial-territorial agreement aimed at strengthening Canadian health care under which the federal government funded health care via the health transfer, in return for provincial/territorial performance undertakings.[111] The federal government also intends to terminate, in 2014, the watch-dog Health Council of Canada with the stated reason that it is no longer needed now that the *Health Accord* is expiring; creation of a Health Council of Canada was Recommendation 1 of the Romanow Commission.[112] The Canadian Medical Association responded: "The recent decision by the Government of Canada to cut funding to the Council is a failure of its responsibility to protect and strengthen Canada's health-care system. Further, cutting the Health Council also means the loss of an important tool to monitor the performance of the health-care system."[113] The provinces say that in lieu of negotiation, the federal government unilaterally slashed $36 billion in transfers to the provinces and territories for the period after the expiry of the *Health Accord*.[114 115] This further reduces provincial/territorial health-care resources and gives the federal government even less leverage to enforce the *Canada Health Act* (a paper written for the Canadian Institute of Actuaries estimates that the federal transfer share of provincial/territorial health expenditures would drop from its current 21 per cent to 14.3 per cent under the new formula by 2037, down from an initial 50 per cent).[116] The federal government could withhold transfers to provinces that allow billing for services covered under the CHA, but it has chosen not to act, which encourages further violations.[117] Furthermore, the federal government has switched to transferring health funds on a per capita basis, which will leave poorer provinces worse off. Former Saskatchewan premier Roy Romanow described the Prime Minister's plan for health-care transfers as a deliberate strategy to abandon health care to the provinces and foster the development of more private, for-profit medical enterprises.[118]

Any doubts that a publicly funded, not-for-profit health-care system provides better outcomes and better value are quickly allayed by a look south of the border. Commercialization of health care in the United States has not served its people well. A review of four decades of experience with privatization found that "for-profit health institutions provide inferior care at inflated prices."[119]

Saving Medicare by Improving the Health System

RNAO agrees changes are needed to make our system more responsive. The changes that RNAO has widely promoted are based on robust evidence, the urgent need to improve health-system integration and reduce harmful infrastructure duplication, and the full utilization of the knowledge and skills of all health-care professionals, including RNs and NPs working in well-resourced interprofessional health-care teams that advance timely and quality access to all Ontarians, wherever they live. When these changes will take hold, Ontarians will experience transformative change that will also result in a system that is more efficient, more cost-effective and delivers better health outcomes for patients and taxpayers.

It is well-known, that nurses – like most Canadians – want to protect our publicly funded and not-for-profit health system, and strengthen it for generations to come. While Ontario's nurses know there are fiscal challenges in today's economy, we also know that cost containment cannot occur at the expense of quality and evidence-based patient care, as it would result in human suffering and higher costs. Nurses know there are better solutions. We say the way to save precious taxpayer dollars is by decreasing duplication and substantively improving health-system integration, while anchoring the health system in primary care.

To achieve a shift to community based care, RNAO's game-changing report *Enhancing Community Care for Ontarians (ECCO)*[120] proposes a three-year plan that addresses the greatest needs of our system. It urges government to ensure every Ontarian has timely access to comprehensive primary care, with a strong emphasis on health promotion, disease prevention, chronic disease prevention and management, and mental health care. It calls for a person-centred, evidence-based approach that will advance the principles of primary health care for all. RNAO's ECCO model strengthens health system integration and alignment by enabling Local Health Integration Networks to effectively lead regional health system planning using population-based needs assessments, service agreements, along with appropriate funding, monitoring and accountability for all health-care sectors. At the centre of the ECCO model is the creation of Patient-Family Councils, which bring the voice of patients directly to the planning table.

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

ordinating "hub" of the local health system. Eliminating the CCAC infrastructure will provide significant cost savings to be re-invested to create more than four million hours of direct home health-care/support services. Nurses know our system can perform better and this alone provides proof.

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

Ontario's 26 nurse practitioner-led clinics (NPLC)[121] [122] have been built from the ground up as a highly successful interprofessional model of primary care delivery that has improved access to care across the province. NPLCs are led by NPs in collaboration with a team of health professionals including RNs, RPNs, social workers, pharmacists, physicians, dieticians and others according to patients' needs. NPLCs offer comprehensive primary care services within a primary health-care framework. Embraced within the community, NPLCs partner with patients to co-ordinate their care and help them navigate the complexities of the health system.

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

As RNAO has urged for many years, NPs must play a bigger role to enhance timely and quality care for residents in long-term care. NPs have the competencies, knowledge and skills to reduce unnecessary transfers to hospital emergency room departments, and to reduce hospitalizations – thus, reducing the trauma to frail clients and making for a more cost-effective health system. NPs can also accelerate access to medical care and help to manage difficult behaviours in clients. Evidence points to a minimum of one NP per 120 residents, with all homes having access to at least one NP. Evidence also points to

minimum staffing standards of four hours per resident day, .59 hours of RN care per day, and two RNs 24/7.

Fiscal Recommendations for Medicare:

1) **Reject efforts to commercialize or privatize health-care delivery. Place a moratorium on new P3 negotiations and contracts. Prohibit medical tourism, and do not allow Canadians or foreigners to buy their way to the front of a queue for insured health-care services.**

2) **Work with the other provinces to bring the federal government back to the table to negotiate a 2014 *Health Accord*. Part of that negotiation would be to preserve the Health Council of Canada.**

3) **Expanding our publicly funded, not-for-profit health-care system to all medically necessary areas, starting with universal home care, universal pharmacare and dental care for people living with low income.**

4) **Focus on well-researched and demonstrated policies and evidence-based clinical practices to optimize the health of people, families, communities, and our health.**

5) **Given the federal threat to close the door on supervised injection services, we urge Premier Kathleen Wynne to demonstrate leadership and immediately fund services in Toronto and Ottawa.**

System Improvement Recommendations for Medicare:

1. **Support Local Health Integration Networks to achieve regional health system planning, integration and accountability for all health sectors, using an evidence-based and person-centred approach rooted within a population health, primary health-care framework.**

2. **Commit to providing all Ontarians with access to integrated interprofessional primary care by 2020, in NP-led clinics (NPLC), community health centres (CHC), Aboriginal Health Access Centres (AHAC) and family health teams (FHT), and fund them to work to full capacity.**

3. **Improve co-ordination and person-centred navigation across our complex system by partnering with patients to co-ordinate their care through primary care.**

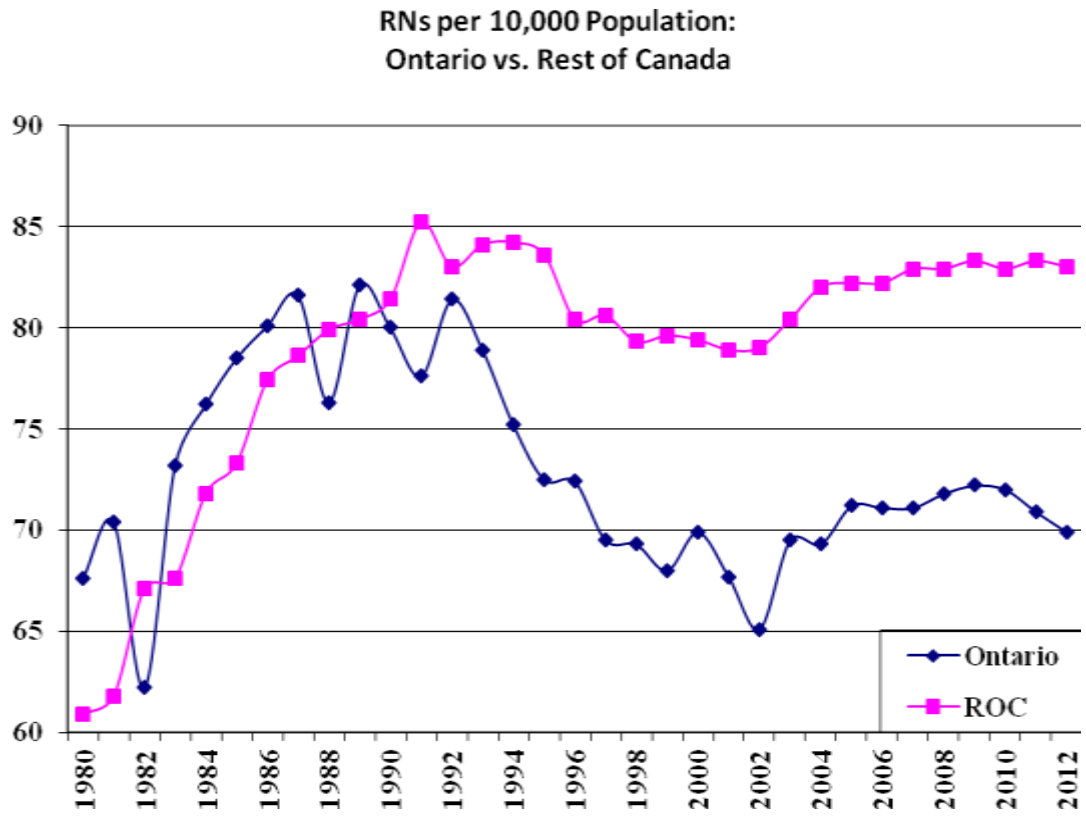
4. **Transition the 3,500 case managers and care co-ordinators from Community Care Access Centres into primary care. Do so through a carefully crafted labour management strategy that retains their salary and benefits.**

E. Nursing Care

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. This meant 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 along with their implications for the nursing profession and client outcomes. Since this time, concerted efforts by successive governments have reversed the downward trend in nursing employment. RN employment has been trending upwards, but has been down and up in the last few years.

RN-to-population ratios. A measure of access to RN services is the RN-to-population ratio. As the graph below shows, it fell steadily starting in the late 1980s, as stagnant RN employment was overtaken by population growth. When RNs were laid off in the late 1990s, the ratio deteriorated more quickly. The strong action noted above by government completely reversed that trend, until cutbacks starting in 2008 undid some of that progress.

Ontario's RN-to-population ratios rank significantly below the rest of the country with a gap that is worsening from year to year. Only British Columbia has the distinction of having a lower RN-to-population ratio than Ontario. As of 2012, Ontario had 69.9 RNs per 10,000 people (a decline from 72.2 in 2009), compared to 83.0 for the rest of the country (a modest improvement from 82.9 in 2010). Thus, while Canada's RN per population ratio is improving, Ontario's is declining. This inevitably has significant workload implications and patient outcome implications.[123] [124] [125] [126] [127] [128] [129] In order for Ontario to catch up with the rest of Canada (ROC), it would have to add an estimated 17,588 more RNs to its workforce, an increase of 18.6 per cent. In terms of direct care alone, 9,286 RNs would have to be added to catch up to the rest of the country. In response to this growing concern, RNAO is recommending that the government provide funding to create 9,000 new full-time equivalent RNs by 2015, while continuing to advance policy that focuses on utilizing the most effective care provider for each patient and advancing continuity of care and continuity of caregiver.



Full-time Employment for RNs. While there has been a temporary setback on RN employment, the news is good on progress towards the consensus goal of 70 per cent full-time employment for nurses. That's good for patients and health outcomes.[130] Full-time employment supports the continuity of care and caregiver that are central to good nursing care. Evidence shows that higher proportions of full-time RN staff are associated with lower mortality rates, continuity of care and continuity of caregiver, as well as improved patient outcomes.[131] [132] [133] Conversely, excessive use of part-time and casual employment for RNs is associated with decreased morale, an unstable workforce where nurses move to other jurisdictions to find full-time work,[134] disengagement among nurses, and a lack of continuity of care for patients.[135] [136] The share of full-time employment for RNs rose from 59.3 per cent to 68.6 per cent between 2004 and 2012. Unfortunately, the ratio deteriorated to 66.8 percent in 2013 due to the loss of many full-time RN positions. Otherwise, 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. Government must get back on track to hit its target of 70 per cent of all nurses working full time.

Scope of Practice. Ontario's nurses also want to work to full scope of practice, allowing the public to benefit from their competencies, knowledge and skills. Moreover, an evolving health system, coupled with the complex care requirements of Ontarians, requires an expanded role of the RN so more people can get timely access to quality care. Right now, RNs in Ontario are limited in what they can do compared to other jurisdictions in Canada and abroad. For example, RNs in the United Kingdom can prescribe laboratory tests and medications. That's where British Columbia, Saskatchewan, Manitoba and Alberta are moving, and that is what Ontario needs. RNAO's groundbreaking report *Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario*[137] – a product of a provincial task force – identifies the need to maximize and expand the scope of practice utilization of Ontario's 4,300 primary care RNs and RPNs over two phases. Consistent application of the full scope of practice of these nurses across all primary care models will be the hallmark of the first phase, and serves as the initial step towards maximizing the scope of each interprofessional primary care team member.

The second phase proposed by the task force involves legislative and regulatory enhancements to expand RNs' scope of practice to include the ability to prescribe treatments and medication, order diagnostic testing and communicate a diagnosis. These activities are within the competencies, knowledge, and skills of the RN and would be authorized pending completion of a focused university pharmacology course. RN prescribing is a recognized international practice and has been subject to rigorous review within the literature.[138] The outcomes of this practice have been highly beneficial at the patient, organization and system level.[139] [140] For example, RN prescribing has the ability to enhance patient access and continuity of care and caregiver in every sector. It also improves efficiency and cost-effectiveness within the system, while contributing to greater job satisfaction and retention of mid and late-career nurses. Premier Kathleen Wynne announced at RNAO's Annual General Meeting in April 2013, her government's commitment to RN role expansion, but little progress has been made. The public and RNs deserve better.

Wage Parity. Lastly, and no less important, in shifting our health system from an illness-based model of care to a preventative one is securing fair wages for registered nurses working in all sectors of health care. Current wage differentials act as a disincentive to working in home health care as well as other sectors. For example, between 1998 and 2004, the community health sector lost 27 per cent of its nursing workforce, due in part to wage differentials.[141] Also, recruitment and retention issues for public health nurses are tied to disparities in compensation.[142] Similarly, long-term care RNs must receive comparable remuneration to the hospital sector in order to sufficiently meet the demand for highly skilled RNs caring for increasingly complex residents.[143] NPs are also affected. The average maximum salary of a primary care NP in Ontario is $90,000.[144] In contrast,

the average maximum salary of a NP in Alberta is $120,000.[145] The role and responsibilities of the primary care NP have greatly expanded in recent years, yet compensation has remained relatively flat. Wage differentials present significant recruitment and retention implications that can impact the sustainability of Ontario's efforts to improve health in the community.

Recommendations:

1. **Narrow the gap of about 17,600 RN positions by immediately focusing attention on RN recruitment and retention.**

2. **To protect the safety of our seniors and to ensure their timely access to quality care, phase in new minimum staffing standards in long-term care, starting with a minimum of one nurse practitioner per 120 residents.**

3. **Ensure 70 per cent full-time employment for all nurses, so that patients have continuity in their care and care provider.**

4. **Maximize and expand the role of RNs to deliver a broader range of care, such as ordering lab tests and prescribing medications to improve access to care and outcomes.**

5. **Secure fair and competitive wages for nurses and nurse practitioners working in all sectors of health care. RNs face substantially lower compensation in primary care and home care, while Ontario NPs receive substantially lower compensation than NPs in jurisdictions like Alberta.**

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OECD: US infant mortality is 6.1 per thousand vs. 4.1 average for the OECD and 0.9 for Iceland. Life expectancy is lower in the US at 78.7 years vs. 80.1 years average for the OECD. Correspondingly, the US performs poorly on potential years of life lost per 100,000: 5,814 vs. 4,633 OECD average for males and 3,447 vs. 2,415 OECD average for females).

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