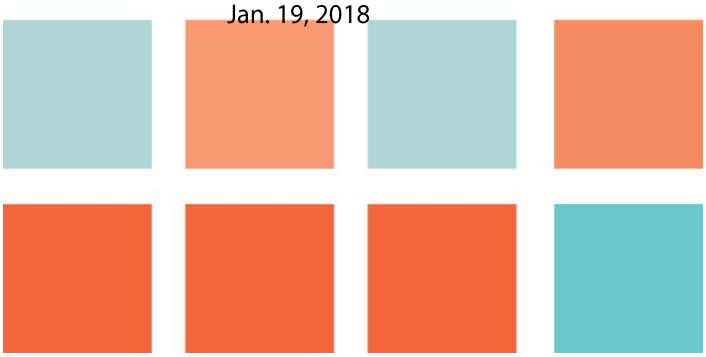
Ontario Pre-Budget Submission 2018: Improving Ontarians' health and healthcare

Submission to Standing Committee on Finance and Economic Affairs

Jan. 19, 2018



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Recommendation 1. Locate LHIN care co-ordination and care co-ordinators in primary care settings.

Recommendation 2. Enable nurse practitioners (NP) to work to their full scope of practice by allowing them to: perform point-of-care testing, order all diagnostic imaging, order ECGs in all situations, certify a death, and complete legal forms for mental health services.

Recommendation 3. Immediately mandate that any new nursing hires in tertiary, quaternary, and cancer care centres be registered nurses (RN), with the long-term goal of having an all RN-workforce in these settings within three years and in large community hospitals within five years.

Recommendation 4. Require that all first home health-care visits be provided by an RN.

Recommendation 5. Review and transform funding models in long-term care (LTC) to support improved resident care. In particular, consider putting resident improvement funding in place to encourage and enable – rather than penalize – improvements in resident outcomes.

Recommendation 6. Legislate minimum staffing and skill mix standards in LTC, accompanied by the necessary funding to support this change. There should be no less than one attending NP for every 120 residents, and a staff mix consisting of 20 per cent RNs, 25 per cent registered practical nurses (RPNs), and no more than 55 per cent personal support workers (PSWs). This ratio would ensure all LTC residents receive care when they need it from the most appropriate provider.

Recommendation 7. Mandate professional models of nursing care that advance care continuity and avoid care fragmentation (primary or total patient care) across all sectors of the health system.

Improving our medicare system

Recommendation 8. Proceed with a universal, single-payer pharmacare program in Ontario covering all medically necessary drugs and associated products, with no means testing, co-payments or deductibles. This will deliver equity, compliance with prescriptions and the efficiency of a single-payer system.

Recommendation 9. Invest $10 million to support the first phase of a public program to provide oral health care to adults and seniors living with low income across the province.

Recommendation 10. Mandate that electronic personal health records (PHR) be made available to patients in order to increase access to medical information and encourage patient participation in health-care decision-making. Patients, families, caregivers, RNs, NPs, and other health-care providers

must be consulted in the development of a provincial PHR plan so that it reflects what patients need and want.

Improving living standards

Recommendation 11. Increase the minimum wage to $15 per hour on Jan. 1, 2019 with annual inflation adjustments every year thereafter, without exemptions by age or sector.

Recommendation 12. Invest one per cent of Ontario's budget ($1.5 billion) to address the backlog of existing affordable housing units in need of repair and to create new affordable and accessible housing stock.

Recommendation 13. Amend the building code to require that all new multi-unit buildings incorporate the principles of universal design for accessibility and visitability.

Recommendation 14. Create at least 30,000 units of supportive housing for people with mental health and addiction issues over ten years.

Recommendation 15. Work with other levels of government to ensure adequate shelter space in communities across the province to address the crisis of homelessness.

Recommendation 16. Invest in mental health and addiction services as well as harm reduction, supervised injection services, and overdose prevention services to address chronic homelessness and the current overdose crisis. Ensure these services are also available in our shelters and drop-in centers.

Recommendation 17. Partner with Indigenous nations to address the urgent health needs they identify, including the ongoing crisis of child and youth suicide.

Improving environmental protection

Recommendation 18. Set the carbon cap at a level that will deliver greenhouse gas (GHG) reductions on the targeted schedule or earlier.

Recommendation 19. Make free or subsidized GHG emission permits highly targeted and temporary.

Recommendation 20. Direct carbon pricing revenues to programs that reduce GHG emissions and mitigate the impact higher carbon prices will have on vulnerable populations. Manage those revenues transparently with strong public oversight.

Recommendation 21. Work with federal and municipal partners to ensure dedicated and sustainable revenue sources to pay for ongoing operation and substantial expansion of transit and active transportation in Ontario.

Improving fiscal capacity

Recommendation 22. Ensure the fiscal capacity to deliver all essential health, health-care, social and environmental services by building a more progressive tax system. Do not cut taxes.

Recommendation 23. Increase revenue sources that encourage environmental and social responsibility. Begin by phasing in environmental levies and continue implementing a cap-and-trade program for carbon emissions.

Recommendation 24. Reject sales of publicly owned crown corporations and assets to fund government programs. Halt the further sale of Hydro One shares.

Recommendation 25. Seize this low-interest, low-deficit opportunity to catch up on investments in human, environmental and physical capital.

Recommendation 26. Ensure transparency and accountability in fiscal measures to deliver services people want and deserve, and to ensure this is done in an efficient manner.

Introduction

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RNs), nurse practitioners (NPs), and nursing students in all settings and roles across Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contributions to shaping the health system, and influenced decisions that affect nurses and the public they serve. A key determinant of public policy is the budget, as it allocates resources between different and competing ends. Accordingly, RNAO welcomes this opportunity to present the views of its members on Ontario's spending priorities to the Standing Committee on Finance and Economic Affairs.

RNAO continues to advocate for the upstream allocation of Ontario's resources. The best public investments proactively keep people healthy and productive. We subscribe to a "Health in All Policies" approach, which the World Health Organization describes as "...an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being."[1]

Our recommendations are organized around five themes: improving access to quality nursing and health care, improving our medicare system, improving living standards, improving the environment, and paying for these improvements. These are familiar RNAO themes, but the current economic situation makes them more feasible and more compelling. Ontario's economy is growing, unemployment has fallen markedly, and the provincial budgetary deficit will soon disappear. However, the employment rate has yet to fully recover and Ontario lags the other provinces in program and social spending. Ontario has fixed the budgetary deficit at the expense of an infrastructure and social deficit, and switching the focus to the latter deficits is long overdue. There has been some progress on infrastructure spending, but Ontario needs to do more, and make a point to address social deficits.

The first section of our submission details the current economic context. It will then proceed to discuss the five themes outlined above.

1. Current economic context

As Minister of Finance Charles Sousa noted in his fall 2017 economic statement, Ontario is in a good place. He noted that "...over the past three years, Ontario's economy has grown faster than Canada's and those of all other G7 nations. Private-sector economists expect solid growth in Ontario to continue."[2] Given this prosperity, the time has come to consider investing more seriously in healthy public policy in Ontario.

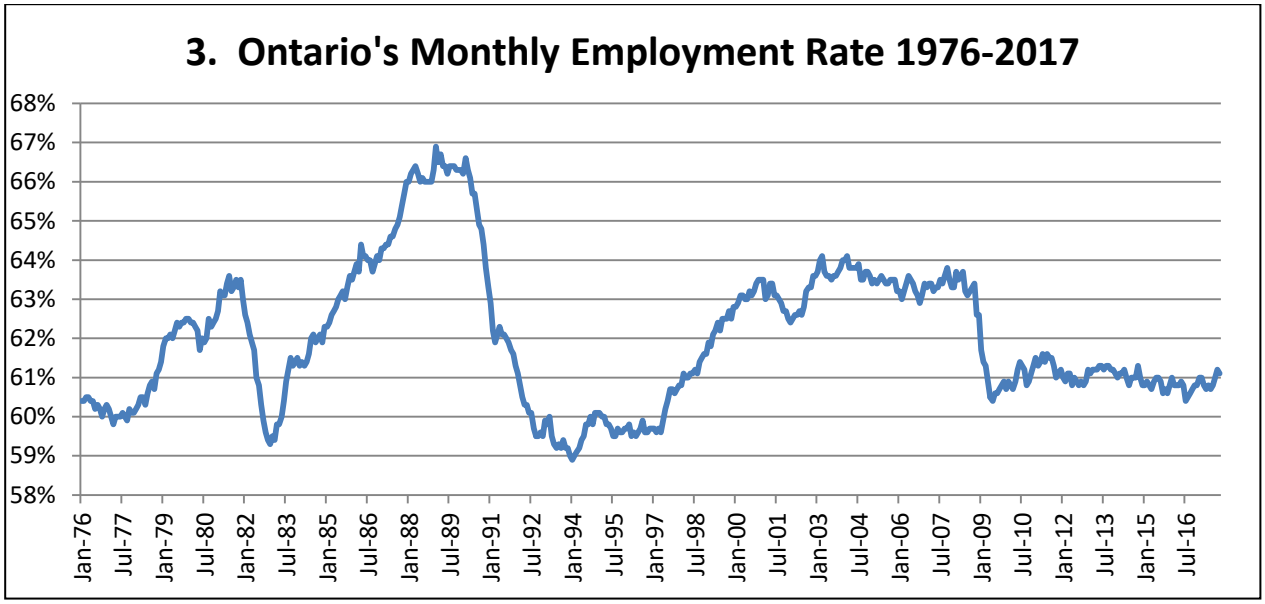
Leader in growth: BMO projects Ontario will lead all provinces except B.C. in GDP growth over the next three years, including three per cent growth for 2017 and 2.3 per cent for 2018:

1. Real GDP Growth by Province (%)[3]											
Year	**Canada**	**BC**	**Alta**	**Sask**	**Man**	**Ont**	**Que**	**NB**	**NS**	**PEI**	**Nfld**
2016	1.5	3.5	-3.7	-0.5	2.2	2.6	1.4	1.2	0.8	2.3	1.9
2017	3.1	3.8	4.1	1.7	2.1	3.0	2.7	1.5	1.6	1.7	-2.0
2018	2.2	2.5	2.3	2.0	2.2	2.3	1.9	0.9	1.1	1.3	0.0
2019	1.8	2.2	2.4	1.8	1.8	2.0	1.6	0.7	0.9	1.1	0.5

Unemployment is down: BMO forecasts Canada's unemployment rate will drop to 5.7 per cent in 2019 from 7.0 per cent in 2015, while Ontario's unemployment rate projects to be more favourable still – dropping from 6.6 per cent to 5.3 over the same period.[4] Both Ontario figures are well below the province's peak unemployment rate of 9.6 per cent in June 2009.[5]

2. Unemployment Rate by Province[6]											
Year	**Canada**	**BC**	**Alta**	**Sask**	**Man**	**Ont**	**Que**	**NB**	**NS**	**PEI**	**Nfld**
2016	7.0	6.0	8.1	6.4	6.2	6.6	7.0	9.6	8.4	10.8	13.5
2017	6.4	5.2	8.0	6.3	5.4	6.0	6.1	7.9	8.4	9.8	14.8
2018	6.0	4.8	7.4	6.2	5.2	5.5	5.8	7.3	8.4	9.4	15.4
2019	5.7	4.5	7.1	5.8	5.1	5.3	5.7	7.2	8.3	9.4	15.0

Employment rate has not recovered to pre-recession levels: Ontario's employment rate (the share of the population over age 14 in the workforce) has stabilized after dropping precipitously during the 2008-09 recession. While Ontario's unemployment rate has come down, its employment rate remains stubbornly low – less than 61 per cent compared to more than 63 per cent between August 2002 and October 2008. There should be capacity for at least two per cent more Ontarians to join the workforce.[7] It is evident from the graph below that the recessions of the early 1980s, early 1990s and 2008-09 were accompanied by dramatic drops in employment rates, while recoveries in the later 1980s and later 1990s brought large increases. Yet there has not been a significant recovery since the 2008-09 recession.



Deficit tamed at the expense of program spending: Ontario's economy has been sufficiently buoyant that the province's net debt-to-GDP ratio has dropped from 39.3 per cent in 2014-15 to 37.3 per cent projected in 2017-18.[8] Ontario is also projected to balance its books in 2017-18, giving the province more latitude when it comes to financing investments. It is evident this was achieved chiefly through budgetary constraints: while revenue/GDP rose from 17.2 per cent in 2009-10 to 17.9 per cent in 2017-18, program expenditures/GDP dropped more significantly from 18.8 per cent to 16.4 per cent over the same time period.

4. Ontario Revenues and Expenditures as Percentages of GDP[9]

	2008–09	2009-10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	Actual 2016-17	Current Outlook 2017-18
Revenue/GDP	17.0	17.2	18.0	17.6	17.7	17.7	17.4	17.9	17.7	17.9
Program Exp/GDP	16.6	18.8	18.6	18.0	17.4	17.6	17.3	16.8	16.4	16.4
Surplus/GDP	-1.1	-3.2	-2.2	-2.0	-1.4	-1.5	-1.4	-0.5	-0.1	0.0
Interest/GDP	1.5	1.5	1.6	1.6	1.6	1.6	1.5	1.5	1.5	1.5

The provincial government projects that inflation will rise from 1.7 per cent in 2017 to 2.0 per cent over the period 2018-20.[10] This is consistent with private forecasts, like that of BMO, which forecasts that Ontario inflation will ramp up very gently, from 1.8 per cent in 2016 to 2.0 per cent by 2019, in line with its projection of two per cent nationally.[11] That will put minimal competitive pressure on Ontario producers. Also, the continued low inflation means that the Bank of Canada will be less likely to raise interest rates, which is also good news for Ontario producers. Raising interest rates would not only increase the cost of investing, it would also increase competitive pressure by driving the Canadian exchange rate higher.

Ontario spends and taxes like a have-not province: Historically, Ontario spends like a have-not province. Only Quebec has lower per capita program spending in the country (see Figure 8 in the appendix). Interestingly, Ontario was lowest per capita spender in the early 1980s, became one of Canada's bigger per capita spenders in the 1990s, and resumed its laggard position by the end of the century. It is important to clarify that this austerity has been a matter of political choice. The public sector has intentionally been starved in favour of private spending due to government policy decisions.

The proportional gap between the per capita spending of Ontario and other provinces is large (see Figure 9 in the appendix). As of 2017-18, Newfoundland's per capita program spending is projected to be 48.2 per cent higher than Ontario's, and even eighth-place B.C. is projected to be 12.4 per cent higher. Only Quebec is edging out Ontario by five per cent, in the race to the bottom.

Ontario also spends a lower share of its GDP on programs than every other province in the country (see Figure 10 in the appendix) – just as it did in the early 1980s. During the recession of the 1990s, Ontario raised its program spending ratio closer to the average of other provinces in an attempt to help the economy recover. But a conscious effort to reduce the size of government resulted in Ontario's program spending dropping to historic lows (13.2 per cent of GDP) from 2000-01 to 2002-03. As of 2016-17, Ontario resumed it last-place position in spending as a share of GDP. The impact of this provincial austerity was compounded by the drop in federal program spending from 20.6 per cent of GDP in 1982-83 to under 12 per cent in the late 1990s, meaning that Ontarians were experiencing cuts in program spending at two levels of government. This austerity is driven by a reluctance to collect revenue: Ontario's revenue share of GDP is the second lowest in Canada (see Figure 11 in the appendix). See the *Paying for these Recommendations* section for the comparative data on provincial spending and revenue.

External factors: Growth in the Canadian economy is expected to be strong in the coming years, as noted above. The Canadian exchange rate is forecast to rise marginally to US$0.806 in 2018, from its US$0.746 level in 2016.[12] This increase will take away some of the advantage Canadian producers had when the dollar was below its "fair" value, as in 2016, when the purchasing power parity value of the Canadian dollar against the U.S. dollar was US$0.788.[13] Thus the rise in the Canadian dollar will replace the small exchange rate advantage with a small disadvantage.

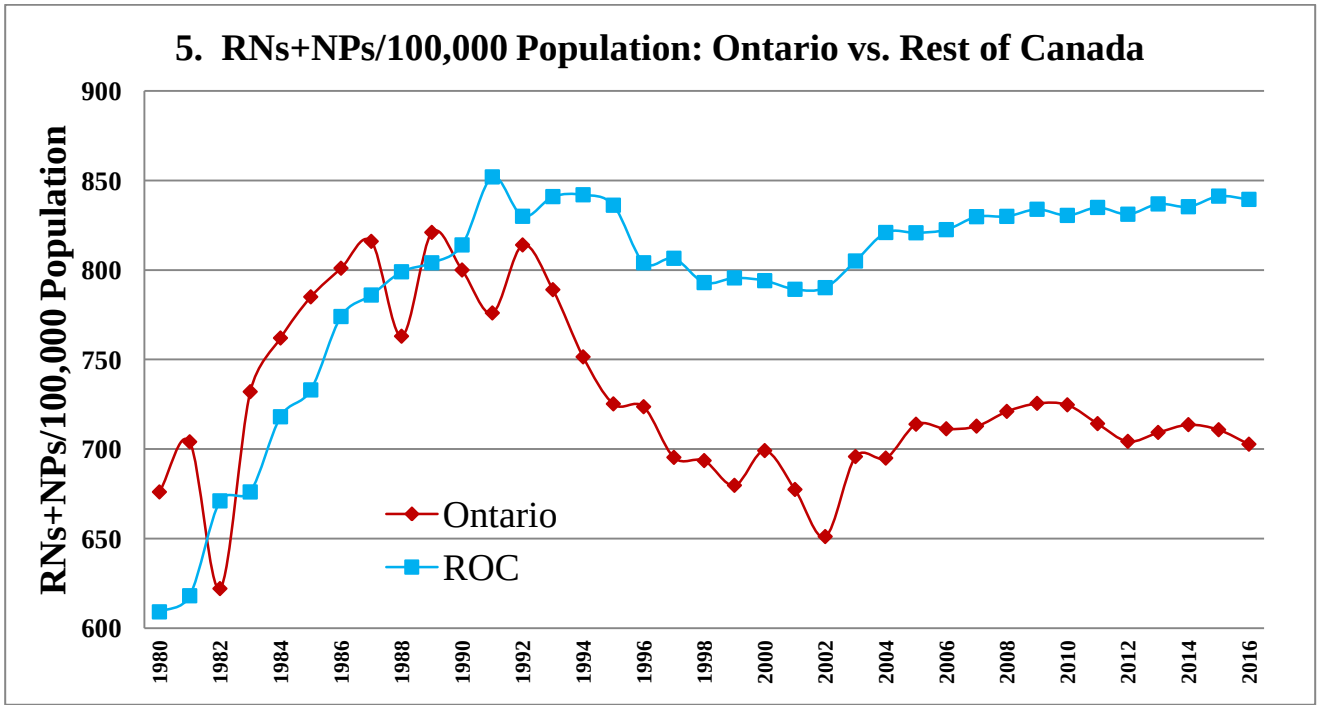
Relations with the U.S.: The change in the U.S. government has resulted in a major shift in economic policy. The U.S. has withdrawn from the Trans-Pacific Partnership (TPP) trade negotiations while Canada has stayed in. The U.S. is also pursuing an aggressive renegotiation of the North American Free Trade Agreement (NAFTA), and has taken actions against Canadian firms in attempts to advantage American producers. These include a 79.82 per cent preliminary anti-dumping duty against Bombardier's CSeries commercial jet to support the U.S. jet manufacturer Boeing,[14] an announced 20 per cent tariff on softwood lumber,[15] and demands for greater U.S. market penetration in the Canadian dairy market[16] and in the B.C. wine market.[17] This could have impacts on employment and output in Ontario. However, these impacts are not necessarily all negative. For example, the Canadian tech sector may be a beneficiary of perceived American political and legislative instability in the global competition for talent and investment.[18] [19] [20]

2. Improving access to nursing and health care

RNs and NPs play a central role in the health system. Yet Ontario lags in access to RN care, even though years of evidence reports their value to the health system. This section identifies ways Ontario can make better use of RNs and NPs: reorient Ontario's health care so that it is anchored in primary care; more fully utilize NPs; ensure we have the right nurse in the right place; review and transform funding in long-term care; get the right staff mix in long-term care; and employ models of nursing care that delivers continuity of client-centred care.

The declining access to RN care: Ontario has the lowest RN-to-population ratio in Canada.[21] Canadian Institute for Health Information (CIHI) figures show the province has only 703 RNs per 100,000 people compared to an average of 839 per 100,000 people in the rest of Canada, meaning that Ontario would need about 19,000 more RNs to catch up.[22] At the same time, the ratio of RPNs-to-population continues to increase.

This is significant because RNs are often a patient's first point of contact with the health system and they are present in every health service delivery setting. Polls consistently show that RNs enjoy the highest public trust compared to other occupations,[23] and evidence conclusively shows that employing RNs improves health and financial outcomes.[24] And yet, the Ontario government continues to enable the replacement of RNs with less qualified health-care workers at a time when patient complexity is increasing. This practice is misguided and puts patient safety and health outcomes at risk.



RN effectiveness: Released in 2017, the largest ever publically available database of research into RN effectiveness comprises 70 years of evidence overwhelmingly showing how RN care results in improved clinical and financial outcomes.[25] The evidence conclusively shows that patient outcomes improve when RNs provide direct care instead of assuming only a supervisory role. [26] Higher levels of care from RNs result in fewer deaths, pressure ulcers, pneumonia and other pulmonary events, sepsis and infections, upper gastrointestinal bleeds, cardiac arrests, falls, and medication errors. [27 28 29 30 31 32 33 34 35 36] The evidence also shows that a higher proportion of RNs is linked to shorter lengths of stay in hospital, and improved organizational effectiveness.[37 38 39]

Health system anchored in primary care: The Ontario Primary Care Council (OPCC), of which RNAO is a founding member, strongly encourages anchoring the health system in primary care. High performing health systems around the world already do this.[40] Ontarians need a better integrated health system where primary care is the patient's main contact with the health system, and where connections are automatically made between different health sectors and providers. There is ample evidence that integrated health systems anchored in primary care deliver the best health outcomes and are the most cost-effective.[41 42 43 44]

Better integrated and co-ordinated care at all levels will enable Ontarians to live healthier lives. Primary care practitioners provide comprehensive first contact and continuing care to patients.[45] Vulnerable populations such as the elderly, people with chronic conditions, severe physical disabilities, developmental or cognitive impairments, and serious mental illnesses and addictions easily fall through the cracks without properly integrated and comprehensive care.[46] Those with high-risk and complex conditions would benefit from primary care co-ordinating their care, including chronic disease prevention and management, on an ongoing basis.[47]

Now that community care access centre (CCAC) functions have been transferred to the local health integration networks (LHIN), RNAO wants the government to move forward with their commitment to relocate the 3,100 former CCAC care co-ordinators (this number excludes those working in hospitals) and the care co-ordination function into primary care settings, to be employed by the LHINs with salary and benefits intact. In the health minister's 2017 mandate letter, and follow-up guidance document, LHINs are expected to "develop and implement a plan with input from primary care providers, patients, caregivers and partners that embeds care co-ordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services as required."[48 49] A Ministry of Health document provides guidance to Ontario's LHINs in developing their plans to place care coordinators in primary care settings.[50] That guidance seeks to extend system coordination beyond home and community care to seamless system navigation throughout the health system.

Moving care co-ordination and care co-ordinators to primary care will expand the reach of primary care practitioners into community care. This shift will facilitate seamless transitions for patients and families, reduce duplication, increase quality of care, facilitate access, and reduce costs.[51] Increasing the workforce capacity of primary care will significantly improve primary care's ability to deliver comprehensive person-centred health services. This will improve co-ordination, continuity and

transitions; reduced service delays; avoid costly hospital re-admissions; improve overall quality and personal health outcomes; and empower patients and families.[52]

Full utilization of nurse practitioners: NPs are RNs who have advanced knowledge and education, and a broader scope of practice.[53] They are registered with the CNO under four specialty categories: primary care, adult, paediatric, and anaesthesia.[54] [55] NPs work in all health-care settings, including public health, primary care, hospitals, rehabilitation, home care, and LTC. For more than four decades, NPs have delivered high quality patient care to meet the needs of Ontarians,[56] and evidence collected over that time conclusively shows the positive value and impact they have on patient care and health system outcomes.[57] [58]

RNAO recognizes the progress government has delivered for Ontario's NPs, yet more barriers must be removed to ensure NPs deliver the access the public needs and deserves. RNAO represents the largest portion of NPs in Ontario and we are calling on the government to speed up in its commitment to work with us to ensure NPs can deliver their full scope of practice services to Ontarians. On Nov. 29, 2017, RNAO held a full day meeting with 60 NP leaders to validate their on-the-ground practice realities. We heard that many barriers to full utilization of NPs remain, such as budget limitations, legislation, regulations and policies. These constraints reduce access to care for patients and increase system costs. For example, while NPs are authorized to order lab tests as appropriate for patient care through regulations under the *Laboratory and Specimen Collection Centre Licensing Act, 1990,* they are not authorized to perform or order point-of-care tests, such as a urinalysis dip or pregnancy tests. NPs must use medical directives[59] for these tests, which are restrictive, risky, and time consuming.

A similar constraint exists with ordering electrocardiograms (ECGs), with NPs only authorized to order ECGs in non-urgent situations. This gap decreases access to a necessary test for clients in critical situations, and creates the need for inefficient medical directives that delay urgently needed client care. In order to increase timely access to necessary care, NPs should be given authority to order this test in *all* situations, especially those that are urgent.

As of Jan. 1, 2018, NPs may apply and order ultrasound. While NPs can only order x-rays itemized on a fixed list, recent changes to the *Healing Arts Radiation Protection Act* will authorize NPs to order all x-rays beginning April 1, 2018. However, NPs will still be unable to order computed tomography (CT) scans, and magnetic resonance imaging (MRIs). This restriction limits their capacity to provide comprehensive timely care, and thus RNAO calls for legislative changes that immediately authorize NPs to order all CT scans and MRIs.

Eliminating barriers for NPs to order necessary tests, medications and procedures will enhance access to quality care for Ontarians in institutional and community settings, and advance health system effectiveness. It will also help meet the goals outlined in the Minister of Health and Long-Term Care's current *Patients First: Action Plan for Health Care*,[60] which aims to promote access to high-quality care by qualified health professionals and the best use of resources.

Another important way to promote the full utilization of NPs is to expand their authority to certify a death, beyond the current eligibility criteria. This would require corresponding changes to Regulation

1094 (General) under the *Vital Statistics Act* to include NPs. Doing so will promote the dignity of deceased persons and support the well-being of their loved ones. It will also ensure the regulation keeps pace with the significant evolution of the NP role in Ontario, as NPs are now serving as most responsible provider (MRP) across all sectors, including as attending NPs in LTC homes.

Finally, NPs are currently not authorized to complete legal forms for mental health services. At present, Section 15 of the *Mental Health Act* authorizes a physician to complete seven forms related to mental health services. These include forms related to bringing a patient to a psychiatric facility, keeping them there, and discharging them. There are also two forms which control access to a patient's clinical records. Given that NPs often serve as entry-points to the health system, restricting the ability to complete legal forms for mental health services to physicians presents a significant safety hazard for vulnerable Ontarians.

The right nurse in the right place: The College of Nurses of Ontario (CNO) indicates that the appropriate nursing skill mix depends on three factors: the client, the nurse, and the environment. The category of health professional assigned to care for a patient, client, or resident should be based on their complexity, predictability, and risk of negative outcomes. More complex patients with less predictability and less stable environments should be cared for by RNs. Less complex patients, with predictability and a stable environment may be cared for by RPNs.[61] Yet RNAO continues to hear about instances of RN replacement which lead to patient assignments that contradict CNO standards and put Ontarians at risk.

RNAO is calling on the Ontario government to mandate that any new nursing hires in tertiary, quaternary, and cancer care centres be RNs with a long-term goal of having an all RN-workforce within these settings in three years and within five years for large community hospitals. These centres are designed to provide care specifically to persons with high degrees of complexity and instability. Diluting RN care in these settings is risky to patient safety and outcomes.

The number of Ontarians receiving home care and their complexity has also increased as patients are being discharged earlier from hospital.[62] The practice of home care nursing is complex, requiring a diverse knowledge base to manage patient care across the lifespan.[63] During the initial visit, the complexity and stability of the patient is often unknown.[64] Thus it is critical that all first home health-care visits be provided by an RN because they are best suited to perform a comprehensive assessment and develop a care plan that ensures a patient's complex needs are met safely in their homes.[65]

Review and transform long-term care funding models: LTC homes provide accommodation and care for people – primarily seniors – with long-term health conditions and/or cognitive disabilities. In LTC facilities, residents have 24-hour access to nursing and personal care as well as assistance with activities of daily living.

Ontario's population is rapidly aging. Experts estimate the number of seniors aged 75 and older will double within the next 20 years.[66] Without dramatic system changes, there will be a shortfall of 48,000 LTC beds over the next five years.[67]

The needs of LTC residents have grown. Compared to previous generations, residents in LTC homes today have increasingly complex care needs, and yet funding has not kept up with this change. LTC admission criteria now require new residents to have high or very high physical and cognitive challenges to qualify for admission.[68] Nearly all residents have multiple chronic conditions (e.g., heart disease, diabetes, arthritis).[69] About 90 per cent of LTC residents have cognitive impairment, including dementia,[70] and about 80 per cent of residents with dementia have behavioural symptoms, including aggressive or severely aggressive behaviour.[71] Seniors are also being cared for longer in the community, and thus are older, frailer, and have greater needs when they are admitted to LTC homes.

Finite resources and complex resident conditions are straining the current system. Adequate and outcomes-based funding would allow LTC homes in the province to provide the highest level of quality care to their residents.

Currently, the MOHLTC funds LTC homes in Ontario on a level-of-care per diem basis within four envelopes. As of July 1, 2017,[72] the total per diem funding amount is $170.14, as follows:

- Nursing and personal care, including direct care staff and supplies: $96.26
- Program and support services: $9.60
- Raw food: $9
- Other accommodations: $55.28

All LTC home beds in Ontario receive the same base per diem funding for all funding envelopes, except nursing and personal care. This funding envelope is adjusted based on resident complexity and care needs, identified by an indicator called the "case-mix index" (CMI) – a measure of relative patient acuity levels in a LTC home.[73] Case-mix classification uses formulas to cluster residents into clinically similar groups that reflect the relative costs of services and supports that individual residents, with different needs, are likely to use.

The current LTC funding model is problematic in a number of ways. First, when homes implement plans that enhance quality of care and lead to improved resident outcomes, their CMI is reduced and their funding is cut. This unintentionally acts as a disincentive to improve quality of care. Second, funding is only provided for indicators captured in the resident assessment tool, meaning there is a disincentive to provide uncovered services.[74] Third, funding is based on 12- to 19-month-old CMI data. Since acuity keeps rising, funding will not keep up with increasing needs. Ontario's LTC funding model must be changed to address these shortcomings. Alberta has implemented ideas worth examining, including quality incentive funding (QIF).[75]

The right staff mix for long-term care homes: It is shocking that the only legislated LTC staffing requirements in Ontario are a vague instruction for care "to meet the assessed needs of residents"[76] and a minimum requirement of RN on duty at all times.[77] Staffing standards have not changed even though the resident population in LTC is increasingly complex, and there is a growing incidence of responsive behaviours (a term used to describe the behavioural and psychological symptoms of dementia).[78] Despite the best efforts of care providers, the needs of LTC residents are not being met due to inadequate staffing resources, inappropriate skill mix, and limited access to RNs.

Of all direct care staff working in LTC right now, RNs account for nine per cent and RPNs for 17 per cent. Other regulated professionals include nutritionists, social workers, and physiotherapists, who together account for eight per cent of all direct care staff. The remaining 65 per cent of direct care is delivered by unregulated staff.[79]

In recent years, there has been a marked increase in the share of nursing and personal care employment held by RPNs and PSWs in Ontario's LTC homes.[80] This is troubling when considered alongside the trend of increasing complexity of LTC home residents, since as previously noted, RNs are best suited to care for complex residents.

Evidence is clear that RNs improve the quality of care in LTC homes. Increasing RN staffing ratios in LTC homes has been proven to reduce the probability of hospitalizations and associated health system costs, increase rates of hospital discharge to back to LTC homes, and improve client outcomes (e.g., reduced mortality, fewer pressure ulcers, fewer urinary tract infections, less urinary catheter use, less restraint use, and fewer falls).[81 82 83 84 85 86 87]

Recently, through its *Aging with Confidence: Ontario's Action Plan for Seniors,* the government committed to increasing staffing levels in LTC to ensure a provincial average of four hours of direct nursing, personal, and therapeutic care per resident, per day. RNAO is concerned that this recommendation includes therapeutic care in the target average number of hours. We believe that funding should be provided for no less than an average of four hours of nursing (NP, RN, and RPN) and personal (unregulated providers) care per resident per day. Therapeutic care should be in addition to these four hours, with more hours for residents with greater acuity.[88 89] RNAO also calls for the minimum standard of care to be legislated.

Given the increasingly complex needs of Ontario's LTC residents, RNAO continues to call for a legislated staffing mix in LTC that includes a minimum of one NP for every 120 residents, as well as 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent PSWs for every LTC home in Ontario. Sufficient staffing numbers, and the right mix of staff, must be in place to deliver high-quality care to LTC home residents and to safeguard their safety.

Models of nursing care: RNAO believes an effective nursing human resources strategy is not as simple as increasing the number of staff, but instead requires matching human resources with the needs of patients.[90] It is also imperative that nurses are fully engaged in the evolution of the health system to ensure service delivery remains person- and family-centred and of high quality.[91] This can only be accomplished through evidence-based practice and policy that includes: the appropriate number of RN staff; full and expanded scope of practice utilization; robust interprofessional practice; effective organizational models of nursing care delivery; the appropriate skill mix; and evidence based clinical practice.

"Primary nursing" or "total patient care models" assign individual patients to the most appropriate nurse (RN or RPN) who acts as their primary nurse throughout the entire care process, providing all aspects of nursing care. This approach facilitates comprehensive care of clients and is linked to

improved patient outcomes, as the nurse is better able to detect threats to patient safety and intervene promptly to avoid adverse events.[92]

Primary nursing is also associated with improved outcomes for patients, nurses, and work environments when implemented through a supportive culture.[93] When nurses practise in primary nursing models, they have more autonomy, increased accountability for the care they provide, and improved clinical decision-making skills.[94] Evidence indicates that models of total patient care[95] and primary nursing[96] [97] [98] are less costly for organizations than team-based models due to the decrease in administrative and supervisory activities. [99]

In contrast, “functional nursing” or “team nursing" parcels out patient care into tasks that are handled by a mix of health professionals. Functional models of nursing care view nursing as a broad set of tasks (e.g. medication administration, dressing changes, baths, and vital signs) that can a be carried out by a variety of workers (e.g. RNs developing care plans, RPNs performing vital signs, and PSWs giving baths).[100] RNAO cautions against implementing this model of care, since it disrupts continuity of care, and is associated with de-skilling and RN replacement.

Nursing and health services recommendations:

Recommendation 1. Locate LHIN care co-ordination and care co-ordinators in primary care settings.

Recommendation 2. Enable nurse practitioners (NPs) to work to their full scope of practice by allowing them to: perform point-of-care testing, order all diagnostic imaging, order ECG’s in all situations, certify a death, and complete legal forms for mental health services.

Recommendation 3. Immediately mandate that any new nursing hires in tertiary, quaternary, and cancer care centres be registered nurses (RN), with the long-term goal of having an all RN-workforce in these settings within three years and in large community hospitals within five years.

Recommendation 4. Require that all first home health-care visits be provided by an RN.

Recommendation 5. Review and transform funding models in long-term care (LTC) to support improved resident care. In particular, consider putting resident improvement funding in place to encourage and enable – rather than penalize – improvements in resident outcomes.

Recommendation 6. Legislate minimum staffing and skill mix standards in LTC, accompanied by the necessary funding to support this change. There should be no less than one attending NP for every 120 residents, and a staff mix consisting of 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent PSWs. This ratio would ensure all LTC residents receive care when they need it from the most appropriate provider.

Recommendation 7. Mandate professional models of nursing care that advance care continuity and avoid care fragmentation (primary or total patient care) across all sectors of the health system.

3. Improving our medicare system

Canada's medicare system is much cherished because it provides equal access to insured health services for all Canadians without user fees, regardless of their income. Under the Canada Health Act, Canadian medicare covers all medically necessary hospital and physician services, which is the bulk of health care. However, there are important omissions which must be addressed, such as prescription drugs, long-term care, home care, dental care and physiotherapy. Provinces provide very different but incomplete levels of coverage in these areas. Here we call for Ontario to expand existing pharmacare and oral health care programs . We are also requesting that the government mandate electronic personal health records (PHR).

An Ontario pharmacare program: Every developed country in the world with a universal health care system also provides universal coverage of prescription drugs – except for Canada.[101] Most Canadians do not have access to public drug coverage, and the absence of common purchasing of pharmacare means Canadians pay some of the highest drug prices in the developed world. Drug prices in Canada are about 35 per cent higher than the median for countries in the Organization for Economic Co-operation and Development (OECD), and Canada has the highest per capita drug expenditure in the OECD after the U.S.[102] This puts the squeeze on all payers: the public, employers and government. It is thus not surprising that public drug spending in Ontario had risen to 9.2 per cent of the health budget in 2016 – up from 1.2 per cent in 1975.[103]

In the absence of a national pharmacare program, many Ontarians rely on a patchwork of existing public drug plans,[104] while the rest have to pay privately or obtain private insurance. Currently, the Ontario Drug Benefit Program covers seniors, people receiving social assistance, and participants in the Ontario Disability Support Program, while the Trillium Drug Program subsidizes those whose drug costs are high relative to their income.[105] [106] [107] Ontario also offers a number of smaller programs that address specific drug needs.[108] In 2016, 40.3 per cent of Ontario prescription expenditures were covered by the provincial government, 1.1 per cent by the federal government, and 0.5 per cent by the Workplace Safety and Insurance Board. The other 58.2 per cent[109] was paid by private insurers and out-of-pocket by the public.[110]

Without universal pharmacare, those who are living with low or modest incomes without access to adequate drug coverage may be forced to go without medication, or choose between paying for medication and purchasing other life necessities such as food, or go into debt.[111] [112] Law et al., writing in the *Canadian Medical Association Journal*, found that one in ten Canadians who received prescriptions reported they did not adhere to them because of the cost of their medications.[113] A 2015 Angus Reid survey found that in the past year, 23 per cent of respondents reported they, or another member of their household, did not take drugs as prescribed due to cost.[114] Numerous

international studies have also confirmed the health consequences of cost-related prescription non-adherence.[115] [116] [117] [118] [119] [120]

RNAO agrees with the overarching principle that "all Canadians deserve equitable access to safe, cost-effective, and appropriately prescribed medicines at a fair and affordable cost to patients and society as a whole."[121] Pharmacare has the potential to help realize this principle by meeting four key policy goals:

- Access: universal access to necessary medicines
- Fairness: fair distribution of prescription drug costs
- Safety: safe and appropriate prescribing
- Value for money: maximum health benefits per dollar spent[122]

Savings to individuals, families, businesses, and the health-care system from pharmacare would come from:

- Reduced administrative, marketing and regulatory costs due to a single-payer system
- More effective, evidence-informed prescribing
- Use of purchasing power to reduce drug prices
- More efficient use of health system resources (uninsured services tend to be underused because of affordability concerns, which leads to an increased risk of costly health complications)

Potential savings for Canadians from pharmacare are significant. Gagnon and Hébert estimate $10.7 billion in annual savings (or 42.8 per cent of total Canadian spending on prescription pharmaceuticals).[123] A 2015 Canadian Medical Association Journal article estimated the expected savings at $7.3 billion.[124] While those estimates would not be as high for a provincial pharmacare program in Ontario, savings would nonetheless be substantial.

RNAO has long advocated for a national pharmacare program.[125] [126] [127] In 2016-17, the federal House of Commons Standing Committee on Health held hearings on the development of a national pharmacare program,[128] and concluded that it was time to implement a pharmacare program that would provide universal access to essential medications, without means testing, user fees or co-payments. Unfortunately, the federal government needs a bigger push than anticipated. Health Minister Jane Philpott has reported as saying “that her mandate, as far as it concerns drug prices and availability, is limited to getting better deals within the status quo.”[129] Thus some support of universal pharmacare may come from the federal government, but if, when and how much is still up in the air. The more pressure the provinces bring to bear in favour of a national pharmacare program, the better.

In the spring of 2017, two Ontario parties – Liberals and NDP – offered competing pharmacare strategies. The Liberals’ pharmacare plan, which was announced as part of their 2017 budget,[130] will cover the full costs of all 4,400[131] prescription drugs covered under the Ontario Drug Benefit (ODB) program for children and youth under age 25, with no co-payments or deductibles.[132] While this is an excellent start towards universal pharmacare, it would result in a three-tiered program with free medication for those under 25; coverage with deductibles and co-payments for those receiving

assistance from the Ontario Disability Support Program (ODSP) or Ontario Works (OW), and seniors; and no public coverage for the remainder of Ontarians between the ages of 25 and 64. The program began Jan. 1, 2018 with a $465 million investment.[133] The proposed NDP plan[134 135] would cover the "most common and essential 125 drugs" for all Ontarians, but this is only a fraction of the 4,400 medications covered under the ODB program. The NDP plan would cap co-payments at the level currently imposed under the ODB program.[136] The NDP said independent experts would develop the list of covered drugs, and that it would expand over time. They also indicated the program will cost $475 million, and could be fully implemented by 2020.[137]

RNAO welcomes both announcements as steps forward, and is calling for a plan that incorporates the best features of each: pharmacare for the entire population with full coverage and no co-payments or deductibles of all prescription drugs currently listed under ODB. Our association had hoped discussions around a national Health Accord would include a national pharmacare program, but so far that has not happened. It is thus fitting for Ontario to lead with its own provincial plan, the way it did when strengthening the Canada Pension Plan.[138]

Oral health services for adults and seniors living with low income: Ontario's RNs, NPs, and nursing students know that oral health is a critical component of overall health and well-being.[139] The problem is that about 2.3 million Ontarians (or 17 per cent of the province's population) cannot afford to visit a dentist or dental hygienist.[140] This includes people who are living in low income because of precarious or low-paying jobs, adults receiving OW, and ODSP recipients who are eligible for public dental benefits, but are often refused treatment by dental providers due to the low level of public compensation. Those suffering from pain and infection are forced to turn to more costly and less effective health services. In 2015, there were nearly 61,000 visits to emergency rooms for dental problems at a cost to the system of at least $31 million.[141] In 2014, there were almost 222,000 documented visits to physicians for oral health problems at a cost of $7.5 million.[142] Instead of spending this money on visits to health providers who often do not specialize in dentistry,[143 144] these resources would be better spent on public dental services for adults and seniors in need.

The 2014 provincial budget committed to extending public dental programs to adults living with low income by 2025, but this promise needs to be delivered more quickly. Inequities in oral health and in access to oral health services are well documented, and need to be urgently addressed both as consequences and causes of poverty in our province.[145 146 147]

RNAO has endorsed the Ontario Oral Health Alliance's recommendation that the province invest $10 million to support the first phase of a public program to provide oral health care to adults and seniors across the province living with low income.[148] This funding should be allocated to maximize the use of existing public investments in dental clinic infrastructure in Community Health Centres, Aboriginal Health Access Centres, and Public Health Units.[149]

Addressing the oral health needs of Ontarians will have physical, mental, and social benefits, and allow people to live with health, dignity, and hope.

Patient-centred health records: Ontario is pursuing two strategies for electronic health record-keeping:

- The electronic health record (EHR), which is a longitudinal, systematic record of clinically relevant information, created from information drawn from multiple data sources. In Ontario, it is held at the provincial level.
- The electronic medical record (EMR), which is a digital version of a paper chart that contains a patient's medical and clinical data gathered from one provider organization (e.g., physician's office, family health team).

In pursuing both strategies, the province is taking important steps to allow the safe and effective management of health. However, these two examples do not facilitate patients readily accessing their own health records, which is an important aspect of person-centred care. RNAO urges mandating the development of electronic personal health records (PHR), which would be controlled by patients. These records would integrate information from a variety of sources (e.g., medical records from multiple health-care providers and patients), and help patients to securely store, monitor and record their own health information. PHRs include all or some information from an EMR or EHR, but are separate from, and not a replacement of, the records of health-care providers.

The design of the PHR system is important. For example, tethered systems are linked to health providers' EMR systems, which allow automatic updating. RNAO prefers this to standalone PHRs which require patients to manually enter data. It is crucial that patients, families, caregivers and health care providers are consulted in development of a provincial PHR plan, so that patient needs will be met.

Health system recommendations

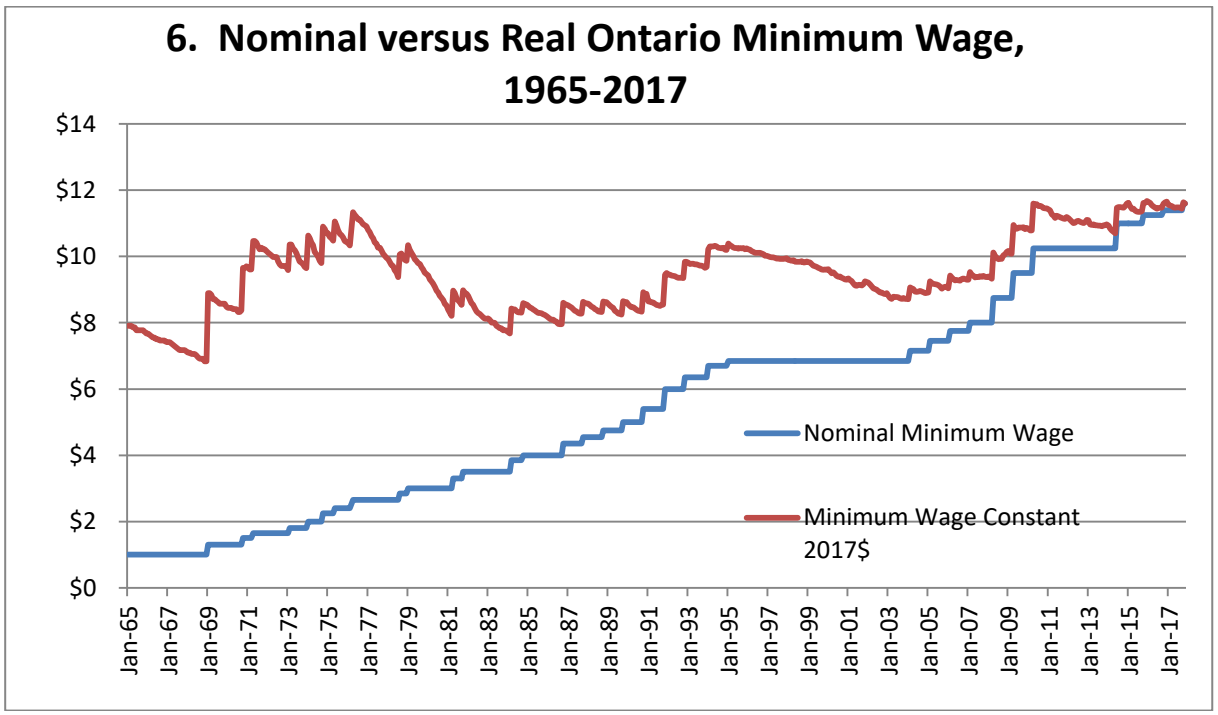
Recommendation 8. Proceed with a universal, single-payer pharmacare program in Ontario covering all medically necessary drugs and associated products,[150] with no means testing, co-payments or deductibles. This will deliver equity, compliance with prescriptions and the efficiency of a single-payer system.[151] [152]

Recommendation 9. Invest $10 million to support
the first phase of a public program to provide oral health care to adults and seniors living with low income across the province.

Recommendation 10. Mandate that electronic personal health records (PHRs) be made available to patients, in order to increase access to medical information and encourage patient participation in health-care decision-making. Patients, families, caregivers, RNs, NPs, and other health-care providers must be consulted in the development of a provincial PHR plan so that it reflects what patients need and want.

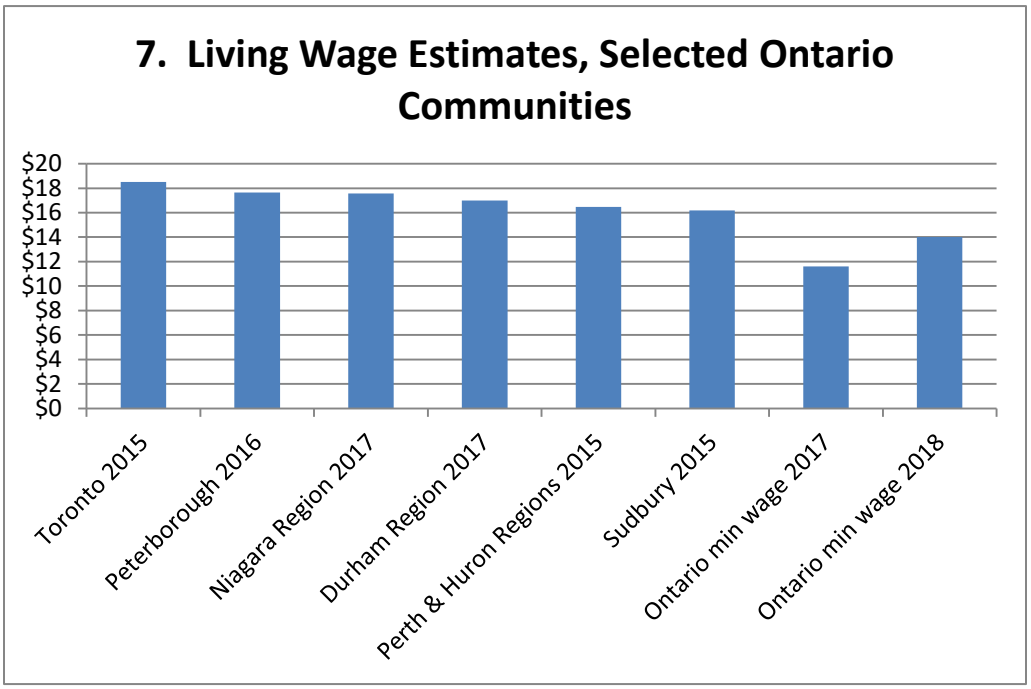
4. Improving our living standards

The minimum wage: While Ontario's minimum wage has trended upwards from 1965 to 2017 through periodic increments from $1 per hour to $11.60 per hour, these improvements have been modest over the past half century when adjusted for inflation (see the red line in the graph below).[153]



As a result of these insufficient increases, the $11.60 minimum wage in 2017 fell far short of a living wage. For example, the living wage in 2015 in Toronto was estimated at $18.52 per hour for a family of four. And of course, the cost of living has risen since that living wage was estimated.

The graph below shows how the Ontario minimum wage in 2017 and 2018 stacks up against the living wage for a family of four in various Ontario communities. An increasing number of communities[154] [155] [156] [157] [158] [159] in Ontario are calculating the living wage to reflect what a family of four would need to "meet its basic needs, participate in the economic and social fabric of their community, and purchase items that can help them escape marginal subsistence."[160] RNAO welcomed the royal assent of Bill 148, *Fair Workplaces, Better Jobs Act, 2017* this past November, which brought increases of the minimum wage to $14 per hour on Jan. 1, 2018 and to $15 per hour on Jan.1, 2019. Yet these increased rates will still fall short of a living wage as calculated for the communities shown below.



Affordable, inclusive housing: Record cold temperatures, dangerously overcrowded shelters, and public disputes between politicians and activists[161] put a particular spotlight on the issue of homelessness over the recent holiday season. The impacts of being homeless to a person's health and human dignity are devastating. To our shame as a society, mortality data in Ontario's largest city has only being officially tracked over the last year and shows an alarming 2 individuals per week dying while homeless in Toronto.[162] With over 5,400 people in Toronto's emergency shelter system on average each night in December 2017 and more than 600 others at warming and respite centres,[163] Toronto's failure is highly visible but not unique in the province. It is estimated that there are about 12,000 Ontarians who are homeless each night and shelters across the province report being over-capacity throughout the year.[164]

Those who are visibly homeless are only the tip of the affordable housing iceberg. This crisis of people sleeping rough on our streets, on chairs in warming centres, or on the floor in an Out of the Cold space needs to be immediately addressed. Specific solutions will vary by community. In Toronto, for example, RNAO joined our members working in the sector to urge the immediate opening of 1,000 new shelter beds and the opening of emergency shelters at the Fort York and Moss Park armouries.[165] Sadly, beneath the tip of the "affordable housing iceberg," there are even larger numbers of people who are staying with friends or "couch surfing" (hidden homeless), living in overcrowded, substandard, inadequate housing, living in core housing need, and living in unaffordable housing.[166]

In 2014, 12.7 per cent of Canada's urban households were in need of affordable housing.[167] Ontario had the highest need of any province at 16.1 per cent of urban households,[168] and all four communities in the country with the highest percentage of households in need were in Ontario: Peterborough (21.8 per cent); Toronto (19.9 per cent); Kingston (18.7 per cent); and St. Catharines-Niagara (17.9 per cent).[169]

As RNAO recommended to the Ministry of Municipal Affairs and Housing in 2015 when it was updating the province's Long-Term Affordable Housing Strategy, one way to reverse this trend is to invest one per cent of the province's budget into affordable housing. The money will help create new affordable housing stock and address the backlog of existing affordable housing units in need of repair.[170] In 2014, the Ontario Non-Profit Housing Association calculated that a provincial commitment of $1.3 billion per year, over 10 years (or roughly one per cent of province's annual budget), would be required to assist households in need of better housing and to help address homelessness.[171] One per cent of the current outlook for Ontario's 2017-18 budget would be about $1.5 billion.[172]

The ability to access affordable housing must be extended to every Ontarian who needs it, including people with physical, sensory, cognitive (including developmental) and learning, mental-health, and acquired-brain injury disabilities. Universal design in the built environment is increasingly recognized as a cost-effective, sustainable best practice critical to accessibility and ease of living for everyone as our population ages.[173] [174] Yet, people looking to buy barrier-free houses find that supply is scarce[175] and even progressive developments (such as Regent Park in Toronto's 2,083 social housing units and 5,400 market-rate apartments) were not designed for people with any type of physical disability.[176]

The cost of not having affordable housing and adequate health and social supports can take its toll on individuals, families, and communities. The status quo has resulted in high rates of homelessness and high financial costs for society. A recent economic analysis found that in five Canadian cities, the average annual cost of health, social, and criminal justice services per homeless person with mental illness averaged $53,144, with Toronto having the highest cost at $58,972.[177] The Mental Health and Addictions Leadership Advisory Council's 2016 recommendations include urging the province to create at least 30,000 units of supportive housing over 10 years for people with mental health and addiction issues.[178]

Preventing homeless by addressing poverty, income insecurity, direct and systemic forms of violence, including all forms of discrimination[179] is crucial. To prevent and address chronic homelessness, it is also essential to close critical service gaps in mental health and addiction services. Investments must be made to provide all Ontarians with high quality and accessible mental health and addiction services.[180] Harm reduction, supervised injection services, and overdose prevention services also need steadfast investment in order to address the current overdose crisis, which often overlaps with the crisis in homelessness and affordable housing. The good news is that other communities in Canada have proven that public policy can make a difference. Edmonton, Montreal, Hamilton, Guelph, and London have all avoided shelter emergencies this year because of their robust investments in moving people from the shelter system to supportive housing.[181]

Indigenous health: The legacy of intergenerational trauma from the residential school system, colonialism, and racism has resulted in Indigenous people experiencing tremendous inequities in health and social outcomes. One alarming example is that suicide rates are up to seven times higher for First Nations youth compared with non-Indigenous youth.[182] In February 2016, Nishnawbe Aski Nation (NAN) Territory and the Sioux Lookout region declared a health and public health

emergency.[183] [184] [185] NAN reported there had been 543 suicides among people of all ages in their territories since 1986.[186] From January to July 2017 alone, there were 22 suicides, of which eight were children between the ages of 10 to 15 years.[187]

The Ontario government has acknowledged the problem, saying "...the youth suicide crisis in northern First Nations...is nothing short of a health and social emergency,"[188] and has made a very important promise: "Ontario is committed to providing immediate support to First Nations in crisis. However, we feel strongly that emergencies will continue to occur and intensify unless meaningful and dramatic realignment and transformation happens to change the status quo and address the systemic disparities facing Indigenous communities, particularly in northern First Nations. It is not up to First Nations to right the wrongs of colonization. Governments must invest in meaningful and lasting Indigenous-led solutions so communities can heal and young people can have hope for a brighter future." [189]

This challenge has been well-known for decades. It will require resources, effort and collaboration far exceeding that which has happened to date.

Living standards recommendations

Recommendation 11. Increase the minimum wage to $15 per hour on January 1, 2019 with annual inflation adjustments every year thereafter, without exemptions by age or sector.

Recommendation 12. Invest one per cent of Ontario's budget ($1.5 billion) to address the backlog of existing affordable housing units in need of repair and to create new affordable housing stock.[190]

Recommendation 13. Amend the building code to require that all new multi-unit buildings incorporate the principles of universal design for accessibility and visitability.69[191]

Recommendation 14. Create at least 30,000 units of supportive housing for people with mental health and addiction issues over ten years.[192]

Recommendation 15. Work with other levels of government to ensure adequate shelter space in communities across the province to address the crisis of homelessness.

Recommendation 16. Invest in mental health and addiction services as well as harm reduction, supervised injection services, and overdose prevention services to address chronic homelessness and the current overdose crisis. Ensure these services are also available in our shelters and drop-in centers.

Recommendation **17.** Partner with Indigenous nations to address the urgent health needs they identify, such as the ongoing crisis of child and youth suicide.

5. Improving health through environmental protection

Greenhouse gases and climate change: RNs, NPs and nursing students are concerned about climate change because of its serious environmental and health implications. Our planet is already seeing weather disturbances causing severe population dislocation (e.g., drought in the Horn of Africa, hurricanes in the Caribbean Sea). Climate change also affects Ontarians' health by contributing to extreme weather events, poor air quality, and the spread of diseases. By fighting climate change, we are not merely protecting the environment; we are protecting people's health. We are also fighting for environmental justice, because the most vulnerable populations are the ones who have contributed the least to climate change.

The pollution that creates greenhouse gases (GHGs) also has other serious health effects. For example, the Ontario Medical Association estimated there were about 9,500 premature deaths in Ontario due to smog in 2008,[193] while the U.S. Environmental Protection Agency (EPA) estimated 200,000 American deaths per year due to particulate matter alone.[194] Particulate matter is a by-product of burning carbon products like diesel fuel. The good news is that by reducing GHG emissions, also reduces pollution, creating a range of health benefits. An example of this positive step came when Ontario closed its coal-fired power plants, which not only reduced carbon emissions, it also improved air quality. The number of smog days in Ontario went from 53 in 2005 to zero in 2014 and 2015.[195]

Economists generally agree pricing carbon emissions can help meet GHG reduction targets. A strong price signal will promote necessary behaviour changes to support the environment. The government is currently implementing a cap-and-trade system to price carbon. This involves creating a capped number of permits to emit carbon, in line with the province's emission targets, and auctioning them off. The 2017 cap-and-trade program covered the bulk of emissions (including electricity, transportation fuel, industry, large commercial and institutions). RNAO is concerned that the program gave the largest emitters 100 per cent of their permits for free for the first four years (2017-2020) in an effort to compete with other jurisdictions that don't have carbon pricing.[196] This is unnecessary because most Ontario producers are not emissions intensive and/or do not tend to compete with companies outside Ontario. To the extent that competition from outside Ontario is an issue, the province should pursue all opportunities to level the playing field by working with the federal government to implement border adjustments whereby imports are taxed according to their carbon content.[197]

Transit and active transportation**:** Automobiles are a major source of pollution, particularly in urban environments. They also cause congestion on our roadways, which costs Ontarians billions of dollars in time, vehicle operating costs, accidents, emissions, and lost economic opportunities.[198] Yet many people in urban areas have little choice but to drive, with public transit options inadequate and opportunities for active transportation like biking and walking undeveloped or unsafe.

The Big Move is the regional transportation plan developed in 2008 by Metrolinx, [199] which focused on transforming transit in the Greater Toronto and Hamilton Area (GTHA). The plan was reviewed in

2013 by the Anne Golden panel,[200] which urged the province to develop substantial new dedicated revenue streams to pay for the next wave of transit infrastructure, and to align the Big Move with the Growth Plan for the Greater Golden Horseshoe. The panel also recommended $300 million funding for a kick-start program to deliver immediate visible improvements in transit service.[201]

The Big Move was also supported by the medical officers of health for the GTHA in their 2014 report on designing healthier transportation systems and healthier cities.[202] The report concluded that better community design and implementing The Big Move could prevent 338 premature deaths every year by increasing physical activity, reducing harmful vehicle emissions and reducing the staggering cost of congestion.[203] It recommended Ontario provide long-term transit funding, work with Metrolinx and the municipalities to implement and optimize access to transportation options, and change government policies to better support active transportation and public transit.

The provincial ($31 billion), municipal ($1.9 billion) and federal ($6.5 billion) governments have since stepped up with transit capital funding.[204] [205] This is a significant step forward, but another $28.8 billion[206] is required to complete the construction of the rapid transit expansion for the GTHA under The Big Move. There has also been a recent scaling back of Metrolinx rapid transit plans,[207] and a recent report put the annual net funding gap for rapid transit construction and operation at over $2 billion.[208]

Environmental protection recommendations

Recommendation 18. Set the carbon cap at a level that will deliver greenhouse gas (GHG) reductions on the targeted schedule or earlier.

Recommendation 19. Make free or subsidized GHG emission permits highly targeted and temporary.

Recommendation 20. Direct carbon pricing revenues to programs that reduce GHG emissions reduction and mitigate the impact higher carbon prices will have on vulnerable populations. Manage those revenues transparently with strong public oversight.

Recommendation 21. Work with federal and municipal partners to ensure dedicated and sustainable revenue sources to pay for ongoing operation and substantial expansion of transit and active transportation in Ontario.

6. Paying for these recommendations

Insufficient revenue means cutting or foregoing services: Taxes and other government revenues pay for the public services required in a civilized and healthy society – including health care, education, social services, environmental protection and public security. They also pay the wages of workers who deliver those services, including nurses and other health professionals.

Historically, Ontario spends like a have-not province: Only Quebec has lower per capita program spending, as the Figure 8 in the appendix shows. [209] Interestingly, Ontario spent the least per capita of any province in the early 1980s, became one of the bigger spenders in the 1990s, and resumed its laggard position by the end of the century. This austerity has been a matter of political choice. The public sector has been starved in favour of private spending.

When provincial per capita spending is compared to Ontario (set to 100) (see Figure 9 in the appendix),[210] the proportional gap is evident: as of 2017-18, Newfoundland program spending was 48.2 per cent higher, and even eighth-place B.C. is 12.4 per cent higher. Only Quebec is edging out Ontario by 5 per cent, in the race to the bottom.

The province has chosen to limit the revenue it receives through taxation: As noted in section 1, Ontario spends like a have-not promise, lagging behind the per capita spending of other provinces for much of the past three decades. But Ontario is not a have-not province. Instead, Ontario's choice to spend a lower share of its GDP on programs than every other province (as the Figure 10 in the appendix shows)[211] is part of an historic reluctance to collect revenue. Ontario's revenue share of GDP is the second lowest in Canada, higher only than Alberta (see Figure 11 in the appendix).[212]

This has resulted in government austerity measures that have reduced critical public services. We must ask: do we really benefit as a society with fewer public services? For example, pharmacare and publicly funded dental care programs would greatly improve access to necessary health services for those with moderate and low incomes. The benefits of these programs for Ontarians would well exceed their costs. However, lack of adequate revenue prevents their implementation.

Ontario's deficit has always been manageable: As mentioned above, the province projects that it will balance its books in 2017-18, as it steadily reduced its deficit from 3.2 per cent of GDP in 2009-10. This was achieved chiefly through budgetary constraints: while revenue/GDP rose from 17.2 per cent in 2009-10 to 17.9 per cent in 2017-18 (0.7 percentage points), program expenditures/GDP dropped from 18.8 per cent to 16.4 per cent (2.4 percentage points) over the same time period. As our submission documents, we could invest much more in supporting Ontarians' health, but that is difficult to do so long as a misplaced focus on deficit reduction dominates the discussion.

The province would be better served by shifting the focus from keeping taxes low and balancing the budget to restoring infrastructure and decent jobs. Ongoing austerity has resulted in a huge social and physical infrastructure deficit, and has likely delayed economic recovery by restraining consumer spending. A society that invests too little in social, educational and physical infrastructure limits its development prospects. Given that borrowing costs are at historically low levels, there is no compelling reason not to make these necessary investments now

Tax cuts are not the way to go: Low taxes are rationalized on the grounds that they stimulate the economy. However, any private spending stimulus is more than offset by corresponding government spending cuts, resulting in net job losses. As the Task Force on Competitiveness indicated, substantial federal and Ontario tax cuts were accompanied by falling investment rates per worker.[213] That isn't the kind of "stimulus" package that benefits the province.

Federal cutbacks: Major federal cutbacks have compounded the problem. The federal government has been cutting its revenue since the early 1980s: in 1981-82, the federal revenue share of Canadian GDP was 18.3 per cent. It dropped to 14.1 per cent in 2011-12, and has only recovered to 14.4 per cent as of 2016-17. As a result, federal program spending fell from 18.5 per cent of GDP to 14.4 per cent over the same time period.[214] We encourage the federal government to restore its own fiscal capacity and urge the same for the Ontario government.

Need for new revenue tools: Leaders like Toronto mayor John Tory have come to the conclusion that new provincial revenue sources are urgently needed to at very least meet current commitments.[215] Yet the province has rejected proposals to do so, such as the recommended Toronto road tolls.[216]

There are many revenue options. Green taxes, such as emission taxes or emission charges, have the advantage of discouraging harmful behaviour by making it more expensive. These taxes are more efficient, and could not only generate revenue but also help replace less efficient taxes, such as payroll taxes that discourage employment. On these grounds, the Task Force on Competitiveness has called for the implementation of an Ontario carbon tax.[217] The Ecofiscal Commission has similarly called for carbon pricing, and in June 2015 released its principles for an Ontario cap-and-trade program. That program is the carbon pricing option chosen by the province.[218] Ontario has started holding auctions of GHG allowances, so the program is well under way.[219] [220]

There are a number of sin taxes already on the books, such as gasoline, diesel, wine and beer. As economist Don Drummond outlined in his report to the government, these taxes apply to volumes rather than value. Unless the taxes are continually raised to account for inflation, this is the equivalent of continual cuts in the tax rate. The Drummond Commission recommended the replacement of such taxes with taxes that apply to value, the way a sales tax is a fixed percentage of the sale price.[221]

Ban asset sales: The government must also be wary of the temptation to sell off assets for one-shot revenue gains. At various times, Hydro One, Ontario Power Generation and the Liquor Control Board of Ontario have been mentioned as candidates for privatization.[222] The Premier's Advisory Council on Government Assets recommended selling off 60 per cent of Hydro One,[223] in spite of the report from Ontario's Financial Accountability Office suggesting that the sale would worsen the province's deficit position over the long run.[224] Nevertheless, Ontario did sell an initial 15 per cent of Hydro One shares in the fall of 2015[225] and a further 15 per cent in April 2016[226], much to the objection of organizations like RNAO.[227] In May 2017, Ontario reduced its holdings of Hydro One to 49.9 per cent through another sale of shares.[228]

Selling off assets is not a sustainable way of addressing revenue-expenditure imbalances, particularly when that asset is a monopoly that provides a large guaranteed stream of revenue. And it is likely to result in receiving poor value as buyers will have to discount the price to cover uncertainty, risk and transactions costs.

Fiscal capacity recommendations

Recommendation 22. Ensure the fiscal capacity to deliver all essential health, health care, social and environmental services by building a more progressive tax system. Do not cut taxes.

Recommendation 23. Increase revenue sources that encourage environmental and social responsibility. Begin by phasing in environmental levies and continue implementing a cap-and-trade program for carbon emissions.

Recommendation 24. Reject sales of publicly owned crown corporations and assets to fund government programs. Halt the further sale of Hydro One shares.

Recommendation 25. Seize this low-interest, low-deficit opportunity to catch up on investments in human, environmental and physical capital.

Recommendation 26. Ensure transparency and accountability in fiscal measures to deliver services people want and deserve, and to ensure this is done in an efficient manner.

Appendix

Trends in Key Fiscal Indicators by Province

8. Per Capita Program Spending											
	B.C.	ALTA	SASK	MAN	ONT	QUE	N.B.	N.S.	P.E.I.	N.&L.	Federal
1981-82	2,585	3,774	2,543	2,238	2,027	2,840	2,602	2,536	2,582	2,548	2,734
1982-83	3,002	4,939	2,915	2,566	2,292	3,043	3,117	2,623	2,945	2,855	3,168
1983-84	3,176	4,868	3,004	2,818	2,437	3,270	3,210	2,759	2,974	3,198	3,043
1984-85	3,232	4,933	3,147	2,947	2,567	3,507	3,377	2,949	3,089	3,182	3,291
1985-86	3,289	5,770	3,354	3,078	2,755	3,658	3,631	3,007	3,424	3,423	3,230
1986-87	3,409	5,488	3,733	3,239	3,035	3,692	3,953	3,123	3,582	3,606	3,367
1987-88	3,454	5,202	3,443	3,503	3,234	3,956	4,260	3,331	3,910	3,974	3,592
1988-89	3,629	5,337	3,598	3,670	3,527	4,045	4,353	3,730	4,300	4,237	3,686
1989-90	3,986	5,540	3,936	3,860	3,694	4,156	4,435	3,985	4,564	4,591	3,805
1990-91	4,414	5,783	4,509	4,103	4,093	4,514	4,738	4,038	4,846	4,891	3,920
1991-92	4,894	5,806	4,378	4,307	4,552	4,825	4,944	4,152	5,078	4,982	4,085
1992-93	4,936	6,144	4,211	4,408	4,629	5,007	4,995	4,259	5,289	5,115	4,306
1993-94	5,042	5,670	4,051	4,252	5,190	4,965	4,948	4,179	5,288	4,938	4,264
1994-95	5,175	4,991	4,175	4,277	5,200	5,040	4,975	4,099	5,276	5,294	4,249
1995-96	5,074	4,637	4,204	4,351	5,317	4,992	5,048	4,210	4,977	5,490	4,124
1996-97	5,058	4,577	4,222	4,346	5,085	4,772	5,105	4,094	5,098	5,524	3,760
1997-98	4,888	4,867	4,295	4,605	5,041	4,541	5,136	4,309	5,158	5,683	3,838
1998-99	5,846	4,948	4,748	4,784	4,930	4,857	5,375	4,737	5,523	5,800	3,861
1999-00	5,954	5,539	5,004	5,289	5,153	4,926	5,621	4,828	5,914	6,159	3,907
2000-01	6,303	5,984	5,218	5,388	5,091	5,219	5,439	4,748	6,265	6,497	4,255
2001-02	6,763	6,563	6,531	5,563	5,198	5,459	5,896	4,885	6,410	6,842	4,392
2002-03	6,753	6,410	7,258	5,797	5,385	5,659	6,285	5,065	6,539	7,248	4,677
2003-04	6,772	6,749	6,881	7,109	5,752	5,824	6,786	5,541	7,200	8,007	4,926
2004-05	6,825	7,365	7,493	7,512	6,165	6,054	6,943	5,964	7,488	7,793	5,594
2005-06	7,235	8,051	7,998	8,040	6,499	6,199	7,393	6,523	7,670	8,573	5,501
2006-07	7,608	8,562	8,539	8,580	6,794	6,459	7,890	7,015	7,877	8,990	5,855
2007-08	8,062	9,497	9,021	9,311	7,369	6,770	8,496	7,709	8,619	9,762	6,160
2008-09	8,394	10,138	10,323	9,461	7,403	7,112	9,025	8,172	9,453	10,824	6,378
2009-10	8,523	9,874	11,318	9,872	8,221	7,422	9,539	8,577	10,559	12,461	7,383
2010-11	8,660	10,173	11,985	10,219	8,466	7,564	10,009	8,383	10,174	12,840	7,156
2011-12	9,171	10,275	12,218	11,246	8,494	7,681	9,780	8,885	10,459	13,424	7,114
2012-13	8,977	10,587	12,562	10,824	8,371	7,698	10,089	9,207	10,320	13,146	7,091
2013-14	8,917	12,294	11,990	10,995	8,540	7,887	10,209	9,517	10,722	13,320	7,071
2014-15	9,029	11,597	12,015	11,360	8,639	7,954	10,761	9,568	10,628	13,542	7,140
2015-16	9,377	11,524	12,938	11,609	9,283	7,938	10,564	9,636	10,153	14,045	7,554
2016-17	9,709	12,267	12,764	11,802	9,298	8,378	11,050	9,755	10,461	14,021	7,914
2017-18	10,234	12,369	12,620	12,019	9,109	8,651	11,402	10,147	10,841	13,504	8,348

9. Index of Per Capita Program Spending (Ontario = 100)										
	B.C.	**ALTA**	**SASK**	**MAN**	**ONT**	**QUE**	**N.B.**	**N.S.**	**P.E.I.**	**N.&L.**
1981-82	127.5	186.2	125.5	110.4	100.0	140.1	128.4	125.1	127.4	125.7
1982-83	131.0	215.5	127.2	112.0	100.0	132.8	136.0	114.4	128.5	124.6
1983-84	130.3	199.8	123.3	115.6	100.0	134.2	131.7	113.2	122.0	131.2
1984-85	125.9	192.2	122.6	114.8	100.0	136.6	131.6	114.9	120.3	124.0
1985-86	119.4	209.4	121.7	111.7	100.0	132.8	131.8	109.1	124.3	124.2
1986-87	112.3	180.8	123.0	106.7	100.0	121.6	130.2	102.9	118.0	118.8
1987-88	106.8	160.9	106.5	108.3	100.0	122.3	131.7	103.0	120.9	122.9
1988-89	102.9	151.3	102.0	104.1	100.0	114.7	123.4	105.8	121.9	120.1
1989-90	107.9	150.0	106.6	104.5	100.0	112.5	120.1	107.9	123.6	124.3
1990-91	107.8	141.3	110.2	100.2	100.0	110.3	115.8	98.7	118.4	119.5
1991-92	107.5	127.5	96.2	94.6	100.0	106.0	108.6	91.2	111.6	109.4
1992-93	106.6	132.7	91.0	95.2	100.0	108.2	107.9	92.0	114.3	110.5
1993-94	97.1	109.2	78.1	81.9	100.0	95.7	95.3	80.5	101.9	95.1
1994-95	99.5	96.0	80.3	82.3	100.0	96.9	95.7	78.8	101.5	101.8
1995-96	95.4	87.2	79.1	81.8	100.0	93.9	94.9	79.2	93.6	103.3
1996-97	99.5	90.0	83.0	85.5	100.0	93.8	100.4	80.5	100.3	108.6
1997-98	97.0	96.5	85.2	91.4	100.0	90.1	101.9	85.5	102.3	112.7
1998-99	118.6	100.4	96.3	97.0	100.0	98.5	109.0	96.1	112.0	117.6
1999-00	115.5	107.5	97.1	102.6	100.0	95.6	109.1	93.7	114.8	119.5
2000-01	123.8	117.5	102.5	105.8	100.0	102.5	106.8	93.3	123.1	127.6
2001-02	130.1	126.3	125.6	107.0	100.0	105.0	113.4	94.0	123.3	131.6
2002-03	125.4	119.0	134.8	107.7	100.0	105.1	116.7	94.1	121.4	134.6
2003-04	117.7	117.3	119.6	123.6	100.0	101.3	118.0	96.3	125.2	139.2
2004-05	110.7	119.5	121.5	121.8	100.0	98.2	112.6	96.7	121.5	126.4
2005-06	111.3	123.9	123.1	123.7	100.0	95.4	113.8	100.4	118.0	131.9
2006-07	112.0	126.0	125.7	126.3	100.0	95.1	116.1	103.3	115.9	132.3
2007-08	109.4	128.9	122.4	126.4	100.0	91.9	115.3	104.6	117.0	132.5
2008-09	113.4	136.9	139.4	127.8	100.0	96.1	121.9	110.4	127.7	146.2
2009-10	103.7	120.1	137.7	120.1	100.0	90.3	116.0	104.3	128.4	151.6
2010-11	102.3	120.2	141.6	120.7	100.0	89.3	118.2	99.0	120.2	151.7
2011-12	108.0	121.0	143.8	132.4	100.0	90.4	115.1	104.6	123.1	158.0
2012-13	107.2	126.5	150.1	129.3	100.0	92.0	120.5	110.0	123.3	157.0
2013-14	104.4	144.0	140.4	128.7	100.0	92.4	119.5	111.4	125.6	156.0
2014-15	104.5	134.2	139.1	131.5	100.0	92.1	124.6	110.8	123.0	156.8
2015-16	101.0	124.1	139.4	125.1	100.0	85.5	113.8	103.8	109.4	151.3
2016-17	104.4	131.9	137.3	126.9	100.0	90.1	118.8	104.9	112.5	150.8
2017-18	112.4	135.8	138.5	131.9	100.0	95.0	125.2	111.4	119.0	148.2

10. Percentage of Provincial GDP Going to Program Spending											
	B.C.	**ALTA**	**SASK**	**MAN**	**ONT**	**QUE**	**N.B.**	**N.S.**	**P.E.I.**	**N.&L.**	**Federal**
1981-82	15.9	15.9	16.4	16.7	13.5	22.6	27.7	26.9	29.8	27.9	18.5
1982-83	18.8	20.1	18.8	18.7	14.6	22.9	30.4	24	31.6	29	20.6
1983-84	19	19.3	18.5	19.4	14.1	22.9	27.7	22.5	27.9	30.6	18.4
1984-85	18.7	18.3	18.4	18.3	13.4	22.6	26.5	21.8	28.4	28.4	18.3
1985-86	17.8	20.1	18.9	17.7	13.2	22.1	26.9	20.7	30.4	29.1	16.8
1986-87	17.7	22.4	21.4	18.2	13.5	20.7	26.2	19.8	27.5	28.2	16.8
1987-88	16.4	20.6	19.2	18.5	13.2	20.4	25.7	19.8	28.4	28.7	16.6
1988-89	15.9	20.1	19.4	18	13.3	19.3	24.8	21	28.6	28.4	15.8
1989-90	16.5	20	19.9	17.9	13.2	19.1	24.3	21.1	28.4	29.2	15.5
1990-91	17.9	19.6	21	18.3	14.7	20.3	25.5	20.9	29	30.4	15.7
1991-92	19.7	20.1	20.2	19.4	16.5	21.7	26.5	20.8	29.3	29.8	16.4
1992-93	19.2	21.1	19.5	19.5	16.7	22.1	26	20.9	30	30.7	17.1
1993-94	18.7	18.2	17.7	18.9	18.4	21.6	24.5	20.4	28.1	29	16.4
1994-95	18.6	15	17.1	18	17.6	20.8	23.7	19.7	27.7	29.2	15.6
1995-96	17.8	13.5	16	17.8	17.3	19.9	22.3	19.7	25	28.7	14.6
1996-97	17.6	12.6	14.8	17	16.2	18.8	22.3	19	24.5	29.1	13
1997-98	16.5	12.6	15	17.3	15.3	17.1	22.2	19.2	24.7	29.2	12.7
1998-99	19.7	13.1	16.2	17.2	14.4	17.7	22.2	20.1	25.2	27.8	12.4
1999-00	19.3	13.7	16.3	18.4	14.2	16.7	21.4	19	25.5	26.6	11.8
2000-01	18.9	12.2	15.3	17.7	13.2	16.7	19.6	17.4	25.3	24.2	11.8
2001-02	20.1	13	19.4	17.8	13.2	16.9	20.6	17	25.4	24.7	11.9
2002-03	19.5	13	20.6	17.8	13.2	16.9	21.4	16.9	24.2	22.5	12.3
2003-04	18.6	12.3	18.3	21.5	13.8	16.8	22	17.4	26	22.6	12.5
2004-05	17.5	12.3	18	21.5	14.3	16.8	21.3	18.2	25.6	20.5	13.4
2005-06	17.4	11.9	17.7	22	14.6	16.8	21.6	19	24.9	19.8	12.5
2006-07	17.1	11.9	18.4	21.8	14.9	17	22	20.1	24.5	18.7	12.8
2007-08	17.4	12.8	17.3	22.3	15.6	17	22.4	21.2	25.6	17.1	12.9
2008-09	17.9	12.3	15.5	21.7	15.7	17.6	23.4	21.6	27.6	17.5	12.8
2009-10	19.2	14.8	19.5	23.5	17.9	18.5	24.8	23	30	25.8	15.8
2010-11	18.9	14.1	19.9	23.4	17.6	18.3	24.9	21.4	27.6	23	14.6
2011-12	19	13	17.4	24.7	17.1	17.8	23.5	22.3	27.8	21	13.8
2012-13	18.4	13.1	17.5	22.6	16.5	17.6	24.1	23	26.9	21.6	13.5
2013-14	17.9	14.3	15.9	22.3	16.6	17.6	24.3	23.3	27.1	20.4	13.1
2014-15	17.4	12.8	16	22.8	16.2	17.6	25.3	23	26	21	12.8
2015-16	18.3	14.8	18.4	22.8	16.8	17.2	24.1	22.6	24.1	24.7	13.6
2016-17	18.5	17	19.1	23	16.3	17.8	24.9	22.5	24.4	24.8	14.2
2017-18	18.7	16.5	17.9	23	15.6	18	25.2	22.8	24.5	23.3	14.5

11. Percentages of Provincial GDP going to Provincial Government Revenue											
	B.C.	**ALTA**	**SASK**	**MAN**	**ONT**	**QUE**	**N.B.**	**N.S.**	**P.E.I.**	**N.&L.**	**Federal**
1981-82	15.5	20	17.6	15.8	13.1	21.7	27.7	24.5	34	29.6	18.3
1982-83	16.7	18.8	17.6	16.8	13.4	22.8	27.9	23.2	33.9	30.4	17.4
1983-84	17.2	19.8	16.8	18.2	13.4	23.3	27.9	22.8	32.3	30.2	15.5
1984-85	17.3	20.6	16.8	16.9	13.3	21.7	27.4	22	32.5	30	15.6
1985-86	16.7	19.3	16.8	16.5	13.3	22	28.8	21.4	33.3	31.4	15.6
1986-87	17.2	16.1	15.6	17.5	13.7	21.2	26.4	21	30.7	30.9	16.5
1987-88	17.4	19.3	17.8	19.4	13.7	21.4	26.4	21.3	31.5	31.9	17
1988-89	18	18.2	19.3	20.3	14.2	20.8	27.5	22.3	32.2	31.1	17
1989-90	17.7	18.6	20.7	19.3	14.6	20.6	27.3	22.2	32.2	32.3	17.3
1990-91	17.7	18.8	21.5	18.9	14.9	21.2	27.6	23.2	32.4	31.9	17.3
1991-92	17.6	18.3	18.6	20.2	14.1	21.9	27.4	22.3	31.7	32	18
1992-93	18.3	18.6	20.1	18.7	14.3	22	27.9	21.8	30.9	33	17.4
1993-94	18.7	18.6	20.3	19.4	17	21.8	26.7	22.1	29.7	32	16.6
1994-95	19.3	18	21.2	19.5	16.9	20.9	27.3	23.3	31.9	34.6	16.6
1995-96	18.3	16.6	19.3	20.5	17.2	21	26	23.2	29.5	33.6	16.9
1996-97	17.7	16.6	18.9	20	16.7	20.2	25.9	23.1	28.3	35	17.5
1997-98	17	16.3	17.7	19.2	16.6	18.7	25.5	22.7	27.8	37.3	17.8
1998-99	21.5	15.4	18.8	18.8	16.2	20.3	24.5	22.9	28.6	33.7	17.7
1999-00	21.6	16.9	18.8	19.5	17	19.3	24.4	22.2	28.5	30.4	17.6
2000-01	22.1	17.4	19.7	19.6	16	19.7	23.4	21.7	28.1	27.6	17.6
2001-02	20.6	14.2	20.6	18.9	15.5	18.7	24.5	21.5	28.2	27	16.1
2002-03	19.6	14.7	21.3	18.9	15.1	18.5	23.9	20.8	26.2	23.6	16
2003-04	19.5	14.9	20.5	22	14.6	18.6	23.9	21.1	26.9	22.8	16.1
2004-05	20.6	15.1	22.2	24.7	15.8	18.5	24.8	21.9	27.7	21.9	16.1
2005-06	20.8	15.8	21.1	25	16.3	18.7	25	22.6	27.5	24.2	15.8
2006-07	20.8	15.5	21.4	24.5	16.8	19.7	25.3	23.3	27.8	21.7	16
2007-08	20.2	14.6	22.4	25.1	17.3	19.4	25.4	25.1	28.1	23.9	15.6
2008-09	18.9	12.1	21.1	24.2	16	18.8	25.1	24	29.2	26.7	14.4
2009-10	19.4	14.5	20.1	24.6	16.1	18.8	24.7	24.5	30.6	28.4	14.2
2010-11	19.8	13	21	24.5	17	19.1	25	25	29.3	27.3	14.5
2011-12	19.3	13.2	18.2	24.4	16.6	19	24.8	23.9	29.3	25.5	14.1
2012-13	19	12.4	18.4	23.1	16.7	19.1	24.5	24.4	28.7	22.7	14.1
2013-14	19.1	14.4	17.3	23.1	16.7	19.2	24.5	23.7	29.4	21.7	14.3
2014-15	19.1	13.3	16.7	23.4	16.3	19.3	26.3	23.9	29	20.3	14.2
2015-16	19	13	17.2	22.9	17.8	19.5	25.4	23.7	26.7	19.8	14.9
2016-17	19.6	13.8	17.8	23.3	17.6	19.8	26.2	24.8	27.2	24.4	14.5
2017-18	19	13.7	17.6	23	17	20	26.8	24.9	27.5	24.1	14.4

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