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

Ontario Pre-Budget 2017: Nurses call for an Upstream Strategy

Submission to the Standing Committee on Finance and Economic Affairs

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1. Federal and provincial governments must work in partnership with the Chiefs of Ontario, Indigenous communities and their leaders to provide funding to ensure safe water, reliable sanitation, affordable housing, and accessible, high quality health care**.**

2. Act on multiple poverty fronts immediately:

    a. Increase Ontario's dangerously low social assistance rates (Ontario Works and the Ontario Disability Assistance Program) to reflect the actual cost of living and index the increased rate for inflation. RNAO supports the recommendation of the Interfaith Social Assistance Reform Coalition (ISARC) and the Income Security Advocacy Centre (ISAC) to invest $1 billion in social assistance in the 2017 budget as a necessary first step. Within this amount, $700 million should be invested in a 10 per cent increase in basic needs and shelter allowance rates. The remaining $300 million should be invested in rule changes to ensure basic fairness, remove punishments, better support relationships and work, and allow savings.

    b. Provide a basic income pilot project for Ontario with strong ethical safeguards. Ensure that no participant is worse off and make sure that there is no erosion of the current social safety net for the broader population. In order to support Indigenous health and reconciliation, RNAO particularly supports Hugh Segal's recommendation that the design of a basic income pilot adapted to the realities of Indigenous communities be "under the full prerogative of the First Nations Chiefs of Ontario."

    c. Raise the minimum wage to $15 per hour with no exemptions regarding age or sector.

3. Ensure all workers have the same protections and benefits enjoyed by workers with standard employment:

    a. Cover all classes of workers and employers under *the Employment Standards Act (ESA)* and *Labour Relations Act.* Update those acts to protect all workers, including access to personal emergency leave, paid sick days, and enhanced enforcement of strengthened labour laws.

    b. Develop and implement a plan (preferably via changes to the ESA) to deliver the same wages, benefits and working conditions to workers in nonstandard employment as those in standard employment, under the same terms and conditions (e.g., doing the same work with the same seniority).

4. Improve access to affordable housing and stimulate job creation by investing one per cent of Ontario's budget (about $1.39 billion) to address the backlog of

existing affordable housing units in need of repair and to create new affordable housing stock.

5. Implement a provincial alcohol strategy policy that is congruent with the public health evidence for better health outcomes:

    a. Roll back recent privatization initiatives and establish a moratorium on further privatization of alcohol sales. In light of the critical evidence of increased harm with increased physical availability of alcohol, strengthen government-run retailing systems and monopolies.

    b. Strengthen Ontario's minimum pricing structure by raising minimum prices; linking prices to alcohol content so that as alcohol content rises, so does price; and close loopholes to the minimum price.

    c. Ban the advertising, promotion, and marketing of alcohol as recommended by the World Health Organization.

6. Fund supervised injection services (SISs) in communities across Ontario where needed. Expedite funding for the proposed supervised injection services in Toronto and Ottawa to address current crisis, and any subsequent SIS needed across the province, as part of existing health services.

7. Invest $10 million to support the first phase of a public program to provide oral health care to low income adults and seniors across the province. This funding should be allocated to maximize use of existing public investments in dental clinic infrastructure in Community Health Centres, Aboriginal Health Access Centres, and Public Health Units.

B Environmental Determinants of Health

8. To ensure Ontario meets its greenhouse gas (GHG) targets:

    a. Set the carbon cap at a level that would deliver GHG reductions on the targeted schedule or earlier.

    b. Only link to other cap-and-trade markets when that maintains Ontario standards

    c. Make the granting of free or subsidized emission permits highly targeted and temporary.

    d. Ensure cap-and-trade revenues are managed transparently with strong public oversight.

9. The government must take all necessary steps to:

    a. Work with federal and municipal partners (starting with a transit summit) to ensure sufficient dedicated and sustainable revenue sources to pay for a

substantial expansion and ongoing operation of transit and active transportation,

b. Avoid resorting to public asset sales like the privatization of Hydro One to fund transit expansions, and

c. Support cost-effective and expeditious delivery of those expansions, implemented by transparent governance and informed expert opinion.

C Medicare

10. Implement a made-in-Ontario pharmacare program, while continuing to aggressively advocate for a national pharmacare program covering all medically necessary drugs.

11. Place greater emphasis on prevention of diabetic foot ulcers:

    a. Provide universal access to preventative foot care services, including supplying preventative shoes, socks and offloading devices to those in need, free at the point of care, for all Ontarians living with diabetes.

    b. Develop policies that enable every Ontarian with diabetes to have at least one foot assessment per year by a qualified health provider;

    c. Adopt an Ontario-wide interprofessional approach to diabetic foot care, with at least one multidisciplinary diabetes foot care team, with a well-defined referral pattern, in each Local Health Integration Network (LHIN);

    d. Publish, on an annual basis, reliable data on diabetes foot care, using internationally recognized metrics, to assist on-going quality improvement efforts.

    e. Provide education for clinicians & patients on the management of diabetic foot complications

12. Implement a complete legislative ban on inbound medical tourism.

D Health System Transformation

13. Advance an integrated health system that is anchored in primary care. Include all of primary care, public health units, home health-care and support service providers as HSPs under LHSIA.

14. Fund interprofessional care models of primary care (such as NP-led clinics, Community Health Centres, Aboriginal Health Access Centres, and Family Health Teams) so they can hire sufficient staff to work to full capacity.

15. Refrain from advancing policy that positions LHINs as delivering and/or managing health service delivery. Instead, focus the scope of LHINs on whole

system planning, integration, funding allocation, monitoring and accountability functions**.**

16. Fully dissolve CCACs and produce true health system transformation by preventing the automatic transfer of all CCAC functions, processes and resources to the LHINs.

17. Locate the nearly 4,100 CCAC care co-ordinators within primary care, while keeping them employed by LHINs.

18. Mandate tri-partite leadership models incorporating medicine, nursing and one other regulated health profession within each LHIN.

E Nursing

19. Immediately initiate and support a permanent table to discuss interprofessional HHR planning with key professions to start e.g. nursing and medicine resulting in an evidence-based interprofessional HHR plan to align population health needs and the full scope of practice of all regulated health professions with system priorities in Ontario.

20. Immediately issue a moratorium on nursing skill mix changes until a comprehensive interprofessional HHR plan is completed

21. Mandate LHINs to use organizational models of nursing care delivery that advance care continuity and avoid fragmented care.

22. The MOHLTC, LHINs and employers eliminate all barriers, and enable NPs to practise to full scope, including: prescribing controlled substances; acting as most responsible provider (MRP) in all sectors; implementing their legislated authority to admit, treat, transfer and discharge hospital in-patients; and utilizing fully the NP-anaesthesia role inclusive of intraoperative care.

23. Achieve 70 per cent full-time employment for RNs in Ontario.

24. Sector specific health human resource recommendations:

    a. Legislate an all-RN nursing workforce in acute care effective within two years for tertiary, quaternary and cancer centres (Group A and D) and within five years for large community hospitals (Group B);

    b. LHINs should mandate that all first home health-care visits be completed by an RN.

    c. The MOHLTC should legislate minimum staffing standards in LTC homes: one attending NP per 120 residents, 20 per cent RNs, 25 per cent RPNs and 55 per cent personal support workers.

25. Implement a model of independent RN prescribing and immediately develop the continuing education course to enable this practice.

F Fiscal Capacity

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

27. Increase revenue sources that encourage environmental and societal responsibility. Begin by phasing in environmental levies and implementing a cap-and-trade program for carbon emissions.

28. Update the gasoline tax by making it a tax on value rather than on volume.

29. Reject fire sales of publicly-owned Crown Corporations and assets to fund government programs (e.g., Ontario Power Generation and the Liquor Control Board). Halt the further sale of Hydro One shares.

RNAO Pre-Budget Submission 2017 – A Call for an Upstream Strategy

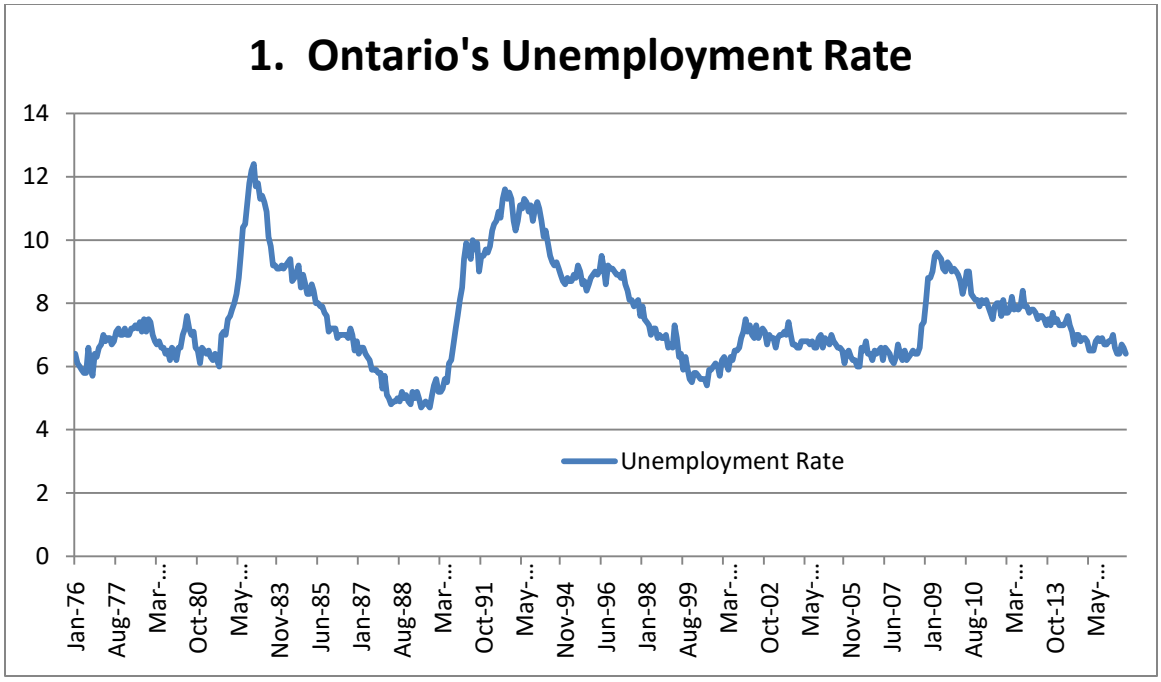
The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP) and nursing students in all settings and roles across Ontario. It is the strong, credible voice leading the nursing profession to influence and promote healthy public policy. That policy starts with the budget, and RNAO is pleased to have this opportunity to present its views as part of the pre-budget consultation.

Our submission covers six areas: social determinants of health, environmental determinants of health, Medicare, health system transformation, nursing, and fiscal capacity. These areas span the policy spectrum and present a unifying theme in our submission where we offer upstream solutions to keep people healthy and productive. Ultimately, this approach can also save large sums of money for the province and for the government. Short-term budgetary considerations tempt governments to scrimp on investing in a healthier society (e.g., reducing poverty). However, this approach is foolhardy because everyone pays the price for past decisions. Courageous steps towards an upstream approach have been taken by the government (e.g., closing coal plants), and the province is now in a good position to take more steps towards a healthier society.

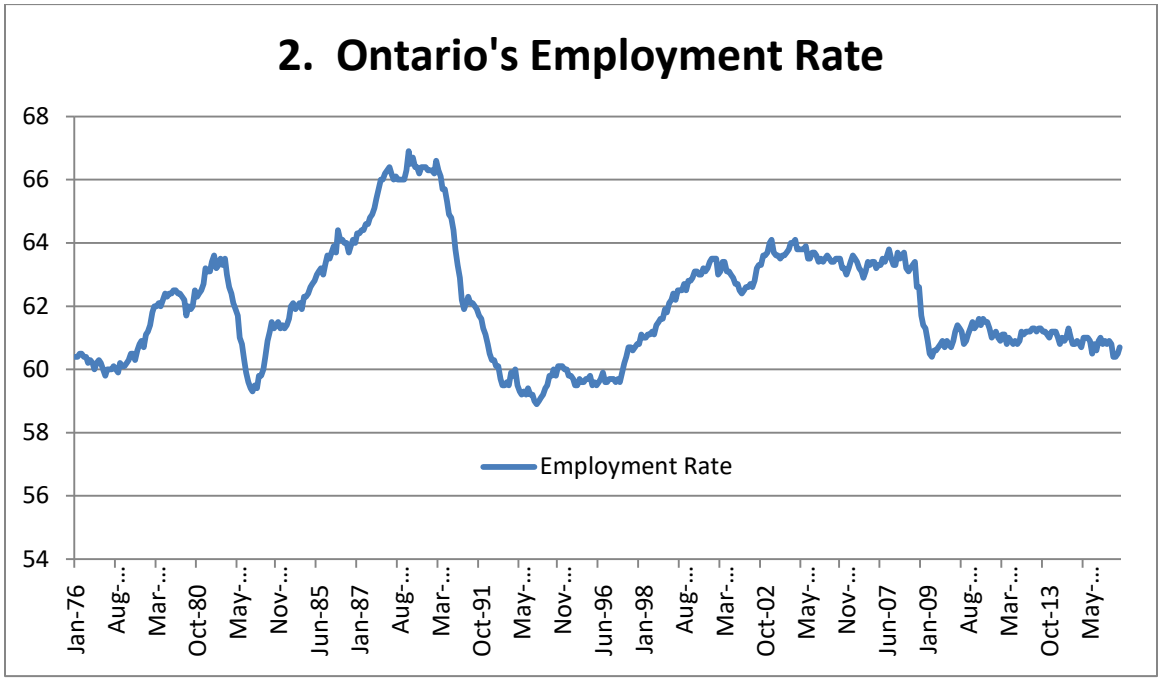
The Current Context

Provincially and nationally, major economic factors are positive. The Ontario government projects steady real Gross Domestic Product (GDP) growth of 2.2 per cent in 2017 and 2.1 per cent in 2018.[1] Ontario's real GDP growth for 2015 was 2.5 per cent, well above that of Organization for Economic Co-operation and Development (OECD) countries such as Japan, Italy, France, Germany, and just lagging behind the United States which had a growth rate of 2.6 per cent.[2] The government in Ontario projects inflation (Consumer Price Index) to be very moderate over the next three years: 2 per cent per year[3] (private sector 2017 CPI forecasts vary: 2.4 per cent from RBC;[4] 2.1 per cent from TD;[5] 1.8 per cent from National Bank[6]), which will not impose a competitive disadvantage on Ontario producers, as it is in line with projected 2017 inflation rates for Canada (1.8 per cent), the U.S. (1.9 per cent) and the OECD (1.8 per cent).[7] Nor is Canadian inflation projected to be so high that the Bank of Canada might be tempted to step on the monetary brakes to cool it off.

The Ontario government's budgetary deficit has steadily fallen as a share of GDP, from 3.2 per cent in 2009-10 to 0.7 per cent in 2015-16, with it projected to drop to 0.5 per cent in 2016-17;[8] the current deficit is no constraint on economic policy. Ontario's October unemployment rate has hit an eight-year low of 6.4 per cent (down from a peak of 9.6 per cent in June 2009), below the average in the rest of the country of 7.4 per cent,[9] and the government projects that the rate will decline to 6.2 per cent by 2019.[10] Figure 1 shows the trend in the unemployment rate since 1976. It has been falling since May 2009, but it is not as low as it has been at points in the past.



The labour force participation rate is a measure of the availability of employment, and in October 2016, it was 60.7 per cent. As Figure 2 shows, that is much lower than much of the post-1976 period, particularly compared to peaks between 1983 and 1991, and between 1999 and 2008. There has been no recovery in participation rates since the 2008 financial crisis. That suggests that there is room for more employment recovery in Ontario.



External factors are mixed. The Canadian dollar is forecast to remain in its current range through 2017 – US$0.75-0.77.[11] That is below its "fair" purchasing power parity (PPP) value of about US$0.80,[12] meaning that Ontario producers will continue to have a small pricing advantage over American competitors, in contrast to the huge competitive

disadvantage they faced in recent years when the dollar was at or above par. The government forecasts a gradual rise in the dollar towards US $0.82 by 2019,[13] which would remove that small exchange advantage, but still keep the currency in the competitive range.

The 2015 federal election installed a government more amenable to supporting provinces. For example, the new government committed itself to negotiating a new health accord,[14] and there is considerable support for extending medicare to cover medically necessary drugs. Indeed, the Standing Committee on Health is holding hearings on the creation of a national pharmacare program.[15] Talks on a health accord broke off in December 2016, and RNAO has urged the federal government to reconvene negotiations.[16]

Globally, the Ontario government is projecting reasonably strong real GDP growth: 3-4 per cent per year over the next three years and over 2 per cent for the US, Ontario's largest trading partner.[17] However, Ontario and Canada are entering a period of considerable uncertainty due to the recent US election. Rules under which trade occurs could change significantly, and that would have considerable impact on Ontario's trade-reliant economy. President-elect Trump has announced that the U.S. would withdraw from the Trans-Pacific Partnership on January 20, 2017 (his first day in office),[18] and that effectively terminates it.[19] The deal covered 12 countries, including Canada and the U.S., and would have brought similar features to those to be found in the North American Free Trade Agreement (NAFTA, a deal between Canada, the U.S. and Mexico), including lower tariffs, strengthened patent protection (including pharmaceuticals, which would raise drug prices), and investor-state arbitration, which allows foreign firms to sue for domestic government actions (laws, regulations, policies and practices) which the former allege could hurt their profits. Mr. Trump's threat to renegotiate NAFTA has been targeted at Mexico, but Canadian goods could get caught in the crossfire.[20] There has been little discussion about the more problematic non-trade parts of the NAFTA agreement (including higher drug prices and investor-state dispute settlement), and one would expect that the trade aspects, which would be most likely to be weakened – meaning uncertainty would arise chiefly in trade.

On balance, it would be prudent to ensure strong domestic demand in the face of trade risks, particularly given the deficit in employment and given the need to reduce the adverse effects of poverty, as will be outlined in the next section.

A Social Determinants of Health

Keeping Ontarians healthy, decreasing health inequities

The circumstances in which people are born, grow up, work and live all play a factor in their health. These social determinants of health are largely shaped by the distribution of money, power, and resources at the global, national and local levels.[21] Why some people are healthy and others are not can be linked to where people fall along the social gradient where hierarchies are often determined by key factors such as income, Indigenous status, racialized status, gender, disability and housing.

A1 Indigenous Health

Building on the evidence of the Truth and Reconciliation Commission of Canada,[22] [23] the Premier and the government of Ontario made a commitment on May 30, 2016 "to being full partners with Indigenous Peoples on our journey towards reconciliation and healing."[24] RNAO appreciates Ontario's acknowledgement of the ongoing traumatic effects of a "society-wide, intergenerational effort of cultural genocide" caused by violent colonialism, racism, and the legacy of residential schools.[25] It is fitting that the government of Ontario recognizes that the disturbing health, security, and opportunity gap between Indigenous and non-Indigenous populations was "created by a country that abused and betrayed its Indigenous Peoples."[26] Situating the government's apology as "but one step on the journey," Premier Kathleen Wynne expressed "hope to demonstrate our government's commitment to changing the future by building relationships based on trust, respect and Indigenous Peoples' inherent right to self-government."[27]

Since RNAO's 2016 pre-budget submission,[28] a declaration of a health and public health emergency in Northern Ontario's Nishnawbe Aski Nation (NAN) Territory and the Sioux Lookout region was released on Feb. 24, 2016 by NAN Grand Chief Alvin Fiddler and representatives from the Sioux Lookout Area Chiefs Committee on Health (CCOH).[29] [30] [31] Attawapiskat Chief Bruce Shisheesh declared a state of emergency after 101 suicide attempts were reported in his community of 2,100 people since September 2015, with 28 attempts in March and 11 attempts in just one night on April 9, 2016.[32] In total, there have been more than 500 suicides across NAN First Nations from 1986 to 2016,[33] including two suicides by 10-year-olds.[34]

Contaminated water;[35] [36] unreliable sewage systems;[37] overcrowded, unsafe housing;[38] and high rates of child and family poverty[39] among Indigenous people across Ontario continue to be urgent unmet needs. Ontario Regional Chief Isadore Day says "the cycle of poverty, poor health, suicides, violence will continue for another generation if determinants of health are not addressed immediately. These are Third World living conditions and these emergency declarations are the result. Not one average Canadian would let their children live in such conditions. This should be our tipping point as a people, as a nation and as a country. Canada must invest billions of dollars now on both clean water and adequate housing to begin with."[40]

Mindful of these urgent social and environmental needs, Ontario's commitment to reconciliation, and ongoing dialogue with First Nations leadership and youth,[41]

Recommendation 1. *Federal and provincial governments must work in partnership with the Chiefs of Ontario, Indigenous communities and their leaders to provide funding to ensure safe water, reliable sanitation, affordable housing, and accessible, high quality health care.*

Key priority areas where immediate, substantive and sustained action must be taken[42] include the following:

Action on Suicide, Mental health, and Addiction

- Immediate steps to ensure the design, development and delivery of mental health and addiction services to address the youth suicide crisis and prescription drug addiction to provide hope, belonging, meaning and purpose[43] [44]

- Intermediate and longer term strategies and resources to prevent crisis situations including suicide prevention, mental health services, counselling, addiction treatment, after-care, and other healing pathways such as land-based programs. Indigenous Canadians are over-represented within the criminal justice system and in segregation.[45] Provincial and federal governments must address the charge that Canada's prisons are the "new residential schools"[46] by tackling systemic discrimination and diverting people with mental health and addiction to treatment, recovery, and traditional healing.

Action on Improving Social and Environmental Determinants of Health:

- Eliminating abject poverty through investments in adequate housing, healthy affordable food, infrastructure, safe drinking water, recreation, education, training and job opportunities;

- Respecting First Nations authority over their lands and resources, as recognized within our Treaties[47]

Action on Improving Health Services:

- Governments of Canada, Ontario and First Nations jointly develop and fully fund a course of action to implement the recommendations made by the Auditor General of Canada outlined in the 2015 report *Access to Health Services for Remote First Nations*.[48]

A2 Income Security for Better Health

Nurses know that meaningful action on poverty is critical to sustaining lives, supporting health, and enabling human dignity. Hugh Segal's recent report on a basic income pilot reported than 15.9 per cent of Ontario adults between 18 to 64 years were living in poverty in 2014 according to the Low Income Measure (LIM).[49] For the same year, there were 513,850 Ontario children under the age of 18 years who were living in poverty (LIM).[50] While this 18.8 per cent poverty rate is an improvement from the 20 per cent of 2013, this still leaves more than one in six children living in poverty across the province.[51] That is why Ontario's RNs, NPs and nursing students continue to implore our

elected leaders to accelerate action to address the poverty that is still a daily reality for 1.57 million Ontarians.[52]

Public health units across the province each year continue to document the gap between the cost of nutritious food and shelter in the context of low social assistance rates and precarious, low paid employment. In 2016 in Toronto, for example, a one-person household receiving Ontario Works (OW) would have a deficit of $464 per month, as average monthly rent would require 123 per cent of income, and the amount required to purchase healthy food would take 38 per cent of income.[53] [54] As of September 30, 2016, a single person receiving OW must currently try to survive on $706 per month.[55] A single person enrolled in the Ontario Disability Support Program must try to get by on $1,128 per month.[56] The single person receiving ODSP would have a monthly deficit of $194, as average monthly rent would take up 93 per cent of income, and healthy food would take up 24 per cent of income.[57] A couple with two children and a full-time minimum wage earner would bring in $1,950 per month from employment, of which 52 per cent would be required for rent and 29 per cent to purchase food.[58]

A snapshot of food banks in Canada and in Ontario found that use remained higher in 2016 than when the recession started in 2008.[59] In March 2016, 335,944 individuals accessed a food bank in Ontario, which is a 6.9 per cent increase since 2008.[60] Food bank use, however, has been found to be a poor indicator of food insecurity as it underestimates the scope of the problem.[61] Interviews with 371 families living in low-income in Toronto, for example, found that 75 per cent had experienced food insecurity but only 23 per cent had used a food bank.[62] According to the Canadian Community Health Survey for 2014, the number of food insecure households in Ontario was 594,900 households.[63] As might be expected, the lower household income is in relation to the Low Income Measure, the greater the likelihood of severe food insecurity.[64] Using data from 2013 and 2014, the proportion of households reliant on social assistance who were food insecure in Ontario was 64 per cent.[65] In 2014, the proportion of food insecure households reliant on wages and salaries in Ontario was 58.9 per cent.[66]

The minimum wage in Ontario was frozen at $6.85 per hour from 1995 to 2004, which corresponded to a 17 per cent cut in purchasing power. From February 2004 to March 2010, overdue increases brought the minimum wage up to $10.25 per hour. After staying flat for four years, the minimum wage increased to $11.00 per hour as of June 1, 2014 and then increased again to $11.25 as of October 1, 2015 and to $11.40 per hour as of October 1, 2016.[67] RNAO continues to support the community's call to set the minimum wage 10 per cent above the Low Income Measure.[68] RNAO estimates that figure to be about $14.78 as of November 2016 in contrast to current minimum wage of $11.40 per hour which is 15.1 per cent below the estimated November 2016 LIM.[69] [70] Using the same methodology with the after-tax LIM, RNAO estimates that LIM + 10 per cent would be $14.23/hour for a single person with no dependents. For comparison purposes to make basic ends meet, a living wage[71] for two working parents with two children was estimated to be $18.52 per hour in Toronto (2015),[72] $17.65 per hour in Peterborough (2016),[73] $17.47 per hour for the Niagara Region (2016),[74] and $16.18 per hour in Sudbury (2015).[75]

An immediate increase to $15 per hour wage with greater attentiveness to ensuring fair legislation and enforcement of labour standards would strengthen the notion that good

jobs represent a pathway out of poverty. Other jurisdictions that have announced regulatory increases to a $15 per hour minimum wage include Alberta (2018),[76] New York City for large employers (of 11 or more) (2018),[77] Los Angeles County for large employers (of 26 or more) (2020),[78] and California for large employers (of 26 or more) (2022).[79]

The minimum wage must apply equally without exemptions by age or sector. Ontario is the only province/territory that permits employers to pay a lower minimum wage to young workers.[80] The vast majority of jurisdictions in Canada (except for British Columbia, Ontario, and Quebec) do not allow a lower wage for those who serve liquor.[81]

As in many other jurisdictions, many Ontario workers find themselves in jobs that neither pay well nor are secure and full-time. So prevalent is this problem that Ontario struck a Changing Workplaces Review to study non-standard employment. The Special Advisors for that Review issued an interim report in July 2016, outlining the current situation and policy options.[82] The Special Advisors will issue a final report in 2017. RNAO's submission[83] had a number of nursing-specific recommendations, as well as a series of recommendations calling for all workers to have equal protections under the Employment Standards Act and the Labour Relations Act, with no exemptions.

Consistent with a RNAO resolution on oral health passed at the 2016 Annual General Meeting, RNAO endorses the Ontario Oral Health Alliance's recommendation that the 2017 budget invest $10 million to support the first phase of a public program to provide oral health care to low income adults and seniors across the province. [84] This funding should be allocated to maximize use of existing public investments in dental clinic infrastructure in Community Health Centres, Aboriginal Health Access Centres, and Public Health Units.[85] This will be a step towards fulfilling the 2014 Ontario budget promise to expand public oral health programs to low income adults by 2025.

Given the clear evidence of better health outcomes linked with income security,[86] RNAO recommends the following:

Recommendation 2. *Act on multiple poverty fronts immediately:*

a. *Increase Ontario's dangerously low social assistance rates (Ontario Works and the Ontario Disability Assistance Program) to reflect the actual cost of living and then index for inflation.[87] Within this amount, $700 million should be invested in a 10 per cent increase in basic needs and shelter allowance rates.[88] The remaining $300 million should be invested in rule changes to ensure basic fairness, remove punishments, better support relationships and work, and allow savings.[89]*

b. *Provide a basic income pilot project for Ontario with strong ethical safeguards. Ensure that no participant is worse off and make sure that there is no erosion of the current social safety net for the broader population.[90] In order to support Indigenous health and reconciliation, RNAO particularly supports Hugh Segal's recommendation that the design of a basic income pilot adapted to the realities of Indigenous communities be "under the full prerogative of the First Nations Chiefs of Ontario."[91]*

c. *Raise the minimum wage to $15 per hour with no exemptions regarding age or sector.*

Recommendation 3. *Ensure all workers have the same protections and benefits enjoyed by workers with standard employment:*

a. *Cover all classes of workers and employers under the Employment Standards Act and Labour Relations Act. Update those acts to protect all workers, including access to personal emergency leave, paid sick days, and enhanced enforcement of strengthened labour laws.*

b. *Develop and implement a plan (preferably via changes to the ESA) to deliver the same wages, benefits and working conditions to workers in nonstandard employment as those in standard employment, under the same terms and conditions (e.g., doing the same work with the same seniority).*[92] [93] [94]

A3 Safe, Affordable Housing for Health and Dignity

Despite over $4 billion in provincial funding for affordable housing since 2003, waiting lists in Ontario grew by 45,257 households from 2003-2015.[95] [96] In 2015, there were 171,360 households across the province on waiting lists for rent-geared-to-income housing. [97] The average wait time for applicants housed in 2015 across Ontario was 3.9 years, however, the predicted wait time for recent applicants in high demand regions is as high as 14 years.[98]

RNAO believes one way to reverse this trend is to invest one per cent of the province's budget. The money will help create new affordable housing stock and address the backlog of existing affordable housing units in need of repair.[99] RNAO recommended this to the Ministry of Municipal Affairs and Housing when it was updating the province's Long-Term Affordable Housing Strategy. The Ontario Non-Profit Housing Association has 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 all households living in Persistent Core Housing Need and help address homelessness.[100]

Recommendation 4: *Improve access to affordable housing and stimulate job creation by investing one per cent of Ontario's budget ($1.39 billion) to address the backlog of existing affordable housing units in need of repair and to create new affordable housing stock.*

A4 Investments to Increase the Health of all Ontarians and Decrease Health Inequities

As RNAO[101] [102] and other public health, academic, and civil society organizations[103] [104] have argued, the province of Ontario is moving in the wrong direction towards unhealthy public policy by facilitating increase access to alcohol. The World Health Organization attributes 3.3 million deaths globally each year due to alcohol.[105] There is a causal

relationship between alcohol consumption and more than 200 health conditions.[106] In addition to acute and chronic diseases and injuries, alcohol use can lead to alcohol poisoning, homicide, impaired driving, suicide, exacerbation of mental illness, alcohol use disorder, and intergenerational effects.[107] Revenues generated from taxes on alcohol are far outweighed by alcohol's social and health costs. A conservative estimate of the annual costs directly attributed to alcohol-related harms for Ontario is $5.3 billion for health care, premature mortality, lost productivity due to disability, law enforcement, and corrections.[108] Instead of implementing the "the biggest change since the repeal of prohibition"[109] by enabling and then expanding access to beer and wine in grocery stores, eliminating fees under a LCBO Special Occasion Permit, and launching a LCBO e-commerce platform,[110] the province should use evidence to improve public health, public safety, and community well-being.

Alcohol availability, pricing, and marketing are three population-based elements that will determine how socially responsible this government is in its approach to reducing harm from alcohol. Lessons can be learned from Ontario's success in reducing tobacco use and exposure through a cultural change prompted by policies, laws, public education, and programs. If Ontario does not make its alcohol policy congruent with the public health evidence, then the province will be undermining its other key initiatives, including those to reduce poverty, address homelessness, strengthen mental health and recovery from addictions, prevent injuries, avoid premature death and promote health by preventing acute and chronic diseases, and prevent violence.

Recommendation 5. *Implement a provincial alcohol strategy policy that is congruent with the public health evidence[111] for better health outcomes:*

a. *Roll back recent privatization initiatives and establish a moratorium on further privatization of alcohol sales. In light of the critical evidence of increased harm with increased physical availability of alcohol, strengthen government-run retailing systems and monopolies.*

b. *Strengthen Ontario's minimum pricing structure by raising minimum prices; linking prices to alcohol content so that as alcohol content rises, so does price; and close loopholes to the minimum price.*

c. *Ban the advertising, promotion, and marketing of alcohol as recommended by the World Health Organization.*[112] [113]

Just as federal Health Minister Jane Philpott and Ontario's Minister of Health and Long-Term Care Eric Hoskins were co-hosting an Opioid Conference and Summit in Ottawa,[114] there was a growing chorus urging the federal government to declare a national public health emergency to address rising and deadly rates of drug addiction.[115] There were 638 people in Ontario who died in 2013 from opioid overdoses and 3, 241 opioid-related emergency department visits in 2014.[116] Ontarians across the province continue to die without access to supervised injection services (SIS). As an example of escalating urgency, Toronto Public Health confirmed a 77 per cent increase in reported deaths from drug overdose from 146 in 2004 to 258 in 2014, the highest annual number in Toronto to date.[117]

The original 2012 Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA) recommended three supervised injection sites (SISs) in Toronto and two in Ottawa as a cost-effective way to prevent premature deaths and improve health outcomes.[118] Since then, the economic case for SIS has strengthened as it has been increasingly recognized as a cost-effective strategy,[119] especially within the proposed model to integrate SISs into already existing health services.[120] Experienced health organizations that already provide harm reduction services in Toronto and Ottawa are in the process of seeking permission from the federal government to open SIS.

On January 9, 2017 Health Minister Hoskins sent letters to federal Health Minister Philpott to support the Sandy Hill Community Health Centre SIS application for Ottawa[121] and Toronto's SIS application for three locations.[122] [123] Minister Hoskins has been reported as committed "to fund"[124] or "help fund"[125] these four SIS, however, "Ontario has not committed a specific dollar amount."[126] [127] London and Thunder Bay are engaged in SIS feasibility studies in their communities.

> **Recommendation 6.** *Fund supervised injection services (SISs) in communities across Ontario where needed. Expedite funding for the proposed supervised injection services in Toronto and Ottawa to address current crisis, and any subsequent SIS needed across the province, as part of existing health services.*

Consistent with a RNAO resolution on oral health passed at the 2016 Annual General Meeting, RNAO endorses the Ontario Oral Health Alliance's recommendation that the 2017 budget invest $10 million to support the first phase of a public program to provide oral health care to low income adults and seniors across the province. [128] This funding should be allocated to maximize use of existing public investments in dental clinic infrastructure in community health centres, aboriginal health access centres, and public health units.[129] This will be a step towards fulfilling the 2014 Ontario budget promise to expand public oral health programs to low income adults by 2025.

> **Recommendation 7.** *Invest $10 million to support the first phase of a public program to provide oral health care to low income adults and seniors across the province. This funding should be allocated to maximize use of existing public investments in dental clinic infrastructure in Community Health Centres, Aboriginal Health Access Centres, and Public Health Units.*

B Environmental Determinants of Health

B1 Carbon Pricing and Climate Change

Climate change is real and happening today, not in the distant future. It is the result of human activity that increases the volume of greenhouse gases (GHGs) in the air. This activity has radically changed the composition of the atmosphere. Concentrations of carbon dioxide have risen steadily since the start of the industrial era, when they were about 280 ppm."[130] Recent estimates have put concentrations over 400 ppm (401.72 ppm globally in July 2016).[131] That is a 43 per cent increase over the pre-industrial concentration. The jump is unprecedented and the levels of carbon in the air far exceed those at any time in the last 800,000 years, when they ranged from 180 ppm to 300 ppm.[132] This is alarming. When other GHGs besides CO_2 are factored in, the increase is even more worrisome - about 37 per cent between 1970 and 2014 alone.[133]

Registered nurses, nurse practitioners and nursing students are concerned about climate change because of its serious environmental and health implications. Already we are seeing severe dislocation in places like the Horn of Africa in part due to weather disturbances (e.g., drought). However, climate change also affects the health of Ontarians by contributing to extreme weather events, poor air quality, and vector-, rodent-, food- and water -borne diseases. By fighting global warming, we are not merely protecting the environment - we are protecting people's health. And we would be contributing to environmental justice, because the most vulnerable populations are the poorest in both Canada and developing countries, who have done the least to cause global warming. One important solution to address climate change is the adoption of carbon reduction programs. Such programs have benefits that go beyond getting rid of pollutants. For example, the closure of Ontario's coal-fired power plants not only reduced carbon emissions, it also improved air quality. Another example would be the creation of walkable, cycle friendly communities, which would both reduce emissions and improve health by promoting exercise.

Ontario has taken significant steps to reduce its carbon emissions, including the above-mentioned coal closures and the promotion of energy conservation and renewable energy. It has set greenhouse gas (GHG) reduction targets of 15 per cent below 1990 levels by 2020, 37 per cent by 2030[134] and 80 per cent below by 2050.[135] The targets are aggressive, but necessary. Economists generally agree pricing carbon emissions can help in meeting those targets. We are all carbon users, and a strong price signal, will promote necessary behaviour changes to support the environment. The government is implementing a cap-and-trade system to price carbon. That works by auctioning permits to emit carbon, with a cap on the number of permits set to meet Ontario's emission targets. RNAO had recommended a carbon tax as a simpler and more efficient way to price carbon, but a cap-and-trade system can work as long as it:

- sets a low enough cap,
- starts soon enough, and
- covers as many emissions as possible.

The government intends to proceed with a cap-and-trade program in 2017 that would cover the bulk of emissions (including electricity, transportation fuel, industry, large commercial and institutions). The timing is reasonable, and the coverage is good for a

first phase. The cap could be much more aggressive, as the proposal would allow for significant growth in emissions between 2015 and 2017. More troubling, the proposal is to give industrial and institutional emitters 100 per cent of their permits for free for the first four years. The intent is in part to avoid "carbon leakage" from emitters shifting production out of Ontario to avoid paying for the fees. But that is not necessary when the low Canadian dollar gives them such a competitive advantage. In any case, the government should pursue all opportunities to provide levelling of the playing field by seeking to implement border adjustments (e.g., imposing taxes on imports equivalent to the carbon prices faced by Ontario firms).[136]

The government plans to link Ontario to cap-and-trade programs in California and Quebec, but according to Ontario's Auditor General, only 3.8 of the 18.7 megatonnes of reduced GHG emissions would take place in Ontario, with the rest happening in the two other jurisdictions; by 2030, Ontario emitters would send $2.2 billion out of Ontario to pay for emission permits issued by the other jurisdictions.[137] [138] The report warns that due to the issue of a surplus of emission permits in California and Quebec that resulted in 60 Mt being unsold at the last auction, Ontario purchases of these permits will result in no reduction in emissions in any of these jurisdictions. It warns also that there is no agreement to prevent double counting of emission reductions in both the issuing and purchasing jurisdictions.[139]

The government recently took a step back on carbon pricing by announcing it would take the Harmonized Sales Tax (HST) off of residential and small business electricity bills.[140] Certainly it makes sense to offer support to families suffering from energy poverty, but it is not helpful to remove the price signal from other users of electricity, at least until the electricity system is fully green and renewable. It would be better to help consumers find more ways to conserve on energy, while financially assisting those suffering from energy poverty.

It took a further step away by cancelling $3.8 billion in renewable energy projects in September 2016, in part to save on cost.[141] Environmental critics like the David Suzuki Foundation pointed out that it would be cheaper to use more renewable energy and less nuclear energy.[142]

Recommendation 8. *To ensure Ontario meets its greenhouse gas (GHG) targets:*[143] [144]

a. *Set the carbon cap at a level that would deliver GHG reductions on the targeted schedule or earlier.*

b. *Only link to other cap-and-trade markets when that maintains Ontario standards*

c. *Make the granting of free or subsidized emission permits highly targeted and temporary.*

d. *Ensure cap-and-trade revenues are managed transparently with strong public oversight.*

B2 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.[145] For many in urban areas, there are limited alternatives to automobile use: public transit is often inadequate and opportunities for active transportation like biking and walking may be undeveloped and unsafe. The Big Move is the regional transportation plan developed by Metrolinx, an Ontario crown agency that manages GTHA transportation,[146] which would transform transit in the GTHA. The Anne Golden panel (appointed by Premier Wynne) has pointed the way with its transit infrastructure recommendations, which includes $300 million funding for a Kick-Start Program to deliver immediate visible improvements in service.[147] The medical officers of health for the GTHA have made an important contribution with their report on designing healthier transportation systems and healthier cities.[148] The report concluded that better community design and implementing *The Big Move* could avoid 338 premature deaths per year and significantly reduce the staggering cost of congestion. It recommended that Ontario should provide long-term funding, work with Metrolinx and the municipalities to implement and optimize access to transportation options and change its policies to better support active transportation and public transit.

All levels of government have stepped up to the plate. A recent report[149] [150] concluded that provincial ($31 billion), municipal ($1.9 billion) and federal ($6.5 billion) governments had committed $39.3 billion for transit capital funding. This is a significant step forward, but a further $28.8 billion is required to complete the transit expansion for the GTHA planned for under the Big Move,[151] the regional transportation plan for the Greater Toronto and Hamilton Area. After funding, the next steps are to promote transparency and accountability in governance of project choice and implementation; to support optimal choice of transit and active transportation projects (cycling, walking, etc); and to support expeditious implementation of those projects. The government has devoted part of the proceeds of the sale of Hydro One to transit, but this is not a sustainable strategy, as Ontario's Financial Accountability Officer pointed out: it will be a net revenue loser.[152] RNAO cautions against further privatization of Hydro One not only on grounds of revenue loss, but also because turning Hydro One to private purposes could result: in unfairly high rates for consumers; the loss of accountability and oversight; the loss in ability to ensure adequate services in smaller communities; and the loss of the ability to serve other social purposes like local development.[153] It is essential that Ontario develop sustainable new streams of revenue. Pricing carbon is one such revenue stream.

Recommendation 9. *The government must take all necessary steps to:*

a. *Work with federal and municipal partners (starting with a transit summit) to ensure sufficient dedicated and sustainable revenue sources to pay for a substantial expansion and ongoing operation of transit and active transportation,*

b. *Avoid resorting to public asset sales like the privatization of Hydro One to fund transit expansions, and*

c. *Support cost-effective and expeditious delivery of those expansions, implemented by transparent governance and informed expert opinion.*

C Medicare

C1 Pharmacare

Canada is the only developed country with a universal health-care system that lacks a pharmacare program.[154] Canadians are hit by a double whammy: not only do most people not have access to public drug coverage, but the absence of the common purchasing of pharmacare means that they face among the highest drug prices in the OECD - about 35 per cent higher than the OECD median.[155] Canada also has the highest per capita drug expenditure in the OECD after the US.[156]

Nurses are all too familiar with the limitations of our current system. They care for patients and clients who often can't afford to pay for prescribed medications, with adverse or even fatal consequences. Numerous studies have confirmed this reality.[157] [158] [159] [160] [161] [162] In Ontario alone, thousands of avoidable deaths among diabetes sufferers under the age of 65 are attributable to insufficient drug coverage. The evidence on diabetes is damning: those 65 and over are covered by a provincial drug plan, and lower income people in that age group do not suffer discrepancies in health outcomes to the same extent that those under 65 do.[163] While pharmacare is needed for all Canadians, the research shows a particular advantage for people with lower incomes.[164] [165] [166] [167] [168] [169] [170]

In the absence of a national pharmacare program, some Canadians rely on by a patchwork of existing drug plans,[171] while the rest have to pay out of pocket or obtain private insurance. 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.[172] [173] In 2015, 40.8 per cent of Ontario prescription expenditures were covered by the provincial government, with the federal government covering 1.1 per cent and the Workplace Safety and Insurance Board paying 0.6 per cent. The rest is paid for privately - 57.5 per cent.[174] Confidentiality considerations make the breakdown of provincial figures unavailable, but nationally 35.0 per cent of prescription drug expenditures are paid by private insurers while 21.8 per cent are out-of-pocket.[175] Public drug spending in Ontario also consumes nine per cent of the health budget - up from 1.2 per cent in 1975.[176] The province has an interest in pharmacare and this is evident through the Minister of Health and Long-Term Care, Dr. Eric Hoskins, who has written op-eds calling for a national pharmacare program,[177] [178] and who has been working with his health counterparts to that same end.[179]

A commentary written for the C.D. Howe Institute neatly summarizes the case for pharmacare in Canada:[180] [181] It would deliver equitable access to medicines; it would protect the ill from exorbitant costs for drugs; and it would result in a net saving of money. The savings come from: reduced administrative, marketing and regulatory costs (due to a single-payer system); from pooling of risk over larger populations; from value-for-money testing; from use of purchasing power to reduce drug prices; and from more rational use of health system resources. Insured services tend to be overused and

uninsured services tend to be underused because both client and health provider are mindful of affordability. In the case of prescription drugs, an uninsured person is less likely to fill a prescription because of cost considerations, and that has health repercussions that come back to haunt the health system.

In a related study, the same authors make the case against means testing and co-payments for pharmacare.[182] 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).[183] A 2015 Canadian Medical Association Journal article provided a range of estimates of saving: $7.3 billion expected, with savings ranging from $4.2 billion to $9.4 billion (worst-case scenario to best-case scenario). Expected savings to the private sector would be $8.2 billion, with net costs to government rising by about $1.0 billion.[184]

An important component of a national pharmacare program would be a national or nation-wide[185] evidence-based formulary and guidance on optimal prescribing.[186] [187]A national/nation-wide formulary helps to pool information on safety, effectiveness and cost, which is particularly important when it comes to dealing with growing pool of drugs targeted at rare diseases, where the evidence is based on very small samples and where manufacturers supply the studies while exerting strong lobbying pressure for coverage of very expensive drugs.[188]

An impressive list of health and other organizations is calling for a national pharmacare program: Over 90 organizations have endorsed the Campaign for National Drug Coverage of which RNAO is a founding member.[189] [190] Newspapers such as the Toronto Star have also called for a national pharmacare program, and not just some national bulk buying arrangement.[191] A listing of some of the endorsing organizations appears in the appendix.

Members of the public agree. According to a May 22, 2013 poll by EKOS, 78 per cent of Canadian respondents supported a universal public drug plan for all necessary prescription drugs.[192] Support was even stronger in a July 2015 Angus Reid poll in which 91 per cent of those polled supported the concept of pharmacare in Canada, and 87 per cent supported adding prescription drugs to the universal health coverage of Medicare. One reason for the overwhelming support is the fact that 23 per cent of respondents were in households that had one or more members who were not taking medicines as prescribed because of the cost.[193] [194]

With the October 2015 election, the federal context has changed and pharmacare advocates are now looking to Ottawa for leadership on this issue given the interest across the country. In January 2016, federal and provincial/territorial health ministers met in Vancouver to lay the groundwork for a new Health Accord, and they promised to work together on drug policy.[195] The federal House of Commons Standing Committee on Health has been holding hearings on the development of a national pharmacare program,[196] and this represents a good current opportunity to implement a pharmacare program that would provide universal access to essential medications, without means testing, user fees and/or co-payments. RNAO urges Ontario to follow a two-track strategy of implementing an Ontario pharmacare program while continuing its advocacy for one at the national level.

Recommendation 10. *Implement a made-in-Ontario pharmacare program, while continuing to aggressively advocate for a national pharmacare program covering all medically necessary drugs.*

C2 Foot Care For Diabetics

In 2015, 1.53 million people in Ontario were living with diabetes. Of those, 16,600 to 27,600 were expected to have diabetic foot ulcers in 2015; 2,000 were expected to have lower limb amputations; and 800 were expected to die prematurely.

The Canadian Diabetic Association estimated that diabetes in Ontario imposed $1,075 million in direct costs and $3,830 million in indirect costs. Those costs were projected to rise to $1,742 million direct and $5,240 million in indirect costs by 2020 (all in constant 2009 dollars).[197] Of those costs, the cost to the provincial health system of diabetic foot ulcers was estimated to be in the range of $320 - $400 million in 2015, with indirect costs of between $35 – 60 million.[198] The tragedy is that 85 per cent of amputations are preceded by foot ulcers,[199] while prevention is 10 to 40 times cheaper than amputation.[200]

One simple cost-saving solution is the use of offloading devices (e.g., total contact casts, removable boots, and therapeutic footwear) that relieve pressure on those ulcers: "provincial funding of offloading devices is likely to increase the use of these devices to up to 75 per cent of patients with diabetic foot ulcers. Offloading devices cost an average of $1,425 per person plus the cost of orthotist visits for a total of between $20-34 million a year. Other associated direct health-care costs are, however, expected to fall by between $2,970 and $5,770 per diabetic foot ulcer (DFU) for a total reduction of between $82-96 million a year yielding a substantial net saving for the government of between $48-75 million a year: a reduction of between 12 and 23 per cent over one year. Indirect costs from morbidity and premature mortality are expected to fall also by about $300 per DFU for a total of between $5-9 million."[201]

Offloading devices are well studied. RNAO's best practice guideline on diabetic foot ulcers includes an assessment of advantages and disadvantages of ten different types of offloading device.[202]

Recommendation 11. *Place greater emphasis on prevention of diabetic foot ulcers:*

a. Provide universal access to preventative foot care services, including supplying preventative shoes, socks and offloading devices to those in need, free at the point of care, for all Ontarians living with diabetes;

b. Develop policies that enable every Ontarian with diabetes to have at least one foot assessment by a qualified health provider per year;

c. Adopt an Ontario-wide interprofessional approach to diabetic foot care, with at least one multidisciplinary diabetes foot care team, with a well-defined referral pattern, in each Local Health Integration Network (LHIN);

d. *Publish, on an annual basis, reliable data on diabetes foot care, using internationally recognized metrics, to assist on-going quality improvement efforts.*

e. *Provide education for clinicians and patients on the management of diabetic foot complications*

C3 Medical Tourism

In the early part of this decade, RNAO became aware that hospitals and other health-care organizations in the province were resorting to medical tourism: the sale of health services at a profit to people who travel abroad to access health services more quickly or more cheaply.[203] RNAO opposes medical tourism because it turns health care into a commodity to be bought and sold,[204] and it joined with other health organizations in its campaign to halt the practice.[205] For nurses, medical tourism is a threat to Medicare.[206] It opens the door to lawsuits driven by wealthy Ontarians denied private care and for-profit interest groups. One could argue that if out-of-country patients can pay their way to preferential treatment, so, too, should Ontarians. On November 21, 2014, the Minister of Health and Long-Term Care asked all hospitals in Ontario to stop soliciting and treating international patients, except for humanitarian work and activities related to existing contracts. In the interim, he has asked hospitals not to enter into new international consulting contracts that include the treatment of foreign nationals in Ontario. This was an important measure, but RNAO continues to hear stories of attempted medical tourism in Ontario. Accordingly, RNAO strongly urges the minister to proceed at once to implement a complete legislative ban on inbound medical tourism.

It should be noted that RNAO supports treatment of patients brought to Ontario on a humanitarian basis.

> **Recommendation 12.** *Implement a complete legislative ban on inbound medical tourism.*

D Health System Transformation

To sustain and expand Ontario's publicly-funded and not-for-profit health system, it is important to carefully examine its structure and service delivery models. Are we getting the best value for the investments being made? While improvements are being made, Canada lags behind many international counterparts when it comes to delivering timely access to care and care co-ordination.[207] Nurses know the system is experiencing:

- Rising expenditures and insufficient federal health transfers;[208] [209]
- Shifting demographics and rising care complexity;[210]
- Delays and inequitable access to timely health services;[211] [212] [213]
- Lack of emphasis on upstream preventative measures;[214]

- Ineffective care transitions and lack of co-ordination;[215]
- Variation in the quality and safety of care.[216]

D1 Advancing Primary Care Reform

These challenges are not insurmountable. In 2012, RNAO released the groundbreaking *Enhancing Community Care for Ontarians* (ECCO) report[217] to build a robust foundation for community care and improve integration between all health sectors. A second version of ECCO was released in 2014[218] to enrich detail accompanying the policy proposal. RNAO was the first organization to recommend a single health system planner/funder – the Local Health Integration Networks (LHIN); while anchoring the health system in primary care and eliminating Community Care Access Centres (CCAC) as structural entities. Our message has been clear and consistent in a number of key policy submissions, including RNAO's response to the review of the *Local Health System Integration Act (LHSIA)*;[219] RNAO's response to the Patients First Discussion Paper[220] and RNAO's response to Bill 41.[221]

The association was encouraged when the Minister of Health and Long-Term Care introduced Bill 41 – *Patients First Act, 2016*. However, the bill fell short in a number of key areas. Now that the bill has received Royal Assent,[222] our concerns remain.

First, it did not designate all health provider organizations as health service providers (HSPs) under LHSIA. Most primary care organizations, public health units and home health-care providers delivering purchased community services are missing in the law. Effective health system integration will not occur unless there is a single body -- LHINs -- making planning and funding decisions that consider the health system as a whole. Otherwise, there is a significant risk of perpetuating existing system limitations, including siloed decision-making that will translate into fragmentation for Ontarians.

RNAO is being joined by a growing number of system stakeholders in asserting that primary care must be the foundation anchoring Ontario's health system.[223] Therefore, RNAO asserts that LHINs should be empowered to oversee the planning, contract management, funding and performance of all primary care entities. Otherwise, the way LHINs approach planning for primary care will be inconsistent and will not lead to a strong primary care foundation, which is fundamental in any high performing health system.[224,225,226]

The bill did seek to strengthen the role of public health units in supporting planning, funding and service delivery. However, RNAO is concerned that the provisions in the bill are insufficient to adequately advance a population-health planning approach in Ontario. For RNAO, public health units must assume a leading role in advancing health equity. They are experts in upstream health promotion and disease prevention, as well as analyzing population health needs and delivering community engagement. Positioning public health units within the LHIN mandate, acknowledging implementation considerations,[227] will better align public health with the rest of the system, and can stimulate a broader reach of health promotion principles in other sectors. RNAO believes that this can only happen if public health units are designated as HSPs.

Recommendation 13. *Advance an integrated health system that is anchored in primary care. Include all of primary care, public health units, home health-care and support service providers as HSPs under LHSIA.*

Recommendation 14. *Fund interprofessional care models of primary care (such as NP-led clinics, Community Health Centres, Aboriginal Health Access Centres, and Family Health Teams) so they can hire sufficient staff to work to full capacity.*

D2 LHINs as System Coordinators

Several provisions within Bill 41, position the LHIN as a provider/manager of health services. RNAO profoundly disagrees with such a role. As captured in RNAO's ECCO report, the most effective role of the LHIN is to plan, integrate, fund, monitor and be ultimately accountable for local health system performance. It would be ineffective for LHINs to engage in direct service provision. It is challenging to "row" and "steer" at the same time. RNAO advises against perpetuating the existing limitations of CCACs by having LHINs act as a case management brokerage that allocates hours of service to Ontarians based on a command and control approach. Rather, service provision and the management of service, including service allocation at the patient level, should be the focus of health providers that have the best understanding of patient need.

Recommendation 15. *Refrain from LHINs delivering and/or managing health service delivery. Instead, focus the scope of LHINs on whole system planning, integration, funding allocation, monitoring and accountability functions.*

D3 CCACs

To strengthen the effectiveness of health service delivery and Ontario's health system as a whole, both structural and service delivery changes are needed.

RNAO was the first organization to call for CCACs to be dissolved, beginning in 2012 with the release of its ECCO report. Maintaining both CCACs and LHINs results in unnecessary structural duplication. It also results in fragmentation - by design - of service delivery. It severs the ability of the LHINs to deliver whole system planning and allocate funding based on demographic and health system changes. RNAO is also concerned, as was Ontario's Auditor General, with the administrative cost of the CCACs.[228] [229] [230] We know that only 61 per cent of the approximately $2.4B dollars allocated to community care in Ontario makes its way to direct service delivery.[231] Furthermore, RNAO has heard significant concern from home health-care agencies, nurses, and the public regarding CCACs' "command and control" model of brokerage. The current duality of these two agencies LHIN and CCACs, while both important in their functions, does not enable the delivery of person-centred care. The impetus for change is clear.

Simply transferring the CCACs, including all of their limitations to the LHINs is not transformative. There is a significant risk that the status quo will continue, albeit under the LHINs and we have identified opportunities to facilitate meaningful transformation:

A. Re-locate the nearly 4,100 care co-ordinators currently in CCACs into primary care. Respecting collective agreements and maintaining compensation and benefits, this can be done through a secondment from the LHIN serving as the employer. This transition and transformation will support effective navigation of the health system, ensuring: seamless transitions, enhanced communication, timely follow-up and referrals, and decreased duplication (e.g. unnecessary tests). Most importantly, it will ensure that Ontarians do not fall through the cracks.

B. LHINs should include home health-care and support service providers as HSPs. Accountability agreements can be developed through a non-competitive process that favors results-based quality and safety; accreditation status and the scope of services being offered. The funding model can be reformed from a per-visit basis to predictable funding baskets that follow evidence-based pathways and leverage provider autonomy. This will assist in stabilizing the sector and make it more person-centred by incorporating a range of interventions, including health promotion. The goal should be to ensure quality, safe, continuous and consistent services for Ontarians.

Recommendation 16. *Fully dissolve CCACs and produce true health system transformation by preventing the automatic transfer of all CCAC functions, processes and resources to the LHINs.*

Recommendation 17. *Locate the nearly 4,100 CCAC care co-ordinators within primary care, while keeping them employed by LHINs.*

D4 Tripartite Leadership Models

Section 14(2) of Bill 41 makes establishing LHIN health professional advisory committees voluntary, which is a departure from their current requirement. For many years, RNAO has been advocating for a tri-partite leadership model within LHINs that includes representation from medicine, nursing and one other regulated health profession.[232] This model champions interprofessional service delivery through leadership and ensures the perspectives of multiple health professionals is incorporated into the planning and funding process. Moreover, to provide consistency, RNAO calls for this leadership model to be mandated within each LHIN.

Recommendation 18. *Mandate tri-partite leadership models incorporating medicine, nursing and one other regulated health profession within each LHIN.*

E Nursing

E1 Interprofessional Health Human Resource (HHR) Plan

Exciting health system changes are underway in Ontario, however, an evidence-based interprofessional health human resource plan that incorporates population health needs and policy priorities for the system, and that ensures all health-care providers are working to their full scope of practice, does not exist. RNs represent the largest group of regulated health professionals in Ontario. RNs are present in virtually every health service delivery setting. The public has ready access to RNs and poll after poll shows that RNs are privileged with the highest public trust compared to any other occupation. RNs are often the first point of contact with the health system. Key features of health system effectiveness involve appropriately utilizing all health professionals to their full competencies, knowledge and skills. Therefore, the development of a permanent table to discuss interprofessional HHR planning, beginning with key professions, is imperative as health system transformation progresses to ensure health-care providers are practising to their full and expanded scopes in alignment with population health needs and health system priorities.

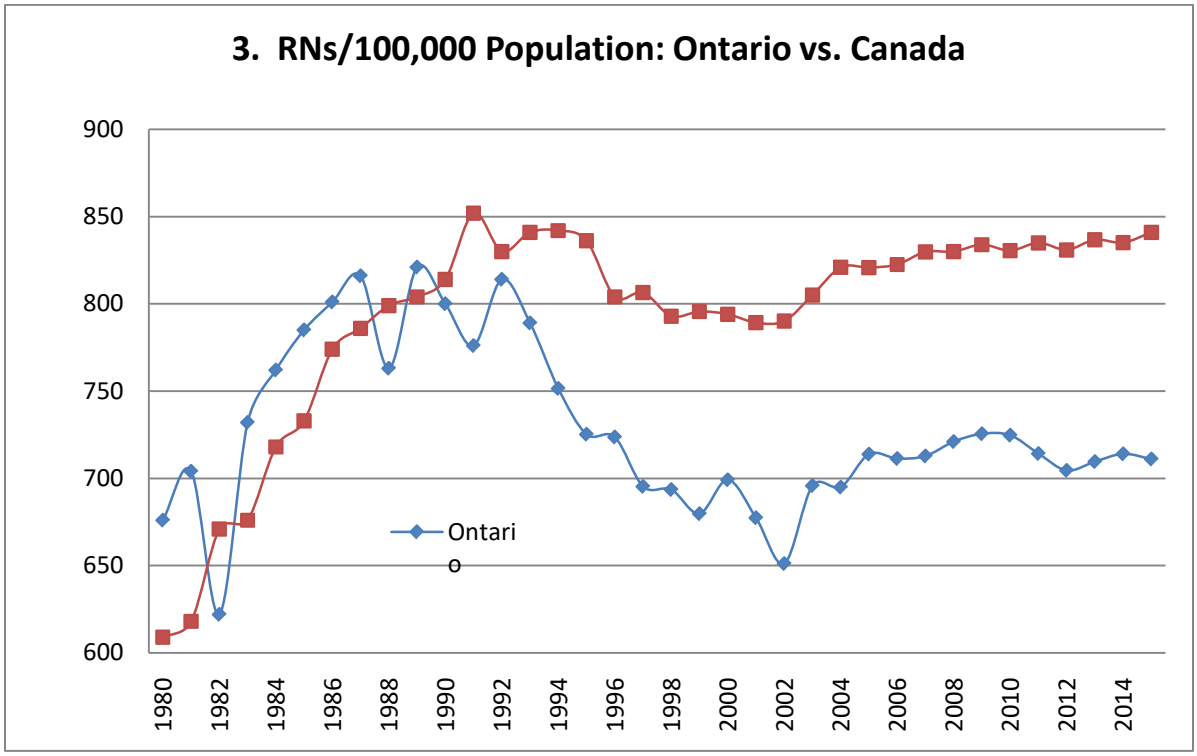
As the health system transitions to increased home and community care, the most complex, medically unstable, unpredictable patients will be cared for in Ontario hospitals. However, in the absence of a health human resource plan, some organizations are replacing RNs with less qualified providers and/or fragmenting nursing care delivery into tasks delegated to practical nurses and unregulated providers. It is often motivated by short-sighted attempts to control local health-care spending. But history clearly tells us that these decisions cost the system much more in the long run, while putting people's health at risk.

Evidence conclusively shows that using RNs results in improved clinical and financial outcomes. 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.[233 234 235 236 237 238 239 240 241 242] Recent evidence demonstrates that patient outcomes improve when RNs provide direct care instead of assuming a supervisory role in functional nursing.[243] A higher proportion of RNs is linked to shorter lengths of stay and improvements in failure to rescue, as well as superior organizational effectiveness (fewer adverse events and staff injuries).[244 245 246 247] A study found that adding full time equivalent RNs to increase the number of hours per patient day to nine would save 5,900 lives per year, reduce hospital days by 3.6 million and increase productivity by $1.3 billion per year.[248] Another study demonstrated an investment in RNs at a cost of $1.36 million resulted in a savings on hospital units from $2.2 million to $13.2 million in prevented adverse events.[249] The evidence is clear: increasing the number of RNs will benefit the public, improve organizational outcomes and save money for the health system. Providing RNs with full time positions further enhances outcomes through improvements in patient outcomes, efficient human resource utilization, cost-effectiveness, better collaboration with physicians, increased organizational commitment, and successful recruitment and retention of RNs.[250] In Ontario, 72.4 per cent of RNs would prefer to work full time compared to the 66.3 per cent that actually do.[251]

E2 Nurse-to-Population Ratios

Despite the growing evidence on the value of RNs to the patients and the health system, their share of nursing employment has been declining.

In the 1990s, Ontario had a low and falling RN/population ratio (RNs and NPs), which is an indicator of declining access to RNs and rising nursing workloads. Concerted government action to restore nursing employment reversed that negative trend. In its first mandate (2003-2007), the current government surpassed its nursing employment target of 8,000 more positions, with 9,669 positions. However, budgetary cutbacks in 2008 stalled that progress, and the government fell short of the 9,000 new nursing positions promised in its second mandate (7,346). This contributed to Ontario lagging behind the rest of the country in its numbers of working RNs per population – a gap that would require an estimated 17,920 more RNs and NPs to close; Figure 3 shows the widening gap. While RN employment growth lagged, RPN employment continued to grow steadily, resulting in a nursing workforce mix that shifted from 21.5 per cent RPN to 28.4 per cent between 2005 and 2015.



E3 Sectoral Considerations

Acute care hospitals are being positioned to provide short-term care for the most complex and unstable patients in response to injuries, critical health issues, and surgical procedures.[252] If a patient is stable and/or has predictable outcomes, they should not be cared for in an acute care hospital, and arguably not in any hospital environment. Not only will the complexity of patients increase, the complexity of the work environment will continue to increase with the use of sophisticated technology and complex

information management systems.[253] These changes require a highly educated nursing workforce with the necessary expertise and skills to analyze and synthesize a variety of information to provide care for patients and can be achieved by immediately mandating a stop to RN replacement and ensuring that any new hires are RNs.

The complexity and prevalence of care in the home has also increased and will continue to do so with current proposals to restructure the health system. The pressure on the home health-care sector has intensified as patients require more services for longer periods of time and more patients are being supported in their home.[254] In the last five years alone, the number of patients with high needs has gone up by 83 per cent.[255] With the rise in complexity, the number of unplanned readmissions to hospitals within 30 days of discharge and falls has risen as well.[256] It is critical that all first home health-care visits be provided by an RN to perform a holistic assessment and develop a comprehensive plan of care to ensure patients' needs are safely met in their homes. During this initial visit, the complexity and stability of the patient is unknown and the RN will fully assess the care complexity and needs, develop a plan, and determine the most appropriate caregiver (i.e. RN, RPN or UCP).

In 2008, a review of human resource implications to improve the quality of care and quality of life of residents in LTC commissioned by the Minister of Health and Long-Term Care was completed.[257] This review found the number of physicians to oversee residents' medical care was inadequate and unsustainable due to early retirements and lack of physicians practising in LTC.[258] Stakeholders participating in the review recommended increased use of nurse practitioners (NP) to ensure the care needs of residents are being met.[259] In 2015, the government of Ontario issued funding for 30 NPs in long term care as part of their pledge to fund 75 NPs in long term care from 2015-2017. RNAO commends the government for their investments in NPs in long term care and urges for the number of funded positions to increase to at minimum one attending NP per 120 LTC residents. Given the evolving health needs of the population, as well as the fiscal realities of tight budgets, nurse practitioners (NP) provide a viable and cost-effective solution. There is evidence to show that NPs contribute to safe, high quality and cost-effective care, thereby meeting both patient and health system needs.[260] [261] NPs are autonomous health professionals that increase patient access to care, and have demonstrated effectiveness in various models of hospital care. NPs can be added to existing inter-professional models of care, where the goal is to improve quality of care, remedy gaps in care, and can also function as the Most Responsible Provider.[262] [263] [264] [265] The complexity of care needed by residents in LTC homes has dramatically increased; only 10 per cent have full cognitive ability, 46 per cent demonstrate aggressive behaviour related to an underlying mental health condition, 97.4 percent have at least two chronic health conditions and at least 40 per cent require monitoring for an acute health condition (this has risen by almost 30 per cent over the past five years).[266] [267] As Ontario's population ages and care is increasingly provided in the community more skilled staff will be required to care for residents in LTC homes.

Primary care is the most appropriate setting for care co-ordination to occur as patients are cared for across their lifespan. Given the rich supply of primary care RNs and the need for full human resource utilization, care co-ordination is a natural fit to the evolving role of the primary care RN with their expert clinical background, awareness of the determinants of health and excellent critical thinking skills. There are over 4,500 RNs currently working in primary care.[268] In addition to these, RNAO proposes transitioning

the approximately 4,100 care co-ordinators currently employed within CCACs into interprofessional primary care models.

E4 Independent RN Prescribing

After years of steadfast advocacy by RNAO, the Ontario government has committed to expand the scope of practice of RNs to include prescribing medications by including it in the mandate letter for the Minister of Health and Long Term Care.[269] RNAO has done an extensive analysis of the three models of RN prescribing the Health Professions Regulatory Advisory Council was asked to assess last year and concluded independent RN prescribing would have the most impact on improving timely access to quality patient care, health system effectiveness, professional accountability, and continuity of care.[270] The benefits of an expanded RN scope of practice will be felt across the health system. Timely access to care and health system efficiencies will be among the greatest benefits reached. When fully implemented, an RN's expanded scope of practice will contribute to the health of all Ontarians by helping to provide same day access to care. Introduction of an expanded RN scope within health teams will decrease the waiting times for health-care services. Within primary care, having an expanded scope for the RN will enable these RNs to lead episodic illness clinics enabling clients to get an appointment within 48 hours and provide chronic disease management.[271] Research shows that RNs with expanded scopes liberate physician time, lower wait times and improve efficiency.[272] There is also a place for an expanded RN scope in acute care[273] and long-term care. An expanded role of the RN will significantly increase flow and efficiency, especially in high volume areas like the rapid assessment/treatment areas of emergency departments. Moreover, the provision of ongoing functional assessments, intervening early, providing direct care services, and encouraging independence, prevents older adults from needing higher levels of care -- resulting in unnecessary transfers and increased wait times.[274] A study comparing a RN-delivered and physician-delivered attention deficit hyperactivity disorder clinic concluded RNs are cost-effective and produce comparable clinical outcomes.[275] A second cost-effectiveness study for antiretroviral treatment found that RNs increased access to care that was not previously available.[276] This study discredits an unfounded belief by some that enabling RNs to prescribe would lead to over prescribing. In fact, any increase in treatments as a result of RNs working to an expanded scope reflects increased access to care that addressed previously unmet needs.

To ensure expedient implementation of independent RN prescribing a continuing education course will need to be developed and initiated. The United Kingdom has pioneered the practice of independent RN prescribing and their government funds RNs working within the National Health Service (NHS) to take the course.[277] Similarly in Ireland the Department of Health supports RNs by paying their tuition costs directly to the educational sector.[278] Depending on the institution the cost of the Non-Medical Prescribing course ranges from £1600.00 - £3000.00 or $2800.00 to $5300.00 Canadian.[279] [280] [281] Government funding in both of these countries has been provided from the inception of the course.

> **Recommendation 19.** *Immediately initiate and support a permanent table to discuss interprofessional HHR planning with key professions to start e.g. nursing and medicine resulting in an evidence-based interprofessional HHR plan to align population health needs and the full scope of practice of all regulated health professions with system priorities in Ontario.*

Recommendation 20. *Immediately issue a moratorium on nursing skill mix changes until a comprehensive interprofessional HHR plan is completed.*

Recommendation 21. *Mandate LHINs to use organizational models of nursing care delivery that advance care continuity and avoid fragmented care.*

Recommendation 22. *The MOHLTC, LHINs and employers should eliminate all barriers, and enable NPs to practise to full scope, including: prescribing controlled substances; acting as most responsible provider (MRP) in all sectors; implementing their legislated authority to admit, treat, transfer and discharge hospital in-patients; and utilizing fully the NP-anaesthesia role inclusive of intraoperative care.*

Recommendation 23. *Achieve 70 per cent full time employment for RNs in Ontario.*

Recommendation 24. *Sector-specific health human resource recommendations:*

a. Legislate an all-RN nursing workforce in acute care effective within two years for tertiary, quaternary and cancer centres (Group A and D) and within five years for large community hospitals (Group B).

b. LHINs require that all first home health-care visits be completed by an RN.

c. *The MOHLTC should legislate minimum staffing standards in LTC homes: one attending NP per 120 residents, 20 per cent RNs, 25 per cent RPNs and 55 per cent personal support workers.*

Recommendation 25. *Implement a model of independent RN prescribing and immediately develop the continuing education course to enable this practice.*

F Fiscal Capacity

Over the business cycle, government budgetary deficits rise during recessions and fall during recoveries. For example, Ontario went from a small surplus in 2007-08 of 0.1 per cent of GDP to a deficit of 3.2 per cent in 2009-10, as Ontario increased expenditures to fight the effects of the global financial crisis. As the economy recovered, the deficit shrank to 0.7 per cent in 2015-16 and is projected to drop to 0.5 per cent this fiscal year.

There is nothing inherently bad about deficits, so long as they do not get out of control and so long as they are incurred for valid purposes. We would argue that the province would be better served by shifting the focus from balancing the budget to continuing to restore decent jobs, particularly given the stubbornly low employment rate in the province. Furthermore, as our discussion of social determinants of health reveals, there is a huge social deficit that is exacerbated by the on-going austerity – not to mention the physical infrastructure deficit. The deficit was fought chiefly through austerity: program spending fell from 17.9 per cent of GDP in 2009-10 to 15.9 per cent – 2 percentage

points; at the same time, revenue rose from 16.1 per cent to 16.8 per cent – 0.7 percentage points. A society that under-invests 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.

Canadian governments have found it politically very easy to cut their revenues, and now they are facing very difficult choices. 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.[282] That isn't the kind of "stimulus" package that benefits the province.

Leaders of all political stripes have come to the realization that new revenue sources are urgently needed, just to meet current commitments, as Toronto's Mayor Tory has now done. 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.[283] 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.[284]

There are a number of taxes on "bads" already on the books, such as gasoline, diesel, wine and beer. As economist Don Drummond outlined in his report to the government, the above taxes apply to volumes rather than value. Unless the taxes are continually raised to account for inflation, this amounts to continual cuts in the tax rate. The Drummond Commission advised replacing such taxes with taxes that apply to value.[285] The cut in the effective tax rate over time from taxing volumes can be dramatic. For example, Ontario has not raised its gasoline tax since January 1992.[286] At that time, a litre of regular unleaded gasoline cost 49.8 cents on average in Ontario. [287] As of January 2016, a litre of regular unleaded gasoline averaged 95.4 cents.[288] Since the tax rate on volume was frozen, this was equivalent to a cut of 47.8 per cent in the tax rate on value. And that was after the cost of gasoline in Ontario had plummeted from $1.41 in June; at that point, the frozen volume tax was equivalent to a 64.8 per cent cut in a tax on value.

The government must also be wary of the temptation to sell off assets for one-shot revenue increments. At various times, Hydro One, Ontario Power Generation and the Liquor Control Board have been mentioned as candidates.[289] The Premier's Advisory Council on Government Assets recommended selling off 60 per cent of Hydro One,[290] in spite of the report of Ontario's Financial Accountability Office that the sale would worsen the province's deficit position.[291] Indeed it is difficult to imagine purchasers paying a price equal to the value of the revenue stream Hydro One would generate, because they would have to discount the offer for uncertainty around prices that Hydro One would receive for delivering power in the future - this is something under the oversight of government - so the risk facing government as owner would be less than that faced by private sector owners. Nevertheless, Ontario did sell an initial 15 per cent of Hydro One shares in the fall of 2015,[292] much to the objection of groups including RNAO.[293]

The Advisory Council did not recommend selling off Ontario Power Generation or the Liquor Control Board,[294] so the immediate risk to those assets is reduced. Selling off assets is not a sustainable way of addressing revenue-expenditure imbalances - particularly when that asset is a monopoly that provides a huge 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.

Recommendations:

Recommendation 26. *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 27. *Increase revenue sources that encourage environmental and societal responsibility. Begin by phasing in environmental levies and implementing a cap-and-trade program for carbon emissions.*

Recommendation 28. *Update the gasoline tax by making it a tax on value rather than on volume.*

Recommendation 29. *Reject fire sales of publicly owned Crown Corporations and assets to fund government programs (e.g. Hydro One, Ontario Power Generation, and the Liquor Control Board.). Halt the further sale of Hydro One shares.*

Appendix

Proponents of a National Pharmacare Program

Over 90 organizations have come out in favour of a national pharmacare program, including the following: RNAO,[295] [296]Canadian Federation of Nurses Unions,[297] [298] [299] Canadian Nurses Association,[300] Canadian Medical Association,[301] [302] Standing Senate Committee on Social Affairs, Science and Technology,[303] Canadian Health Coalition,[304] [305] Canadian Association of Retired Persons,[306] [307] Canadian Doctors for Medicare,[308] [309] Union des consommateurs,[310] the Nurse Practitioners' Association of Ontario, the Canadian Association of Community Health Centres, the Association of Ontario Health Centres, the Association of Family Health Teams of Ontario, Unifor, the College of Family Physicians of Canada, Health Providers Against Poverty, the United Steelworkers, the Canadian Diabetes Association, the Phoenix Centre for Families and Children, the National Council of Women Canada, The Canadian Treatment Action Council, the Council of Canadians, the Canadian AIDS Society, the Association of Local Public Health Agencies, the National Union of Public and General Employees, the Canadian Union of Public Employees, 25 in 5: Network for Poverty Reduction, Planned Parenthood Toronto, the Human Development Council, the Child Poverty Action network, Alternatives North, and the Centre for Social Justice.[311] There are very active campaigns for a national pharmacare program, including the Campaign for National Drug Coverage of which RNAO is a founding member (and which has a long list of endorsing organizations,[312] only some of whom are listed above),[313] and the Campaign for a National Drug Plan.[314] Newspapers such as the Toronto Star have also called for a national pharmacare program, and not just some national bulk buying arrangement.[315]

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