Ontario Pre-Budget 2015: Moving Forward on Deficits: Social, Health, Environment and Infrastructure

Submission to the Standing Committee on Finance and Economic Affairs

January 29, 2015

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1) Ensure the fiscal capacity to deliver all essential health, health care, social, and environmental services by building a more progressive tax system. Do not cut taxes.
2) Increase revenue sources that encourage environmental and societal responsibility. Begin by phasing in environmental levies, such as a carbon fee, to help pay for the damage polluters cause and to support the social programs and services most needed.
3) 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.].

Medicare: Fiscal Issues

4) Reject efforts to commercialize or privatize health-care delivery by
    a. legislating a complete ban of inbound medical tourism.
    b. probibiting new P3 negotiations and contracts.
5) Work with the other provinces to bring the federal government back to the table to negotiate a Health Accord.
6) Expand our publicly funded, not-for-profit health-care system to all medically necessary areas, starting with universal home care and pharmacare.
7) Focus on well-researched and demonstrated policies and evidence-based clinical practices to optimize the health of people, families and communities.

Medicare: System Improvements in quality and cost-effectiveness

8) Anchor the health system in primary care by expanding interprofessional primary care delivered in nurse practitioner-led clinics (NPLC), community health centres (CHC), Aboriginal Health Access Centres (AHAC) and family health teams (FHT).
9) Support Local Health Integration Networks to achieve regional health system planning, integration and accountability for all health sectors.
10) Phase out CCACs and transition the 3,500 care co-ordinators from Community Care Access Centres into primary care through a carefully crafted labour management strategy that retains their salary and benefits.

Nursing Care

11) Narrow the gap with the rest of the country of about 17,239 registered nurse (RN) positions as quickly as possible by creating more positions. Ensure that staffing mix decisions are based on patient need and stop RN replacement with other providers as a short-sighted and erroneous attempt to save money.
12) Maximize and expand the role of RNs to deliver a broader range of care, including delivering on government promises regarding RN prescribing.
13) Secure fair compensation and benefits for RNs and nurse practitioners (NPs) working in all sectors of health care by eliminating the discrepancy between community settings and hospitals/CCAC.
14) To protect the safety of our seniors and to ensure their timely access to quality care, phase in new minimum staffing standards in long-term care, starting with a minimum of one nurse practitioner per 120 residents
15) Ensure 70 per cent of all nurses work full-time so patients have continuity in their care and care provider.

Social Determinants of Health

16) Update and strengthen Ontario's Poverty Reduction Strategy with a detailed implementation plan, complete with targets and timelines, accompanied by substantive public investment.
17) Improve access to affordable housing and stimulate job creation in the process by investing one per cent of Ontario's budget to address the backlog of existing affordable housing units in need of repair and to create new affordable housing stock.
18) Raise the dangerously low social assistance rates to reflect the actual cost of living by setting up an expert panel that includes people with lived experience.
19) Increase the minimum wage to $14 per hour in 2015 and continue to index the minimum to inflation and ensure equal pay for equal work by expanding protections for temporary workers.

Environment

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

21) Regulate the use of neonicotinoids in agriculture to achieve a 15 per cent over-winter honey bee mortality rate by 2020, as a first step towards a complete ban.

22) Minimize the energy footprint by: focusing first on conservation and energy efficiency, and increasing reliance on renewable energy.

23) Take all necessary steps to:

    a. ensure sufficient dedicated revenue sources to pay for a substantial expansion of transit and active transportation. and

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

RNAO Pre-Budget Submission 2015 - Moving Forward on Deficits: Social, Health, Environment and Infrastructure

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing RNs, NPs 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. RNAO understands that budgets profoundly affect people's health and nursing services. For this, we welcome this opportunity to participate in the pre-budget consultation.

The Role of Government at this Point in the Business and Political Cycle

Context: Missing Jobs and Health: Ontarians elected a majority government in 2014 that committed to preserve and restore public services. They have endured an extended bout of high unemployment, which represents a major loss in productive capacity. More importantly, that unemployment causes a great deal of human suffering, ill health and permanent loss of human capital. RNs and NPs are very aware of the adverse health effects of unemployment and falling incomes.[1][2][3][4][5][6][7][8] This should be a key focus of governments at the federal and provincial levels.

When the recent recession started in 2008, Ontario's unemployment rate jumped from 6.5 per cent in October to 7.2 per cent in November and 9.4 per cent in June of 2009. It remained above 9 per cent until 2010 and above 8 per cent in 2011. Given what the research says about the adverse health effects of unemployment, that is an extended period of suffering. Ontario's unemployment rate did not fall below 7 per cent until October 2014. As of December 2014, the unemployment rate returned to 7 per cent, higher than the national average of 6.6 per cent. Youth unemployment continues to be painfully high, at 15.8 per cent. [9] We can do better. The graphs below illustrate recent trends.

1. Ontario Unemployment Rate 1976-2014

Figure 1 shows the trend in the unemployment rate over time for Ontario. Spikes occur in the early 1908s, early 1990s, early 2000s (a smaller spike) and in 2008-9. There was a somewhat quicker recovery in the early part of the recession (corresponding to government expansionary efforts), and a slower recovery after mid 2010 (corresponding to a phasing out of expansionary efforts). The graph shows that the unemployment rate remains above its pre-recession level.[10]

2. Ontario Employment Rate 1976-2014

Figure 2 provides cause for concern about progress on the jobs front. It shows that the employment rate is stuck at a level well below its pre-recession level. The employment rate is a strong indicator of the availability of employment. In December 2014, the employment rate was 61 per cent, while it was well over 63 per cent before the latest

recession. And it had been as high as 66.9 per cent in 1989.[11] If the December 2014 employment rate were 63.4 per cent (a fairly typical pre-recession rate), there would be 166,961 more jobs in Ontario. If the employment rate were at its 1989 peak, 410,445 more Ontarians would have had jobs.[12] That is a significant loss of economic and human potential.

3. Ontario Labour Force Participation Rate 1976-2014

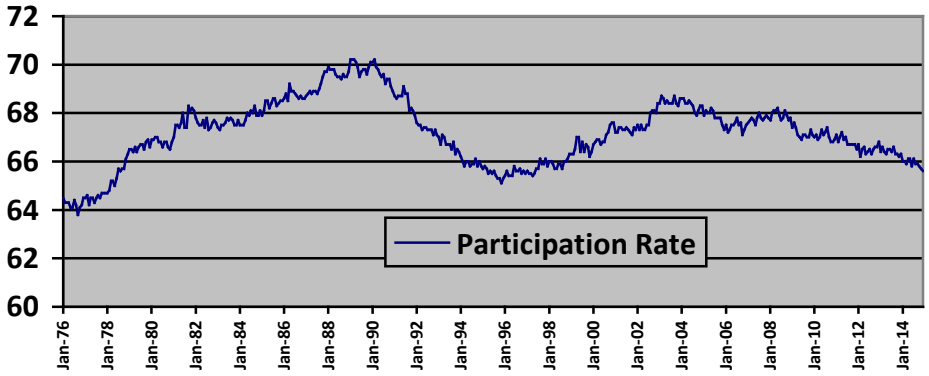


Figure 3 helps explain the low employment rate: labour force participation rates have dropped as jobs evaporated. There was a small drop during the sharp recession in the early 1980s, and longer drop during the prolonged recession of the 1990s, and there is a continued drop in the latest, persistent recession and jobless recovery.[13]

The Role of Government in Employment Recovery: Governments can reduce unemployment through appropriate expansionary policies. Indeed, after the latest recession started in 2008, governments (including that in Ontario) heeded wide-spread calls to boost spending to fight the downturn, which threatened to turn catastrophic. As a result, Ontario avoided a disastrous decline; this was an important achievement. Nevertheless, Ontario GDP still fell and many jobs were lost due to the severity of the global recession. As expected, the deficit rose, and Ontario shifted its focus to deficit reduction. RNAO had concerns with the timing and approach to deficit reduction.[14] Based on shares of GDP, the reductions came disproportionately at the expense of program spending. Between 2009-10 and 2013-14, the deficit fell from 3.2 per cent of GDP to 1.5 per cent. Program spending dropped from 17.9 per cent of GDP to 16.6 per cent, while revenue rose from 16.2 per cent to 16.7 per cent.[15]

There are a variety of reasons why Ontario should carefully consider its debt-reduction options:

- as noted above, there remains considerable economic slack, with a disturbingly low employment rate.
- Ontario's deficit is not large by its own standards (it reached 4.3 per cent of GDP during the recession of the early 1990s),[16] and the deficit has dropped substantially since its 3.2 per cent peak in 2009/10.[17]
- Borrowing for investment continues to be available at historically low rates.
- Forecasts for economic growth in Ontario have improved, in part due to the falling Canadian dollar. TD Economics expects Ontario to lead all provinces at 2.5 per cent real growth over the 2015-16 period (2.6 per cent in 2015 ND 2.3 per cent in 2016).[18] Those figures are echoed by Scotiabank.[19] RBC Economics is more bullish at 3.1 per cent for 2015.[20]
- The dropping exchange rate will be a boon to Ontario's traded goods sector, including manufacturing. As of January 21, 2015, the dollar had fallen to $0.81 US, compared with values well above par in 2011. It had already dropped over 5 cents since the end of 2014.[21] This should trigger even more economic growth for Ontario.

4. Canada-US Exchange

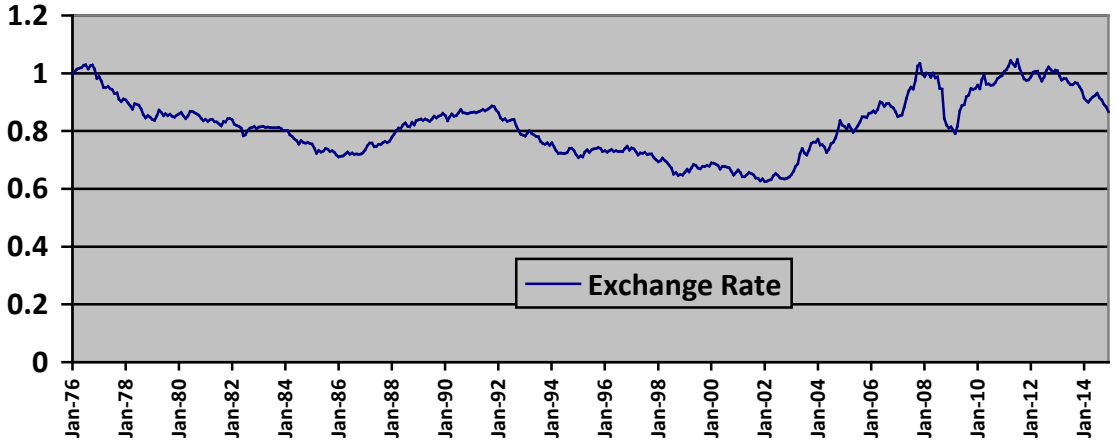


Figure 4 shows trends over time for the Canadian exchange rate. It rose in the early 1990s, contributing to the deep and prolonged recession in that period. After the early 1990s, the exchange rate fell, reflecting a change in the policy of the Bank of Canada, dropping below $0.63 US in 2002. This was a great boon for the Ontario traded good sector. Estimates of a fair price for the Canadian dollar (the purchasing power parity exchange rate) in recent years have been in the $0.80-$0.85 US range.[22] [23] The latest available estimate is $0.80 US for 2013.[24] In 2002, the Canadian dollar was greatly

undervalued, but this was not to last. By late 2007, the Canadian dollar was equally overvalued, trading above par with the US dollar. After that, it fluctuated, but the comparatively expansionary US monetary policy drove the Canadian dollar above par. Combined with falling international demand, Ontario manufacturers were hit by a double whammy and shed a large portion of manufacturing jobs -- a drop of 290,000 jobs and a reduction from 18 per cent to 11 per cent of the Ontario workforce between 2000 and 2013.[25] The current downward trend in the dollar has been accelerated by the January 21, 2015 cut in interest rates by the Bank of Canada.[26] Now that the dollar has now slid to $0.81 US, it is back into its fair value range, and Ontario businesses are on a level playing field with their international competitors. There is no exchange rate reversal on the immediate horizon, given the stance of the Bank of Canada. That lower dollar will be good for the Ontario's trade-exposed sector and for the Ontario economy as a whole. In turn, that will be of great assistance in reducing the government deficit, which should reduce the temptation to resort to unnecessary austerity.

In view of the ongoing slack in the Ontario economy, the government should consider its very realistic option to grow out of the deficit without compromising the restoration of physical, social and environmental infrastructure.

Instead, there remain calls to rein in public expenditures, which threaten public services and cost jobs. Yet by Canadian standards, Ontario's program expenditures are low, consuming 16.6 per cent of GDP as of 2013-14. Only two (high income) provinces have lower ratios: Saskatchewan and Alberta.[27] The current spending is not high by historic Ontario standards either: the 16.6 per cent is roughly in the middle of the range of 13.6 per cent to 18.9 per cent over the past 30 years. As noted above, provincial and federal governments' deficits ballooned in the desperate but successful battle to stave off a major economic collapse. Ontario went from three annual surpluses to a small deficit (1.1 per cent of GDP) in 2008-09, to a large deficit in 2009-10 (3.2 per cent of GDP). Since that time, the deficit declined steadily to 1.4 per cent of GDP in 2012-13 before rising slightly to 1.5 per cent in 2013-14. The government cautiously projects a 1.7 per cent deficit for 2014-15.[28] However such projections invariably overstate the actual deficit; for example, Ontario projected a deficit that 1.6 per cent of GDP for 2013-14 and it came in at 1.5 per cent.[29] The Ontario deficit is projected to virtually disappear by 2017-18. Pundits from all sides called on government to step in where the financial system had failed. But the job of recovering from the recession is far from finished. We do not believe that the need to reduce the deficit outweighs the urgency to maintain a level of services consistent with a health society, including healthy levels of employment.

There is no question that fiscal deficits and debts must be taken seriously. Over the business cycle, there must be a reasonable balance between revenues and expenses. But deficits must be understood as constraints and not as principal objectives. The objective is to harness physical, human and natural resources in a way that builds a healthy, dynamic, sustainable, inclusive society. Runaway fiscal debts and deficits could limit capacity to

pay for needed services in the future. But growing social, infrastructure and environmental deficits have immediate and long-term consequences that are not top-of-mind in budget discourse, and that must change. We can deal with the manageable fiscal deficit on a schedule that doesn't harm the economy while getting the right mix of expenditures and revenues.

The problem is: if priority is placed on balancing the budget and doing so by austerity, everything else takes a back seat. This approach, Ontario's RNs say, has failed elsewhere in the world, [30] and is bad for Ontarians.[31] Governments can, and must, take the lead – through policy and budgetary decisions – that protect the most vulnerable and promote health, if we truly care for a just and fair society

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

A. Fiscal Capacity

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

During the mid-1990s and early 2000s, the Government of Ontario cut revenues and expenditures severely. Government revenues as a share of GDP fell from 17.6 per cent in 1995-96 to 15.1 per cent in 2003-04. Over the same period, program expenditures were cut from 18.1 per cent to 14.3 per cent of GDP.[32] This created a severe social deficit and limited the ability to deal with it due to lower tax rates. Subsequently, the government restored much of the program spending and brought in more revenue with the introduction of a health tax. With economic recovery, rising revenues pushed the government into a modest surplus. However, the 2008 recession called for major spending to help head off economic collapse. Program spending jumped from 15.8 per cent of GDP in 2008-09 to 18.0 per cent the following year.[33] The deficit spending strategy in Ontario and across the country did succeed in averting a much worse economic decline. A negative side effect was very large deficits at a time when the economy remains fragile.

Ontario must, of course, take its debt and deficit seriously. Taking them seriously means thinking carefully about when and how to reduce them. The province must resist the temptation to punish the economy further with untimely spending cuts. Ill-advised austerity policies in Europe plunged country after country into severe recession and social strife. That does not need to happen in Ontario, nor in Canada. The government deficit in Ontario dropped from 3.2 per cent of GDP to 1.4 per cent in 2012-13, with a rise to 1.5

per cent in 2013-14. Ontario's deficit is significant but manageable. Thanks to continuing low interest rates, now is a good time to invest in rebuilding the economy. In spite of the growing debt, interest charges on the debt have remained at a fairly flat 1.5 to 1.6 per cent of GDP in recent years.[34] Enhanced revenue measures, such as reducing tax avoidance, more green taxes, prices on carbon and surcharges on those better able to pay, will help to reduce the deficit and restore Ontario's fiscal capacity. New revenue measures are required to address growing needs in a number of areas, including transit (as gridlock imposes a worsening toll on the environment) productivity and health. Green taxes have the advantage of discouraging harmful behaviour. These taxes are more efficient, and could help replace less efficient taxes. On these grounds, the Task Force on Competitiveness has called for the implementation of an Ontario carbon tax.[35]

There are a number of taxes on "bads" already on the books, such as gasoline, diesel, wine and beer. As the Drummond Report pointed out, 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. Drummond advised replacing such taxes with taxes that apply to value.[36] 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.[37] At that time, a litre of regular unleaded gasoline cost 49.8 cents on average in Ontario. [38] As of December 29, 2014, a litre of regular unleaded gasoline averaged 96.7 cents.[39] Since the tax rate on volume was frozen, this was equivalent to a cut of 48.5 per cent in the tax rate on value. And that was after the cost of gasoline in Ontario had plummeted from 141.8 cents in June; at that point, the frozen volume tax was equivalent to a 64.8 per cent cut in a tax on value.

It is not responsible to consider tax cuts unless alternative revenue sources are in place. The benefits of tax cuts are elusive, as any private spending stimulus may be more than offset by corresponding government spending cuts. As the Task Force on Competitiveness admitted, substantial federal and Ontario tax cuts were accompanied by falling investment rates per worker.[40]

The government must be very 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.[41] Selling off assets is not a sustainable way of addressing revenue-expenditure imbalances. 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. As these are large assets, there will be few buyers, and the government would be putting itself into a poor bargaining position, particularly if buyers sense that there is a seller facing short-term political/budgetary pressures.

Recommendations:

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

B. Medicare

Expanding Medicare. The *Canada Health Act* (CHA) is a valued tool to deliver health care to all Canadians in an equitable way. It guarantees universal access to hospital and medical care via first-dollar coverage. Unfortunately, omitted are key health-care services, including pharmacare, home care, long-term care, physiotherapy, and dental care. The omissions lead to very uneven access to uncovered services across the country. They also result in inefficient overuse of covered services and underuse of uncovered services. In 1997, the National Forum on Health called for protection of the single-payer model and "expanding publicly funded services to include all medically necessary services and, in the first instance, home care and drugs."[42] In 2002, the Romanow Commission recommended expansion of home health care for mental health, post-acute care and palliative care.[43] It also recommended coverage for catastrophic drug expenses.[44] The Kirby Report called for a national post-acute home care program, catastrophic drug coverage and a national drug formulary.[45] RNAO has long advocated for expansion of medicare "to all uncovered areas, including home care, pharmacare, long-term care, rehabilitation services, public health and truly comprehensive primary health care."[46]

Pharmacare. Canadians are covered by a patchwork of partial pharmacare coverage.[47] A commentary written for the C.D. Howe Institute neatly summarizes the case for pharmacare in Canada:[48] [49] it would deliver equitable access to medicines; it would better financially protect the ill; and it would result in a net saving of money. The savings come from reduced administrative, marketing and regulatory costs (due to being a single-payer system), from integration of decisions on pharmaceutical care into overall health care (e.g., health-care providers have more incentive to rationally optimize between medical and pharmaceutical care), from pooling of risk over larger populations, from value-for-money testing, and from use of purchasing power to reduce drug prices. In a related study, the same authors make the case against means testing and copayments for seniors' pharmacare.[50] 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).[51] RNAO,[52] Canadian Federation of Nurses Unions[53] [54]; Canadian Medical Association,[55] Standing Senate Committee on Social Affairs, Science and Technology,[56] Canadian Health Coalition,[57] Canadian Association of Retired Persons,[58] [59] the Toronto Star,[60] [61] and Canadian Doctors for Medicare[62] have called for a national pharmacare program. The public is game: a May 22, 2013 poll by EKOS found 78 percent of Canadian respondents supported a universal public drug plan for all necessary prescription drugs.[63] The poll also found strong support (82 per cent) for bulk purchasing of drugs and strong negotiations to lower drug prices. And there is support from a key player in the Ontario government; the Minister of Health and Long-Term Care, Dr. Eric Hoskins, has written an op-ed calling for a national pharmacare program.[64]

It would be ideal if pharmacare was implemented nation-wide, but as the C.D. Howe article points out, in the current policy environment, one or more provinces must lead the way. Ontario would serve its citizens and all Canadians well if it were to play that role. The Ontario government has indicated an interest in a full provincial pharmacare program.[65] 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.[66] [67] RNAO will continue to mobilize for a national pharmacare program, and urge Premier Wynne and Minister Hoskins to take the lead by launching Ontario's universal and comprehensive pharmacare program. Such a plan, however, must be consistent with principles of Medicare. RNAO will only endorse a plan that is accessible, universal and that does not include co-payments, means testing or user-fees.

Home care. Expansion of Medicare to include home care would yield similar types of benefits to those related to a national pharmacare program. As noted above, the National Health Forum, the Romanow Report and the Kirby Report called for various forms of national home care programs, and home care expansion was one of the mandates of the 2004 *Health Accord*, which committed provinces to cover two weeks of home care for the acute, mental health and palliative areas.[68] RNAO, the Canadian College of Family Physicians,[69] and the Canadian Healthcare Association[70] have called for a national home care program. The result would be: much broader and more equitable access to home care services; reduction in the need for more costly long-term care and acute care; better outcomes; and greater client satisfaction. RNAO will advocate for an accessible and universal homecare program that does not include co-payments, means testing or user-fees.

Making Medicare More Efficient. We do not need to wait for the Federal government to act. Expanding Medicare by creating universal and comprehensive pharmacare and homecare programs would improve outcomes and make more rational use of resources, instead of overusing covered services and underutilizing uncovered services. That would

help make Medicare more efficient. But that is not enough. Transparency and accountability are important in all public activities, including health care, to ensure that services are efficiently and effectively delivered. The loss of the Health Council of Canada weakens transparency and accountability at the national level. Health Quality Ontario[71] and the provincial Auditor General[72] do provide accountability for health at the provincial level for Ontario, and the same accountability is required nationally.

Threats to Medicare

Private Payment. Private payment restricts access to health-care services, based on income, meaning that lower income people without insurance get delayed, reduced or no access to health care. Private payment results in higher costs due to limited buying power, higher administrative costs, and skewed usage to insured versus uninsured services. The American health-care system is an example. As of 2013, 13.2 per cent of Americans had neither public nor private health insurance for the entire calendar year; this number has mercifully been dropping.[73] In part due to its multi-payer nature, U.S. health expenditures exceed those of the rest of the OECD, but health outcomes are comparatively poor.[74]

Hospitals and other health-care organizations are grappling with tight fiscal realities as stagnant budgets attempt to accommodate changing population health needs. An area of concern for RNAO is medical tourism: the sale of health care at a profit to well-heeled people who travel abroad to access health services more quickly or more cheaply. RNAO is aware of hospitals that have provided health services to non-urgent paying patients from abroad.[75] RNAO is in staunch opposition to medical tourism because it turns health care into a commodity to be bought and sold.[76] For nurses, medical tourism is the beginning of the end of Medicare,[77] as it opens the door to lawsuits driven by wealthy Ontarians denied private care and for-profit interest groups. They will argue that if out-of-country patients can pay their way to preferential treatment, so, too, should Ontarians. On November 21st the Minister of Health and Long-Term Care asked all Ontario hospitals 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. While this is an encouraging first step, RNAO strongly urges the Minister to implement a complete ban on inbound medical tourism through legislation.

For-Profit Delivery. Delivery of services is another area of privatization. In the home care and long-term care sectors, services are delivered by a combination of for-profit and not-for-profit bodies. The profit incentive turns out to be perverse in health care, because it harnesses human ingenuity in ways that inflate costs and deliver worse outcomes. Health care is particularly vulnerable because it is very difficult to assess and monitor quality of care; the incentive to cut corners is very powerful, and the penalty for not cheating may be loss of market share. A review of four decades of experience with

privatization in the United States with a combination of public funding and private health-care management and delivery found that "for-profit health institutions provide inferior care at inflated prices."[78] For-profit provision leads to cherry-picking of profitable services and clients, leaving the public sector to deal with high-cost clients. [79] [80] An abundance of literature points to poorer outcomes from for-profit health care[81] [82] [83] [84] [85] [86] [87] [88] [89] and at higher cost. [90]

Public-private partnerships (also known as P3s or Alternative Financing and Procurement (AFPs)[91]) are a variation on for-profit provision, in the case of infrastructure. They generally involve the private sector organizing the financing, design, and construction of infrastructure. Controversially, they tend to involve very complicated and long-term contracts that also include private operation and maintenance of the facility after it has been built. P3s tend to be more expensive because private borrowing costs are higher than public borrowing costs, because of the high negotiation costs of these complex deals, and because the representatives of the public sector are ill-equipped to negotiate such complex contracts. The public ends up absorbing higher costs and lower quality of services as a result.[92] [93] [94] [95] [96] [97] [98] [99] [100] Ontario's Auditor General confirmed the critics[101] by finding that the choice of AFPs was justified by questionable overevaluations of risk that tipped the cost-benefit analysis in favour of AFPs, which otherwise showed to be $8 billion more costly.[102]

The Loss of the *Health Accord*. The federal government has walked away from renegotiating the *Health Accord,* and has allowed it to expire. This was a federal-provincial-territorial agreement aimed at strengthening Canadian health care under which the federal government funded health care via the health transfer, in return for provincial/territorial performance undertakings.[103] The federal government also terminated the watch-dog Health Council of Canada in 2014 over the strenuous objections of organizations like RNAO.[104] The government stated that the Council was no longer needed now that the *Health Accord* was expiring and yet the creation of such a council was the number one recommendation of the Romanow Commission, led by former Saskatchewan premier Roy Romanow.[105] The provinces say that in lieu of negotiation, the federal government unilaterally slashed $36 billion in transfers to the provinces and territories for the period after the expiry of the *Health Accord*.[106] [107] This further reduces provincial/territorial health-care resources and gives the federal government even less leverage to enforce the *Canada Health Act* (a paper written for the Canadian Institute of Actuaries estimates that the federal transfer share of provincial/territorial health expenditures would drop from its current 21 per cent to 14.3 per cent under the new formula by 2037, down from an initial 50 per cent).[108] The federal government could withhold transfers to provinces that allow billing for services covered under the CHA, but it has chosen not to act, which encourages further violations.[109] Furthermore, the federal government has switched to transferring health funds on a per capita basis, which will leave poorer provinces worse off. Romanow described the Prime Minister's plan for health-care transfers as a deliberate strategy to abandon health care to

the provinces and foster the development of more private, for-profit medical enterprises.[110]

Saving Medicare by Improving the Health System. RNAO agrees changes are needed to make our system more responsive. It is well-known, that nurses – like most Canadians – want to protect our publicly funded and not-for-profit health system, and strengthen it for generations to come. While Ontario's nurses know there are fiscal challenges in today's economy, we also know that cost containment cannot occur at the expense of quality and evidence-based patient care, as it would result in human suffering and higher costs. Nurses know there are better solutions. The changes that RNAO has widely promoted: are informed by robust evidence and the urgent need to improve health-system integration, reduce harmful infrastructure duplication, and utilize the full utilization of the knowledge and skills of all health-care professionals, including RNs and NPs. When these changes take hold, Ontarians will experience transformation that will also result in a system that is more efficient, more cost-effective and delivers better health outcomes for patients and taxpayers.

We say the way to save precious taxpayer dollars is by decreasing duplication and substantively improving health-system integration, while anchoring the health system in primary care. The time has come to have these important discussions as the Standing Committee on Social Policy is expected to release its report on the review of the Local Health Integration Networks (LHIN) very soon. Moreover, the Ministry of Health and Long-Term Care has convened a Home and Community Care Expert Panel[111] to address deficiencies within the sector. The report of this committee is also forthcoming, creating a policy window for change.

To achieve a shift to community based care, RNAO's game-changing report *Enhancing Community Care for Ontarians (ECCO)*[112] proposes a three-year plan that addresses the greatest needs of our system. It urges government to ensure every Ontarian has timely access to comprehensive primary care, with a strong emphasis on health promotion, illness prevention, chronic disease prevention and management, and mental health care. It calls for a person-centred, evidence-based approach that will advance the principles of primary health care for all. RNAO's ECCO model strengthens health system integration and alignment by enabling LHINs to effectively lead regional health system planning using population-based needs assessments, service agreements, along with appropriate funding, monitoring and accountability for all health-care sectors.

Ontarians cannot afford to have their tax dollars invested in a costly system fraught with duplication. This is one of the reasons the ECCO model proposes a transition of Community Care Access Centre (CCAC) functions into established areas of the health system. It calls for transitioning the 3,500 care co-ordinators from CCACs into primary care through a carefully crafted labour strategy, maintaining compensation and benefits, that anchors their role in serving Ontarians with complex needs and multiple co-

morbidities. To achieve this type of renewal, it is imperative to strengthen and organize Ontario's 4,000 individual primary care entities into local primary care networks, configured according to geographical referral patterns. The end goal will be to position primary care as the co-ordinating "hub" of the local health system. Eliminating the CCAC infrastructure will provide significant cost savings nearly $200M reinvested into direct home health-care/support services annually.

As with any transformation, this will take time, however, it is within reach. RNAO challenges the government to commit to provide all Ontarians with access to interprofessional primary care by 2020. This can be fully accomplished by expanding existing interprofessional primary care practices that hold infrastructure capacity, and by creating new sites where such capacity does not currently exist. To achieve this, government must target its investments in nurse practitioner-led clinics, community health centres, Aboriginal health access centres, and family health teams, and stop enabling new solo physician practices. In addition, the government can expand primary care capacity immediately by forming primary care networks. These networks are anchored by a 'lead' primary care organization and enable horizontal organization of local primary care entities.

Ontario's 25 nurse practitioner-led clinics (NPLC)[113] [114] have been built from the ground up as a highly successful interprofessional model of primary care delivery that has improved access to care across the province. NPLCs are led by NPs in collaboration with a team of health professionals including RNs, registered practical nurses (RPN), social workers, pharmacists, physicians, dieticians and others according to patients' needs. NPLCs offer comprehensive primary care services within a primary health-care framework. Embraced within the community, NPLCs partner with patients to co-ordinate their care and help them navigate the complexities of the health system.

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

As RNAO has urged for many years, NPs must play a bigger role to enhance timely and quality care for residents in long-term care. NPs have the competencies, knowledge and skills to reduce unnecessary transfers to hospital emergency room departments, and to reduce hospitalizations – thus, reducing the trauma to frail clients and making for a more cost-effective health system. NPs can also accelerate access to medical care and help to

manage difficult behaviours in clients. Evidence points to a minimum of one NP per 120 residents.

Fiscal Recommendations for Medicare:

- Reject efforts to commercialize or privatize health-care delivery by
    - legislating a complete ban of inbound medical tourism.
    - prohibiting new P3 negotiations and contracts.
- Work with the other provinces to bring the federal government back to the table to negotiate a Health Accord.
- Expand our publicly funded, not-for-profit health-care system to all medically necessary areas, starting with universal home care and pharmacare.
- Focus on well-researched and demonstrated policies and evidence-based clinical practices to optimize the health of people, families and communities.

System Improvement Recommendations for Medicare:

- Anchor the health system in primary care by expanding interprofessional primary care delivered in nurse practitioner-led clinics (NPLC), community health centres (CHC), Aboriginal Health Access Centres (AHAC) and family health teams (FHT).
- Support Local Health Integration Networks to achieve regional health system planning, integration and accountability for all health sectors.
- Phase out CCACs and transition the 3,500 care co-ordinators from Community Care Access Centres into primary care through a carefully crafted labour management strategy that retains their salary and benefits.

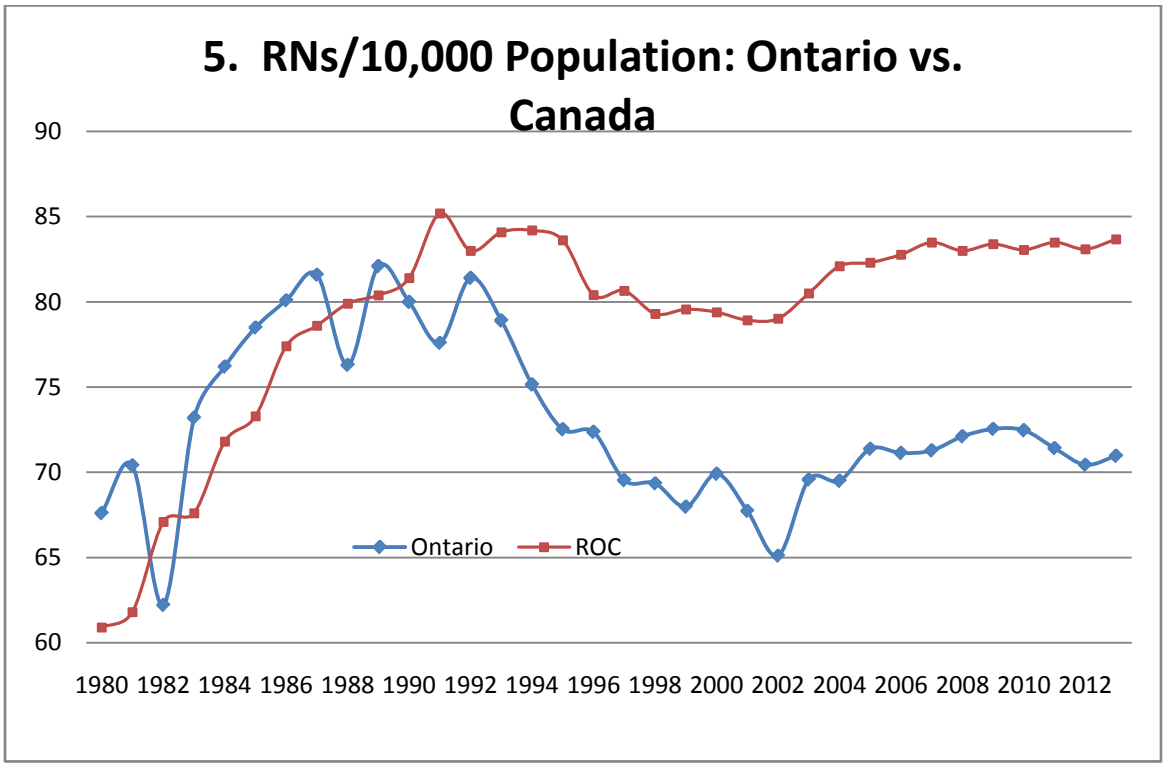
C. Nursing Care

The 1990s saw stagnation in the growth of the RN workforce, with falling employment in the latter 1990s. At the same time, the population of Ontario continued to grow rapidly and age. This meant the need for nursing services was growing at the same time as RNs were being laid off. The 1999 Nursing Task Force report outlined these problems along with their implications for the nursing profession and client outcomes. Since this time, concerted efforts by successive governments have reversed the downward trend in nursing employment. RN employment has been trending upwards, but has been down and up in the last few years.

RN-to-population ratios. A measure of access to RN services is the RN-to-population ratio. As the graph below shows, it fell steadily starting in the late 1980s, as stagnant RN employment was overtaken by population growth. When RNs were laid off in the late

1990s, the ratio deteriorated more quickly. The strong action noted above by government completely reversed that trend, until cutbacks starting in 2008 undid some of that progress.

Ontario's RN-to-population ratio ranks significantly below the rest of the country, with a gap that opened up in the early 1990s. As of 2013, Ontario had 71 RNs per 10,000 people (a decline from 72.2 in 2009), compared to 83.7 for the rest of the country. Only British Columbia has a lower RN-to-population ratio than Ontario. This inevitably has significant implications on workload and patient outcomes.[115 116 117 118 119 120 121] For Ontario to catch up with the rest of Canada, it would have to add an estimated 17,239 more RNs to its workforce, an increase of 17.9 per cent. In response to this growing concern, RNAO is recommending that the government seek to close the gap as quickly as reasonably possible, while continuing to advance policy that focuses on utilizing the most effective care provider for each patient and advancing continuity of care and caregiver.



Full-time Employment for RNs. While there has been a temporary setback on RN employment, the news is good on progress towards the consensus goal of 70 per cent full-time employment for nurses. That's good for patients and health outcomes.[122] Full-time employment supports the continuity of care and caregiver that are central to good nursing care. Evidence shows that higher proportions of full-time RN staff are associated with

lower mortality rates, continuity of care and continuity of caregiver, as well as improved patient outcomes.[123] [124] [125] Conversely, excessive use of part-time and casual employment for RNs is associated with decreased morale, an unstable workforce where nurses move to other jurisdictions to find full-time work,[126] disengagement among nurses, and a lack of continuity of care for patients.[127] [128] The share of full-time employment for RNs (general class and extended class, or NPs) rose from 59.3 per cent to 68.6 per cent between 2004 and 2012. Unfortunately, the ratio deteriorated to 66.8 percent in 2013 due to the loss of many full-time RN positions, with a modest recovery to 66.9 per cent in 2014. Otherwise, the trend has been very positive since 1998, when the share of full-time employment for RNs in the general class was below 50 per cent. Government must get back on track to hit its target of 70 per cent of all nurses working full time.

The other good news is that willingness to work full-time is no obstacle: If all Ontario RNs in the general class had their preferred work status, 72.0 per cent would be full-time, whereas just 66.6 per cent have it.

6. RN (GC)s: Preferred vs. Actual Work Status

	Actual Work Status						Preferred		Actual	
Preferred	**Full-time**		**Part-time**		**Casual**					
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Full-time	61,565	95.1	7,460	29.4	944	13.4	69,969	72.0	64,745	66.6
Part-time	2,711	4.2	17,331	68.2	1,008	14.3	21,050	21.7	25,405	26.1
Casual	469	0.7	614	2.4	5,115	72.4	6,198	6.4	7,067	7.3
Total	64,745	100	25,405	100	7,067	100	97,217	100.0	97,217	100.0

Scope of Practice. Ontario's nurses also want to work to full scope of practice, allowing the public to benefit from their competencies, knowledge and skills. Moreover, an evolving health system, coupled with the complex care requirements of Ontarians, requires an expanded role of the RN so more people can get timely access to quality care. Right now, RNs in Ontario are limited in what they can do compared to other jurisdictions in Canada and abroad. For example, RNs in the United Kingdom can prescribe laboratory tests and medications and have been doing so for 17 years. That's where British Columbia, Saskatchewan, Manitoba and Alberta are moving, and that is what Ontario needs. RNAO's groundbreaking report *Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario*[129] – a product of a provincial task force – identifies the need to maximize and expand the scope of practice utilization of Ontario's 4,000 RNs over two phases. Consistent application of

the full scope of practice of these nurses across all primary care models is the hallmark of the first phase, and serves as the initial step towards maximizing the scope of each interprofessional primary care team member.

The second phase proposed by the task force involves legislative and regulatory enhancements to expand RNs' scope of practice to include the ability to prescribe treatments and medication, order diagnostic testing and communicate a diagnosis. These activities are within the competencies, knowledge, and skills of the RN and would be authorized pending completion of a focused university pharmacology course. RN prescribing is a recognized international practice and has been subject to rigorous review within the literature.[130] The outcomes of this practice have been highly beneficial at the patient, organization and system level.[131] [132] For example, RN prescribing has the ability to enhance patient access and continuity of care and caregiver in every sector. It also improves efficiency and cost-effectiveness within the system, while contributing to greater job satisfaction and retention of mid and late-career nurses. RN prescribing will enable Ontarians to receive timely access to primary care services, including after-hours access. Premier Kathleen Wynne announced her government's commitment to RN role expansion at RNAO's Annual General Meeting in April 2013 and made RN prescribing a platform commitment as part of the 2014 election,[133] but little progress has been made. Nurses are calling on the government to speed up implementation as the public deserves better and the government must be accountable for its commitments.

Compensation Equity. Lastly, and no less important, in shifting our health system from an illness-based model of care to a preventative one is securing fair wages for RNs and NPs working in all sectors of health care. Current wage differentials act as a disincentive to working in the community sector as well as other sectors. For example, between 1998 and 2004, the community health sector lost 27 per cent of its nursing workforce, due in part to wage differentials.[134] Primary care NPs earn as much as $20K less annually than their counterparts within hospitals and CCACs.[135] As a consequence, one in five positions for NPs in the community is vacant.[136] This comes at a time when Ontarians still struggle to receive timely access to primary care services. The role and responsibilities of the primary care NP have greatly expanded in recent years, yet compensation has remained relatively flat. Wage differentials present significant recruitment and retention implications that can impact the sustainability of Ontario's efforts to improve health in the community.

Recommendations:

- Narrow the gap with the rest of the country of about 17,239 registered nurse (RN) positions as quickly as possible by creating more positions. Ensure that staffing mix decisions are based on patient need and stop RN replacement with other providers as a short-sighted and erroneous attempt to save money.

- Maximize and expand the role of RNs to deliver a broader range of care, including delivering on government promises regarding RN prescribing.
- Secure fair compensation and benefits for RNs and nurse practitioners (NPs) working in all sectors of health care by eliminating the discrepancy between community settings and hospitals/CCAC.
- To protect the safety of our seniors and to ensure their timely access to quality care, phase in new minimum staffing standards in long-term care, starting with a minimum of one nurse practitioner per 120 residents
- Ensure 70 per cent of all nurses work full-time so patients have continuity in their care and care provider.

D. Social Determinants of Health

Nurses know that beyond helping individuals, families, and communities to realize their potential, meaningful action on poverty is critical to sustaining lives, supporting health, and enabling human dignity. That is why Ontario's RNs, NPs and nursing students continue to implore our elected leaders to accelerate our collective efforts to address poverty with meaningful action lest more lives be lost.

On September 3, 2014, Deputy Premier Deb Matthews released the "government's renewed, refocused effort to reduce poverty" in *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019.*[137] An important lesson learned from the province's first Poverty Reduction Plan is that investments such as the Ontario Child Benefit are effective in reducing child poverty rates and preventing additional families from falling into poverty.[138] While a good start, the 1.57 million Ontarians[139] living in poverty need action, which will be enabled by a detailed implementation plan, complete with targets and timelines, accompanied by substantive public investment.

The recent deaths of four individuals who were homeless (one each in a bus shelter, van, make-shift shelter, and city-run facility)[140] during the space of an extremely cold period in Toronto are dramatic reminders of the link between access to safe, affordable housing and health.[141] The most recent Ontario Non-Profit Housing Association's statistics indicate that at the end of 2013, there were 165,069 households waiting for rent-geared-to-income housing.[142] Average provincial waiting times for rent-geared-to-income housing continue to increase from 3.2 years in 2012 to 3.89 years in 2013.[143] Peel region continues to have the longest overall waiting time of 8.39 years.[144] For every household occupied, two cancel their applications and three more apply.[145] With existing rental stock aging and almost no new purpose-built rental housing being created,[146] prospects are grim without leadership and action from government. The Ontario Non-Profit Housing Association has proposed a model that would invest $13 billion over ten years that would repair existing social housing stock and assist all households living in

Persistent Core Housing Need and homelessness.[147] An investment of $1.3 billion per year would equal one per cent of the current provincial budget.[148]

Public health units across the province continue to document the gap between the cost of nutritious food, shelter, and Ontario's dangerously low social assistance rates. In Toronto, for example, a one-person household receiving Ontario Works would have a deficit of $337.06 per month, as average monthly rent would require 113 per cent of income, and the amount required to purchase healthy food would take 31 per cent of income.[149] [150] A single person receiving Ontario Works must currently try to survive on $656 per month.[151] In addition to increasing social assistance rates so that recipients can live in health and dignity, it is critical that the Work-Related Benefit that provides $100 per month for ODSP recipients and family members who work be reinstated.[152]

Food bank use in Canada and Ontario in 2014 remained higher than when the recession started in 2008[153] and "within the food bank network, crisis has become the norm."[154] According to the Canadian Community Health Survey for 2012, the number of food insecure households in Ontario was 571,300.[155] This survey found that the proportion of households reliant on social assistance who were food insecure was 64.5 per cent in Ontario.[156] The proportion of food insecure households reliant on wages and salaries in Ontario was 58.3 per cent.[157]

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, important increases brought the minimum wage 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.[158] While the raise and indexing of the minimum wage were welcome, this amount still leaves a full-time worker 16 per cent below the poverty line.[159] RNAO continues to support the community call to set the minimum wage 10 per cent above the Low Income Measure. A $14 per hour wage with increased attentiveness to ensuring fair legislation and enforcement of labour standards would strengthen the possibilities of good jobs being a pathway out of poverty.

Recommendations:

- Update and strengthen Ontario's Poverty Reduction Strategy with a detailed implementation plan, complete with targets and timelines, accompanied by substantive public investment.
- Improve access to affordable housing and stimulate job creation in the process by investing one per cent of Ontario's budget to address the backlog of existing affordable housing units in need of repair and to create new affordable housing stock.
- Raise the dangerously low social assistance rates to reflect the actual cost of living by setting up an expert panel that includes people with lived experience.

- Increase the minimum wage to $14 per hour in 2015 and continue to index the minimum to inflation and ensure equal pay for equal work by expanding protections for temporary workers.

E. Environmental Determinants of Health

Nurses know environmental determinants of health play a huge role in each community's overall health and well-being, as evidenced in Ontario[160] [161] [162] [163] and around the world.[164] [165] [166] [167] It is much healthier and more cost effective to prevent pollution: the EPA estimated that the benefits of its Clean Air Act alone to outweigh costs by a factor of 30 to one.[168] Access to clean air, a safe environment, and reliable and sustainable forms of electricity help preserve our planet and secure the future for our children. That's why RNAO continues to focus on strengthening three key environmental determinants of health:

- supporting the use of green energy,
- reducing all exposure to toxics, including from the environment, in homes, in workplaces and in consumer products, and
- building a transportation system that reduces pollution and promotes healthier living.

Green energy. RNAO strongly supports an electricity system that is safe, reliable, equitable and environmentally sustainable; one that supports community sustaining green jobs, and one that does not pollute the air or leave a legacy of toxic waste and bankrupt Ontario residents and businesses.[169] We must use best available evidence on the health effects of energy sources as a guide. RNAO's position statement on healthy energy solutions summarizes available information.[170] A recent study by Health Canada verified previous findings about wind turbines, which when properly sited are a part of the energy solution for Ontario.[171] Healthy public policy demands aggressive conservation and energy efficiency targets as well as increasing reliance on cleaner renewable energy. Ontario has made a huge step forward in closing all coal-for-energy plants. Commitments to progress on climate change are very promising, and RNAO will work with other stakeholders and government to maximize progress in this regard.

RNAO's vision of a clean, healthy energy future is balanced and comprehensive. It includes:

- Reducing consumption through conservation and energy efficiency;
- Solid targets and implementation plans for increasing reliance on renewable energy such as community controlled, appropriately located and scaled water, wind, solar and bio-energy; subject to comprehensive environmental assessments

- Phasing in a fee on carbon, which would act as a tool to build fiscal capacity, as well as a signal to users to economize on carbon use.
- Cancelling plans for construction of new risky and expensive nuclear power plants.
- Negotiating long-term contracts with Quebec for renewable hydro power, which is in surplus in that province;
- Strategic use of natural gas to meet peak needs until renewable power is online while ensuring any new natural gas-supplied electricity is not from shale gas extraction ("fracking") and uses highly efficient combined heat and power (CHP).

Toxics. New toxics are being discovered and released on a regular basis, and the public is often unaware of their presence or effects. Concern has been growing about a worrisome class of toxics called endocrine disruptors. These particular toxics can cause serious health effects, even in very low concentrations and particularly in young children.[172] [173] [174] The range of effects are not fully understood, but based on what is known, RNAO calls for extreme caution and tougher protection from the government on toxics by:

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

At this point, Ontario's *Toxics Reduction Act* (TRA) lacks targets, mandatory substitution and an independent academic institute. We urge the government to fix these gaps, which greatly weaken the effectiveness of the Act. We also urge the government to bring into force sections of the Act on: compliance and enforcement; product labelling; toxics regulation; and substances of concern (Section 11, which concerns substances not yet covered under the Act. The Ministry of the Environment has a list of at least 155 such substances. [175]). We further urge the government to use whatever other opportunities to present themselves to reduce Ontarians' exposure to toxics, such as including toxics reduction targets in pending legislation like the Great Lakes Protection Act.

Neonicotinoid Pesticides. One class of toxics has received much attention of late. Neonicotinoids (Neonics) are insecticides. They work by attacking nerve receptors in insects. They are toxic to animals, but more toxic to insects than to mammals. Lethal and sub-lethal exposures are both problematic. We know that sub-lethal exposures can compromise the health of pollinators, which makes them susceptible to diseases and parasites. The removal of many pollinators from the environment affects the success of

plants and removes a substantial source of sustenance from creatures further up the food chain. There is strong consensus that neonics can harm pollinators and other invertebrates and vertebrates. [176] [177]

RNAO applauds the government's proposal to restrict the use of neonicotinoid pesticides in agriculture[178] as an important first step towards a complete ban. It is important that the regulation be written in a way that ensures its aspirational goal of reducing the over-winter mortality of honey bees to 15 per cent by 2020. Given the threat to pollinators and diversity, and given the concern about adding more neurotoxics to the environmental toxic load, RNAO is calling for a ban on neonics.

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.[179] For many in urban areas, there are limited alternatives to automobile use: public transit may be inadequate and opportunities for active transportation like biking and walking may be limited and unsafe. Approximately $50 billion over 25 years (or about $2 billion per year) is needed for transit infrastructure for the GTHA alone (*The Big Move*, the regional transportation plan for the GTHA developed by Metrolinx, an Ontario crown agency that manages GTHA transportation).[180] The Ann Golden panel has pointed the way with its transit infrastructure recommendations, which include $300 million funding for a Kick-Start Program to deliver immediate visible improvements in service.[181] The medical officers of health for the GTHA have made an important contribution with their report on designing healthier transportation systems and healthier cities.[182] The report concluded that better community design and implementing *The Big Move* could avoid 338 premature deaths per year significantly reduce the staggering cost of congestion. It recommended that Ontario should:

- provide long-term funding for *The Big Move* and work with Metrolinx and the municipalities to implement *The Big Move* to optimize access to transportation options
- change its policies to better support active transportation and public transit

The government has made an important first step with its commitment to fund municipal transit infrastructure to the tune of up to $15 billion over 10 years (about $1.5 billion per year);[183] more funding for infrastructure, services and active transportation is necessary, as *The Big Move* called for about $2 billion per year over 25 years. 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; and to support expeditious implementation of those projects

Recommendations:

- Set ambitious toxics reduction targets. Ensure people have the right-to-know about the existence of toxics in the environment, in their homes, in their workplaces, and in consumer products.
- Regulate the use of neonicotinoids in agriculture to achieve a 15 per cent over-winter honey bee mortality rate by 2020, as a first step towards a complete ban.
- Minimize the energy footprint by: focusing first on conservation and energy efficiency, and increasing reliance on renewable energy.
- Take all necessary steps to:
    - ensure sufficient dedicated revenue sources to pay for a substantial expansion of transit and active transportation. and
    - support cost-effective and expeditious delivery of those expansions, implemented by transparent governance and informed expert opinion.

References

[1] Muntaner, C., Ng, E., and Chung, H. (2012). *Better Health: An analysis of public policy and programming focusing on the determinants of health and health outcomes that are effective in achieving the healthiest populations.* Canadian Health Services Research Foundation. Retrieved January 22, 2015 at http://archives.enap.ca/bibliotheques/2013/06/030429303.pdf.

[2] Public Health Agency of Canada. (2011). *What Determines Health?* Retrieved January 22, 2015 at http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants.

[3] World Health Organization. (2015). *Health Impact Assessment: The determinants of health.* Retrieved January 22, 2015 at http://www.who.int/hia/evidence/doh/en/.

[4] World Health Organization. (2015). *Employment Conditions.* Retrieved January 22, 2015 at http://www.who.int/social_determinants/themes/employmentconditions/en/.

[5] Mikkonen, J., and Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts.* Retrieved January 22, 2015 at http://www.thecanadianfacts.org/the_canadian_facts.pdf.

[6] Canadian Public Health Association. (n.d.). *What are the Social Determinants of Health?* Retrieved January 22, 2015 at http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/sdh.aspx.

[7] Access Alliance. (nd). *Bad Jobs are Making Us Sick.* Retrieved January 22, 2015 at http://accessalliance.ca/sites/accessalliance/files/Bad%20jobs%20are%20making%20us%20sick_FINAL.pdf.

[8] Block, S. (2010). *Work and Health: Exploring the impact of employment on health disparities.* Wellesley Institute. Retrieved January 22, 2015 at http://www.wellesleyinstitute.com/wp-content/uploads/2010/12/Work_and_Health.pdf.

[9] Statistics Canada. (2015). *Table 282-0087: Labour force survey estimates (LFS), by sex and age group, seasonally adjusted and unadjusted* monthly. , January 8. Retrieved January 13, 2015 at http://www5.statcan.gc.ca/cansim/a47.

[10] Ibid.

[11] Ibid.

[12] RNAO calculation, based on above Statistics Canada data table.

[13] Statistics Canada, op. cit.

[14] E.g., see RNAO. (2013). *Ontario Pre-budget 2013: Finding the Right Balance.* Pp 4-5. Retrieved January 22, 2015 at http://rnao.ca/sites/rnao-ca/files/2013_prebudget_submission_--_March_22_2013.pdf.

[15] Ontario Ministry of Finance. (2014). *Ontario Economic Outlook and Fiscal Review.* P. 125. Ratio calculated by RNAO. Retrieved January 14, 2015 at http://www.fin.gov.on.ca/en/budget/fallstatement/2014/paper_all.pdf.

[16] RBC Economics. (2014). *Canadian Federal and Provincial Fiscal Tables.* Retrieved January 14, 2015 at http://www.rbc.com/economics/economic-reports/pdf/provincial-forecasts/prov_fiscal.pdf.

[17] Ontario Ministry of Finance. (2014). *Ontario Economic Outlook and Fiscal Review.* P. 125. Ratio calculated by RNAO. Retrieved January 14, 2015 at http://www.fin.gov.on.ca/en/budget/fallstatement/2014/paper_all.pdf.

[18] TD Economics. (2014). *Provincial Economic Forecast.* P. 7. Retrieved January 14 at http://www.td.com/document/PDF/economics/qef/ProvincialEconomicForecast_Dec2014.pdf.

[19] Scotiabank. (2015). *Global Forecast Update.* January 8. P. 6. Retrieved January 14, 2015 at http://www.gbm.scotiabank.com/English/bns_econ/forecast.pdf.

[20] RBC Economics. (2014). *Provincial Outlook/December 2014: Ontario.* Retrieved January 14, 2015 at http://www.rbc.com/economics/economic-reports/pdf/provincial-forecasts/ont.pdf.

[21] Bank of Canada. (2015). *Daily Noon Exchange Rates: 10-Daily Noon Exchange Rates: 10-Year Lookup.* Retrieved January 22, 2015 at http://www.bankofcanada.ca/rates/exchange/10-year-lookup/.

[22] Estimates for the period 1981 to 2001 range from $0.80 US to $0.85: Lafrance, R. and Schembri, L. (2002) Purchasing-Power Parity: Definition, Measurement, and Interpretation. P. 27. *Bank of Canada Review*. Autumn. Retrieved January 15, 2015 at http://www.bankofcanada.ca/wp-content/uploads/2010/06/lafrance_e.pdf.

[23] Estimates for 2009 to 2013 range from $0.80 to $0.83 US: OECD. (n.d.). *Purchasing Power Parities for GDP and related indicators.* Retrieved January 15, 2015 at http://stats.oecd.org/Index.aspx?DataSetCode=PPPGDP

[24] Ibid.

[25] Tiessen, K. (2014). *Seismic Shift: Eontario's Changing Labour Market*. Canadian Centre for Policy Alternatives Ontario Office. P. 6, Retrieved January 15, 2015 at

https://www.policyalternatives.ca/sites/default/files/uploads/publications/Ontario%20Office/2014/03/Seismic%20ShiftFINAL.pdf.

[26] CBC News. (2015). *Bank of Canada shocks markets with cut in key interest rate.* January 21, Retrieved January 21 at http://www.cbc.ca/news/business/bank-of-canada-shocks-markets-with-cut-in-key-interest-rate-1.2921370.

[27] RBC Economics. (2014). *Canadian Federal and Provincial Fiscal Tables.* Retrieved January 14, 2015 at http://www.rbc.com/economics/economic-reports/pdf/provincial-forecasts/prov_fiscal.pdf.

[28] Ontario Ministry of Finance. (2014). *Ontario Economic Outlook and Fiscal Review.* P. 125. Ratio calculated by RNAO. Retrieved January 14, 2015 at http://www.fin.gov.on.ca/en/budget/fallstatement/2014/paper_all.pdf.

[29] Ontario Ministry of Finance. (2013). *Creating Jobs and Growing the Economy 2013: Ontario Economic Outlook and Fiscal Review.* P. 125. Ratio calculated by RNAO. Retrieved January 14, 2015 at http://www.fin.gov.on.ca/en/budget/fallstatement/2013/paper_all.pdf.

[30] See for example the IMF's internal evaluation of its own response to the financial and economic crisis in 2010-11, when its endorsement of "consolidation" was deemed "premature". Independent Evaluation Office of the International Monetary Fund. (2014). *IMF Respone to the Financial and Economic Crisis: An IEO Assessment.* October 8. P. v. Retrieved January 22, 2015 at http://www.ieo-imf.org/ieo/files/completedevaluations/Full%20Text%20of%20the%20Main%20Report.pdf.

[31] See for example Hennessy, T. and Stanford, J. (2013). *More Harm Than Good: Austerity's Impact in Ontario.* Canadian Centre for Policy Alternatives: Ontario. Retrieved January 22, 2015 at https://www.policyalternatives.ca/sites/default/files/uploads/publications/Ontario%20Office/2013/03/More%20Harm%20Than%20Good_0.pdf.

[32] RBC. (2014). *Canadian Federal and Provincial Fiscal Tables.* December 18. Retrieved January 19, 2015 at http://www.rbc.com/economics/economic-reports/pdf/provincial-forecasts/prov_fiscal.pdf.

[33] Ibid. Sousa, C, (2013). *Creating Jobs and Growing the Economy 2013: Ontario Economic Outlook and Fiscal Review.* Table 3.9, p. 124-5. Retrieved January 19, 2015 at http://www.fin.gov.on.ca/en/budget/fallstatement/2013/paper_all.pdf.

[34] Ontario Ministry of Finance. (2014). Ibid. Ratios calculated by RNAO.

[35] Task Force on Competitiveness, Productivity and Economic Progress. (2013). *Course Correction: Charting a new road map for Ontario.* P. 50. Retrieved January 19, 2015 at http://www.competeprosper.ca/uploads/2013_AR12_Final.pdf.

[36] Commission on the Reform of Ontario's Public Services. (2012). *Public Services for Ontarians: A Path to Sustainability and Excellence.* P. 426. Retrieved January 22 at http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf.

[37] Government of Ontario. (2014). *Gasoline tax rates.*Retrieved January 22, 2015 at http://www.ontario.ca/taxes-and-benefits/gasoline-tax-rates.

[38] Ontario Ministry of Energy. (2015). *Fuel Price Data: Regular Unleaded Gasoline 1992*. Retrieved January 22, 2015 at http://www.energy.gov.on.ca/en/fuel-prices/fuel-price-data/?fuel=REG&yr=1992.

[39] Ontario Ministry of Energy. (2015). *Fuel Price Data: Regular Unleaded Gasoline 2014*. Retrieved January 22, 2015 at http://www.energy.gov.on.ca/en/fuel-prices/fuel-price-data/?fuel=REG&yr=2014.

[40] Ibid, p. 47.

[41] Benzie, R. (2014). TD Bankk chhief to 'optimize' LCBO, Hydro One and Ontario Power. *Toronto Star*. April 11. Retrieved January 22, 2015 at http://www.thestar.com/news/queenspark/2014/04/11/ontario_ropes_in_td_bank_chief_to_optimize_lcbo_hydro_one_and_ontario_power.html.

[42] Health Canada. (1997). *Canada Health Action: Building on the Legacy - Volume I - The Final Report*. Retrieved January 19, 2015 at http://www.hc-sc.gc.ca/hcs-sss/pubs/renewal-renouv/1997-nfoh-fnss-v1/index-eng.php.

[43] Romanow, R. (2002). Op. cit. p. 252, Recommendation 34.

[44] Ibid. p. 252, Recommendation 36.

[45] Debortoli, K. (2004). *Kirby, Romanow Proposals Revealed. World At Work: Canadian News.* Retrieved January 19, 2015 at https://www.worldatwork.org/waw/canadanews/html/canv11n1-1.html.

[46] Registered Nurses' Association of Ontario. (2001). *Ontario Nurses Speak Out for Medicare, November 2001*. Retrieved January 19, 2015 at http://healthcoalition.ca/wp-content/uploads/2010/05/submission-rnao.pdf.

[47] Canada Online. (2014). *Provincial Prescription Drugs Insurance Programs.* Retrieved January 19, 2015 at http://canadaonline.about.com/od/prescriptiondrugsprograms/.

[48] Morgan, S.G., Daw, J.R., and Law, M.R. (2013). *Rethinking Pharmacare in Canada.* C.D. Howe Institute. Retrieved January 19, 2015 at http://www.cdhowe.org/pdf/Commentary_384.pdf.
[49] See also Canadian Association of Retired Persons. (2012). *The Case for a National Drug Strategy*. Retrieved January 19, 2015 at http://www.carp.ca/2012/09/20/the-case-for-a-national-drug-strategy/.
[50] Morgan, S.G., Daw, J.R., and Law, M.R. (2014). *are Income-Based Public Drug Benefit Programs Fit for an Aging Population?* IRPP. No. 50, Dec. Retrieved January 19, 2015 at http://irpp.org/wp-content/uploads/2014/12/study-no50.pdf.
[51] Gagnon, M. and Hébert, G. (2010). *The Economic Case for Universal Pharmacare*. Canadian Centre for Policy Alternatives and Institute de recherché et d'informations socio-économiques. P. 10. Retrieved January 19, 2015 at https://s3.amazonaws.com/policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2010/09/Universal_Pharmacare.pdf.
[52] Registered Nurses' Association of Ontario. (2010). RNAO says economic analysis shows Canada can't afford not to have pharmacare. Retrieved January 19, 2015 at http://rnao.ca/news/media-releases/RNAO-says-economic-analysis-shows-Canada-cant-afford-not-to-have-pharmacare.
[53] Canadian Federation of Nurses Unions. (2011). *A National Pharmacare Strategy.* November. Retrieved January 19, 2015 at http://nursesunions.ca/sites/default/files/2011.backgrounder.pharmacare.e.pdf.
[54] White, J. (n.d.). *Speaking out for public pharmacare.* Retrieved January 19, 2015 at http://nursesunions.ca/sites/default/files/speaking_out_for_PHARMACARE-en.pdf.
[55] Canadian Medical Association. (2013). *Healthier Generations for a Prosperous Economy: Canadian Medical Association 2013-2014 pre-budget consultation submission to the Standing Committee on Finance*. November 6. **"**Recommendation # 7: The CMA recommends that the federal government, in consultation with the provincial and territorial governments, health care providers, the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies " Retrieved January 19, 2015 at https://www.cma.ca/Assets/assets-library/document/en/advocacy/Pre-Budget-Submission-2013-2014_en.pdf.
[56] Standing Senate Committee on Social Affairs, Science and Technology. (2012). *Time for Transformative Change: A Review of the 2004 Health Accord.* Retrieved January 19, 2015 at http://www.parl.gc.ca/content/sen/committee/411/soci/rep/rep07mar12-e.pdf. "Recommendation 28: That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug-coverage program and a national formulary."
[57] Canadian Health Coalition. (n.d.). *The Case for Pharmacare.* Retrieved January 19, 2015 at http://pharmacarenow.ca/wp-content/uploads/2010/01/PharmacareFactsheet1.pdf.
[58] Canadian Association of Retired Persons. (2013). *Canada Need Pharmacare.* Retrieved January 19, 2015 at http://www.carp.ca/2013/06/28/canada-needs-pharmacare/.
[59] Canadian Association of Retired Persons. (2010). *CARP Pharmacare Report: October 7 2010.* Retrieved January 19, 2015 at http://www.carp.ca/2010/10/07/carp-pharmacare-report/ .
[60] Toronto Star. (2014). *Canada needs a national pharmacare plan: Editorial.* Nov. 28. Retrieved January 19, 2015 at http://www.thestar.com/opinion/editorials/2014/11/28/canada_needs_a_national_pharmacare_plan_editorial.html.
[61] http://www.theglobeandmail.com/globe-debate/editorials/should-canadian-medicare-include-drug-coverage/article21979136/comments/
[62] Canadian Doctors for Medicare. (2013). *RX: National Pharmacare*. Retrieved January 19, 2015 at http://www.canadiandoctorsformedicare.ca/images/2013-07-21_CoF_Pharma_.pdf.
[63] EKOS. (2013). *Canadian Views on Prescription Drug Coverage.* May 22. Retrieved January 19, 2015 at http://www.ekospolitics.com/wp-content/uploads/press_release_may_22_2013.pdf.
[64] Hoskins, E. (2014). Eric Hoskins: The time for national pharmacare has come. Dec. 15. *Toronto Star.* Retrieved January 21, 2015 at http://www.thestar.com/opinion/commentary/2014/12/15/eric_hoskins_the_time_for_national_pharmacare_has_come.html.
[65] Ontario Minister of Health Deb Matthews indicated the government would make prescription drug coverage a priority if it had sufficient money. See: Morgan, S. (2013). *Why Ontario should pioneer the*

expansion of prescription drug coverage in Canada. Retrieved January 19, 2015 at http://umanitoba.ca/outreach/evidencenetwork/archives/12588.

[66] Ontario Ministry of Health and Long-Term Care. (2012). *Ontario Public Drug Programs.* Retrieved January 19, 2015 at http://www.health.gov.on.ca/en/public/programs/drugs/default.aspx.

[67] Advocating for a Poverty Free Ontario. (2013) *Pharmacare: What is Publicly Funded in Ontario.* August 13. Retrieved January 19, 2015 at http://povertyfreeontario.blogspot.ca/2013/08/pharmacare-what-is-publicly-funded-in.html.

[68] Seggewiss, K. (2009). Variations in home care programs across Canada demonstrate need for national standards and pan-Canadian program. *Canadian Medical Association Journal*. Vol. 180. No. 12, E90-E92. Retrieved January 19, 2015 at http://www.cmaj.ca/content/180/12/E90.full.pdf+html.

[69] College of Family Physicians of Canada. (2013). *The Role of the Federal Government in Health Care: Report Card 2013.* Retrieved January 19, 2015 at http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/CFPC_FederalReportCard2013_EN.pdf.

[70] Canadian Healthcare Association. (2009). *Home Care in Canada: From the Margins to the mainstream.* Retrieved January 19, 2015 at http://www.cha.ca/wp-content/uploads/2012/11/Home_Care_in_Canada_From_the_Margins_to_the_Mainstream_web.pdf.

[71] See for example Health Quality Ontario. (2013). *Public Reporting*. Retrieved January 19, 2015 at http://www.hqontario.ca/public-reporting.

[72] See for example Auditor General of Ontario. (2013). *Reports by Topic: Health.* Retrieved January 19, 2015 at http://www.auditor.on.ca/en/reports_health_en.htm.

[73] United States Census Bureau. (2014). *Income, Poverty and Health Insurance Coverage in the United States: 2013*. Retrieved January 19, 2015 at http://www.census.gov/newsroom/press-releases/2014/cb14-169.html.

[74] OECD. (2013). *OECD Health Data 2013 – Frequently Requested Data.* Retrieved December 16, 2013 at http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm. In 2011, US health expenditures consumed 17.7 percent of GDP; the next highest was 11.9 percent for the Netherlands, while the OECD average was 9.3 percent. In spite of the elevated costs, American health outcomes lag the OECD: US infant mortality is 6.1 per thousand vs. 4.1 average for the OECD and 0.9 for Iceland. Life expectancy is lower in the US at 78.7 years vs. 80.1 years average for the OECD. Correspondingly, the US performs poorly on potential years of life lost per 100,000: 5,814 vs. 4,633 OECD average for males and 3,447 vs. 2,415 OECD average for females).

[75] Grinspun, D. (2013). Ontario's health care system should serve need, not greed. *Toronto Star.* April 1. Retrieved January 19, 2015 at http://www.thestar.com/opinion/commentary/2013/04/01/ontarios_health_care_system_should_serve_need_not_gree.html.

[76] Open letter: strengthen Ontario's health system by immediately banning medical tourism and rejecting for-profit plasma collection (2014, July 3). *Registered Nurses' Association of Ontario.* Retrieved from: http://rnao.ca/sites/rnao-ca/files/RNAO_Open_Letter_to_Premier_-_Reject_For-Profit_Health_Care.pdf

[77] Medical tourism: the beginning of the end of Medicare (May/June 2014). *Registered Nurse Journal.* Retrieved from: http://rnao.ca/sites/rnao-ca/files/CEODispatchMayJune2014.pdf

[78] Himmelstein, D., & Woolhandler, S. (2008). Privatization in a publicly funded health care system: the U.S. experience. *International Journal of Health Services*. 38 (3), (2008), 409.

[79] Himmelstein & Woolhandler. (2008), 410-412.

[80] Himmelstein & Woolhandler. (2008), 415.

[81] Himmelstein, D., Woolhandler, S., Hellander, I. & Wolfe, S. (1999). Quality of care in investor-owned vs. not-for-profit HMOs. *Journal of the American Medical Association, 282*(2), 159-163.

[82] Garg, P. P., Frick, K., Diener-West, M., & Powe, N.. (1999). Effect of the ownership of dialysis facilities on patients' survival and referral for transplantation. *New England Journal of Medicine, 341*(2), 1653-60.

[83] Rosenau, P., & Linder, S. (2003). A comparison of the performance of for-profit and nonprofit health provider performance in the United States. *Psychiatric Services, (54)*2,183-187.

[84] Rosenau, P., & Linder, S. (2003). Two decades of research comparing for-profit health provider performance in the United States. *Social Science Quarterly, 84*(2), 219-241.

[85] Schneider, E., Zaslavsky, A., & Epstein, A. (2005). Quality of care in for-profit and not-for-profit health plans enrolling Medicare beneficiaries. *American Journal of Medicine, 118,* 1392-1400.

[86] Devereaux, P., Choi, P., Lacchetti, C., Weaver, B., Schünemann, H., Haines, T et al. (2002). A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal, 166*(11), 1399-1406.

[87] Devereaux, P. Schünemann, H , Ravindran, N., Bhandari, M., Garg, A., Choi, P,Guyatt, G. (2002). Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: A systematic review and meta-analysis. *Journal of the American Medical Association, 288*(19), 2449-2457.
[88] Hillmer, M., Wodchis, W., Gill, S., Anderson, G., & Rochon, P. (2005). Nursing home profit status and quality of care: Is there any evidence of an association? *Medical Care Research and Review, 62* (2), 139-166.
[89] Comondore, V., Devereaux, P., Zhou, Q., Stone, S., Busse, J., Ravindran, N….Guyatt, G. (2009). Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. *British Medical Journal*. 339 (42).
[90] Devereaux, P., Heels-Andell, D., Lacchetti, C., Haines, T., Burns, K. , Cook, D., Guyatt, G. (2004). Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *Canadian Medical Association Journal, 170* (12), 1817-24.
[91] Infrastructure Ontario. (2013). FAQs. Retrieved January 15, 2014 at http://www.infrastructureontario.ca/Templates/Projects.aspx?id=2147485351&langtype=1033#afp.
[92] Pollock, A., Shaoul, J., & Vickers, N. (2002). Private finance and "value for money" in NHS hospitals: a policy in search of a rationale? *British Medical Journal*, 324(7347), 1205-1209.
[93] Pollock, A., Player, S., & Godden, S. (2001). How private finance is moving primary care into corporate ownership. *British Medical Journal*, 322(7292), 960-963.
[94] Gaffney, D., Pollock, A., Price, D., & Shaoul, J. (1999). The private finance initiative. NHS capital expenditure and the private finance initiative – expansion or contraction? *British Medical Journal*, 319**(**7201), 48-51.
[95] Auerbach, L., Donner, A., Peters, D., Townson, M., & Yalnizyan, A. (2003). *Funding Hospital Infrastructure: Why P3s Don't Work, and What Will.* Ottawa: Canadian Centre for Policy Alternatives. Retrieved January 22, 2015 at http://www.policyalternatives.ca/sites/default/files/uploads/publications/National_Office_Pubs/p3_hospitals.pdf.
[96] Office of the Auditor General. (1998). *Report of the Auditor General--1998*. Fredericton, New Brunswick: Author. Retrieved January 22, 2015 at http://www.gnb.ca/oag-bvg/1998/1998-e.asp
[97] Huebl, S. (2007, September 8). Hospital Tab Battle Continues. *Sarnia Observer*, A1.
[98]Ontario Health Coalition. (2008). *When Public Relations Trump Public Accountability: The Evolution of Cost Overruns, Service Cuts and Cover Up in the Brampton Hospital P3*. Toronto: Author. Retrieved January 15, 2014 at www.web.net/ohc/jan08report%20final.pdf
[99] Walkom, T. (2008, January 10). Brampton case shows P3s work – just not for the public. *Toronto Star*. A13. Retrieved January 22, 2015 at http://www.thestar.com/opinion/columnists/2008/01/10/brampton_case_shows_p3s_work_ndash_just_not_for_the_public.html.
[100] Block, S. (2008). *From P3s to AFPs: New Branding But Same Bad Deal*. Ottawa and Toronto: Canadian Centre for Policy Alternatives and the Registered Nurses' Association of Ontario. Retrieved January 15, 2014 at http://www.policyalternatives.ca/sites/default/files/uploads/publications/Ontario_Office_Pubs/2008/From_P3s_to_AFPs.pdf
[101] Block, S. (2008.). *Frm P3s to AFTs: New Branding but Same Bad Deal.* Canadian Centre for Policy Alternatives. Retrieved January 21, 2015 at http://www.policyalternatives.ca/sites/default/files/uploads/publications/Ontario_Office_Pubs/2008/From_P3s_to_AFPs.pdf.
[102] Auditor General of Ontario. (2014). *Infrastructure Ontario -- Alternative Financing and Procurement.*Pp. 197-200. Retrieved January 21 at http://www.auditor.on.ca/en/reports_en/en14/305en14.pdf.
[103] Mehra, N. and McBane, M. (2013). Ottawa edges away from public medicare. July 8. *Toronto Star.* Retrieved January 22, 2015 at http://www.thestar.com/opinion/commentary/2013/07/08/ottawa_edges_away_from_public_medicare.html.
[104] RNAO. (2013). *Nurses want Hand-on Medicare and Hands-off Health Council of Canada.* Retrieved January 15, 2015 at http://rnao.ca/policy/action-alerts/nurses-want-hands-medicare-and-hands-health-council-canada.
[105] Romanow, R. (2002). *Building on Values: The Future of Health Care in Canada.* P. 247. Commission on the Future of Health Care in Canada. Retrieved January 22, 2015 at http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

[106] Fekete, J. (2012). Federal health cuts would drain $36B from provincial coffers, premiers warn. *Vancouver Sun*. July 28. Retrieved January 22, 2015 at http://www2.canada.com/vancouversun/news/archives/story.html?id=bae696e6-6526-4a88-9b73-3a811f23ab73.

[107] Bailey, I. and Curry, B. (2012). Flaherty's 10-year health-care plan divides provinces. *Globe and Mail*. Retrieved January 22, 2015 at http://www.theglobeandmail.com/news/politics/flahertys-10-year-health-care-plan-divides-provinces/article4181493/

[108] Levert, S. (2013). *Sustainability of the Canadian Health Care System and Impact of the 2014 Revision to the Canada Health Transfer*. Canadian Institute of Actuaries and Society of Actuaries. September. P. 2. Retrieved January 22, 2015 at http://www.cia-ica.ca/docs/default-source/2013/213075e.pdf.

[109] Canadian Doctors for Medicare. (2012). *Physicians Call on PM to Enforce the Health Act.* Nov. 26. Retrieved December 3, 2013 at http://archive-ca.com/page/757249/2012-11-26/http://www.canadiandoctorsformedicare.ca/physicians-call-on-pm-to-enforce-the-health-act.html.

[110] Kennedy, M. (2012*).* Stephen Harper's hand's off stance could signal end to national health-care system: Romanow. *National Post*. Retrieved January 22, 2015 at http://news.nationalpost.com/2012/01/08/stephen-harpers-hands-off-stance-could-signal-end-to-national-health-care-system-romanow/

[7] Woolhandler, S & Himmelstein, D. (2007). Competition in a publicly funded healthcare system. In *British Medical Journal*, December, Vol. 335. Retrieved January 22, 2015 at www.pnhp.org/PDF_files/BMJ_Woolhandler_Market_Failure.pdf

[111] Ministry of Health and Long-Term Care (2014). *Health care experts:* http://www.health.gov.on.ca/en/news/bulletin/2014/bg_20140424_1.aspx.

[112] Registered Nurses' Association of Ontario. (2012). *Enhancing Community Care for Ontarians*. Retrieved January 22, 2015 at http://rnao.ca/policy/reports/rnaos-ecco-report-enhancing-community-care-ontarians-%E2%80%93-three-year-plan.

[113] Ministry of Health and Long-Term Care. (n.d.). *Nurse Practitioner-Led Clinics*. Retrieved January 22, 2015 at: http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html

[114] Nurse Practitioners' Association of Ontario. (n.d.). *Nurse Practitioner-Led Clinics*. Retrieved January 15, 2014 at: http://npao.org/nurse-practitioners/clinics/

[115] Aiken, L., Clarke, S. P., Sloane, D. M., Lake, E. T., & Cheney, T. (2008). Effects of hospital care environment on patient mortality and nurse outcomes. *Journal of Nursing Administration, 38*(5), 223-229.

[116] Aiken, L., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA: Journal of the American Medical Association., 288*(16), 1987-1993.

[117] Estabrooks, C. A., Midodzi, W. K., Cummings, G. G., Ricker, K. L., & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research, 54*(2), 74-84.

[118] Hye Park, S., Blegen, M.A., Spetz, J., Chapman, S.A., & De Groot, H. (2012). Patient turnover and the relationship between nursing staffing and patient outcomes. *Research in Nursing & Health, 35*(3), 277-288.

[119] Tourangeau, A., Doran, D. M., McGillis Hall, L., O'Brien Pallas, L., Pringle, D., Tu, J., et al. (2007). Impact of hospital nursing care on 30-day mortality for acute medical patients. Journal of Advanced Nursing, *57*(1), 32-44.

[120] Twigg, DG., Duffield, C., Bremner, A., Rapley, P., Finn, J. (2012). Impact of skill mix variations on patient outcomes following implementation of nursing hours per patient day staffing: a retrospective study. *Journal of Advanced Nursing, 68*(12), 2710-2718.

[121] Tourangeau, A. (2006). *Nurse staffing and work environments relationships with hospital-level outcomes*. Ottawa, Ont.: Canadian Health Services Research Foundation.

[122] Registered Nurses' Association of Ontario. (2005). *The 70 Per Cent Solution: A Progress Report on Increasing Full-Time Employment for Ontario RNs.* Toronto: Author. Retrieved January 22, 2015 at: http://rnao.ca/policy/reports/70-percent-solution.

[123] Estabrooks, C., Midodzi, W., Cummings, G., Ricker, K., & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. Nursing Research, 54(2), 74-78.

[124] O'Brien-Pallas, L., Thomson, D., Hall, M., Pink, G., Kerr, M., Wang, S., Li, X. & Myer, R. (2004). *Evidence-based Standards for Measuring Nurse Staffing and Performance*. Ottawa: Canadian Health Services Research Foundation. Retrieved January 22, 2015 at: http://fhs.mcmaster.ca/nru/documents/_VTI_CNF/Evidence%20Based%20Standards%20for%20Measuring%20Nurse%20Staffing%20and%20Performance.pdf.

[125] Meyer, R., Wang, S., Li, X. & Thomson, D. (2009). Evaluation of a Patient Care Delivery Model: Patient Outcomes in Acute Cardiac Care. *Journal of Nursing Scholarship, 41*(4), 399-410, 408.

[126] McGillis Hall, L., Pink G., Jones C., Leatt P., Gates M. & Peterson, J. (2009) Is the grass any greener? Canada to United States of America nurse migration. *International Nursing Review*, 56(2), 198–205.
[127] Grinspun, D. (2003). Part-time and casual nursing work: The perils of health-care restructuring. *International Journal of Sociology and Social Policy, 23* (8/9), 54-80.
[128] Meyer, R., Wang, S., Li, X. & Thomson, D. (2009). Evaluation of a Patient Care Delivery Model: Patient Outcomes in Acute Cardiac Care. *Journal of Nursing Scholarship, 41*(4), 399-410.
[129] Registered Nurses' Association of Ontario. (2012). *Primary solutions for primary care*. Retrieved January 22, 2015 at: http://rnao.ca/policy/reports/primary-solutions-primary-care.
[130] International Council of Nurses. (2009). *Implementing Nurse Prescribing*. Retrieved March 20, 2012 at: http://www.icn.ch/vmchk/English/Implementing-Nurse-Prescribing.html.
[131] Ibid.
[132] Registered Nurses' Association of Ontario. (2012). *Primary solutions for primary care*. Retrieved January 15, 2014 at: http://rnao.ca/policy/reports/primary-solutions-primary-care.
[133] Liberal Party of Ontario (2014). More nursing powers, better care. Retrieved from: http://www.ontarioliberal.ca/NewsBlog/NewsDetails.aspx?id=More+Nursing+Powers%2C+Better+Care
[134] Nursing Health Services Research Unit. (2006).*Home Health Nurses in Ontario Fact Sheet.* Hamilton/Toronto: McMaster University/University of Toronto. Retrieved January 19, 2010 at: www.nhsru.com
[135] Toward a primary care recruitment and retention strategy for Ontario: Compensation structure for Ontario's interprofessional primary care organizations (June 2013). *AFHTO/NPAO/AOHC*. Retrieved from: http://www.afhto.ca/wp-content/uploads/PC-Retention-and-Recruitment-Compensation-Structure-for-IPCOs-Report-to-MOHLTC-June-2013.pdf
[136] Nurse Practitioners' Association of Ontario (2014). Better care. Better value-priorities for NPs: http://npao.org/2014/03/better-care-better-value-priorities-nps/#.VL52G010zct
[137] Government of Ontario (2014). *Realizing Our Potential: Ontario's Poverty Reduction Strategy, 2014-2019*. Toronto: Author, 1. Retrieved January 19, 2014 at https://dr6j45jk9xcmk.cloudfront.net/documents/3384/en-prs-bklt-aug-28th-approved-final-s.pdf.
[138] Ibid, 9-12.
[139] Ibid, 9.
[140] Church, E. (2015). Toronto to open 90 new shelter spaces by renting motel rooms. *Globe and Mail*, January 15, 2015.
[141] Wellesley Institute (2012). *Housing and Health: Examining the Links*. Toronto: Author. http://www.wellesleyinstitute.com/wp-content/uploads/2012/10/Housing-and-Health-Examining-the-Links.pdf
[142] Ontario Non-Profit Housing Association (2014). Waiting List Survey 2014: ONPHA's Report on Waiting Lists Statistics for Ontario. Toronto: Author, 4. http://www.onpha.on.ca/onpha/web/Policyandresearch/Waiting_lists_survey_2014/Content/PolicyAndResearch/Waiting_Lists_Survey_2014/Waiting_Lists_Survey_2014.aspx?hkey=4e2e0fee-e3d3-4c4e-9d76-252e07060439
[143] ONPHA, 5.
[144] ONPHA, 28.
[145] ONPHA, 5.
[146] ONPHA, 5.
[147] Ontario Non-Profit Housing Association (2014b). *Big Problems Need Bold Solutions: An Ambitious Model for Solving Ontario's Most Pressing Housing Needs.* Toronto: Author, 3. http://www.onpha.on.ca/onpha/Content/PolicyAndResearch/BIG_PROBLEMS_NEED_BOLD_SOLUTIONS/BigProblemsNeedBoldSolutions.aspx
[148] ONPHA, (2014b), 3.
[149] Toronto Public Health (2014). May 2014-Nutritious Food Basket Scenarios. Toronto: Author. http://www.toronto.ca/legdocs/mmis/2014/hl/bgrd/backgroundfile-73627.pdf
[150] Toronto Public Health (2014). Cost of the Nutritious Food Basket—Toronto 2014. Toronto: Author. http://www.toronto.ca/legdocs/mmis/2014/hl/bgrd/backgroundfile-73625.pdf
[151] Income Security Advocacy Centre (2014). *OW and ODSP Rates and OCB Amounts as of September/October 2*014. Toronto: Author. http://www.incomesecurity.org/documents/OWandODSPratesandOCBasofSeptOct2014.pdf
[152] ODSP Action Coalition (2015). 2015 Pre-Budget Consultation to Standing Committee on Finance and Economic Affairs. Toronto: Author, January 6, 2015. http://www.odspaction.ca/resource/2015-ontario-budget-submission

[153] Food Banks of Canada (2014). Hunger Count 2014. Toronto: Author, 1, 6. http://www.foodbankscanada.ca
[154] Food Banks of Canada (2013). Hunger Count 2013. Toronto: Author, 1, 11. http://www.foodbankscanada.ca/Learn-About-Hunger/Publications/Research.aspx
[155] Tarasuk, V., Mitchell, A., Dachner, N. (2014). *Household Food Insecurity in Canada, 2012*. Toronto: Research to Identify Policy Options to Reduce Food Insecurity (PROOF), 9. http://nutritionalsciences.lamp.utoronto.ca/resources/proof-annual-reports/annual-report-2012/
[156] Tarasuk, 11.
[157] Tarasuk, 12.
[158] Ministry of Labour (2014). Minimum Wage. Toronto: Author. Retrieved September 23, 2014: http://www.labour.gov.on.ca/english/es/pubs/guide/minwage.php
[159] Workers Action Centre (2014). Minimum Wage. Toronto: Author. http://www.workersactioncentre.org/issues/minimum-wage/
[160] Ontario Medical Association. (2008, June 6). *Ontario's Doctors: Thousands of Premature Deaths due to Smog*. Retrieved January 19, 2015 at http://www.newswire.ca/en/story/355713/ontario-s-doctors-thousands-of-premature-deaths-due-to-smog.
[161] Ontario Medical Association. (2005). *The Illness Costs of Air Pollution: 2005-2026 Health & Economic Damage Estimates.* Toronto: Author, 2. Retrieved January 19, 2015 at https://www.oma.org/Resources/Documents/e2005HealthAndEconomicDamageEstimates.pdf.
[162] Commission for Environmental Cooperation. (2006). *Toxic Chemicals and Children's Health in North America*: A Call for Efforts to Determine the Sources, Levels of Exposure, and Risks that Industrial Chemicals Pose to Children's Health. Montreal: Author, 25. Retrieved January 19, 2015 at www.cec.org/Storage/59/5221_CHE_Toxics_en.pdf. This influential report was cited by the Ontario Ministry of the Environment. (2008). *Creating Ontario's Toxics Reduction Strategy: Discussion Paper.* Toronto: Author, 3. Retrieved January 19, 2015 at http://www.ebr.gov.on.ca/ERS-WEB-External/displaynoticecontent.do?noticeId=MTA0MzAy&statusId=MTU1ODkz
[163] Muir, T. & Zegarac, M. (2001). Societal Costs of Exposure to Toxic Substances: Economic and Health Costs of Four Case Studies That Are Candidates for Environmental Causation. *Environmental Health Perspectives*. 109 (S6), 885-903. Retrieved January 19, 2015 at http://www.jstor.org/discover/10.2307/3454651?uid=2129&uid=2&uid=70&uid=4&sid=21102941290491.
[164] Prüss-Üstün, A. & Corvalán, C. (2006). *Preventing disease through healthy environments: Towards an estimate of the environmental burden of disease*. Geneva: World Health Organization, 9. Retrieved January 19, 2015 at http://www.who.int/quantifying_ehimpacts/publications/preventingdisease.pdf .
[165] World Health Organization. (2013). *Environmental Health*. Retrieved January 19, 2015 at http://www.who.int/topics/environmental_health/en/
[166] Centers for Disease Control and Prevention. National Center for Environmental Health. (2011). *Environmental Hazards and Health Effects.* Retrieved January 19, 2015 at http://www.cdc.gov/nceh/ehhe/
[167] European Commission. (2012). *Environment and Health.* Retrieved January 19, 2015 at http://ec.europa.eu/research/environment/index_en.cfm?pg=health
[168] U.S. Environmental Protection Agency Office of Air and Radiation. (2011). *The Benefits and Costs of the Clean Air Act from 1990 to 2020.* April. Retrieved January 19, 2015 at http://www.epa.gov/cleanairactbenefits/prospective2.html and http://www.epa.gov/cleanairactbenefits/feb11/fullreport_rev_a.pdf.
[169] RNAO. (2012). Position Statement: Healthy Energy Solutions for Ontario. Retrieved January 19, 2015 at: http://rnao.ca/sites/rnao-ca/files/RNAO_Position_Statement_on_Healthy_Energy_Solutions_-_FINAL_and_dated_March_3_2011.pdf
[170] Ibid.
[171] Health Canada. (2014). *Wind Turbine Noise and Health Study: Summary of Results.* Retrieved January 22, 2015 at http://www.hc-sc.gc.ca/ewh-semt/noise-bruit/turbine-eoliennes/summary-resume-eng.php. The study found that annoyance with wind turbine features was statistically associated with increasing levels of wind turbine noise, but that this noise was not statistically associated with self-reported illnesses or sleep disturbance or stress or quality of life effects.
[172] European Environmental Agency. (2012). *The impacts of endocrine disrupters on wildlife, people and their environments – The Weybridge+15 (1996–2011) report*. Retrieved January 19, 2015 at: http://www.eea.europa.eu/publications/the-impacts-of-endocrine-disrupters
[173] National Institutes of Health. National Institute of Environmental Health Sciences. (2012). *Endocrine Disruptors.* Retrieved January 19, 2015 at: http://www.niehs.nih.gov/health/topics/agents/endocrine/index.cfm

[174] Solomon, G, and Schettler, T. (2000). Environment and health: 6. Endocrine disruption and potential human health implications. *Canadian Medical Association Journal*,63(11, 1471-6. Retrieved January 19, 2015 at: http://www.cmaj.ca/content/163/11/1471.full.pdf

[175] Castrilli, J.F. (2014). *Ontario's Living List -- A Dead Thing?*. Canadian Environmental Law Association. Retrieved January 19, 2015 at http://www.cela.ca/blog/2014-05-20/ontarios-living-list-dead-thing.

[176]Task Force on Systemic Pesticides. (2014). *Resources.*Retrieved December 12, 2014 at http://www.tfsp.info/resources/.

[177]Environmental Commissioner of Ontario. (2014). *A look at the science on neonicotinoids.*October 14. Retrieved December 15, 2014 at http://www.eco.on.ca/blog/2014/10/14/look-science-neonicotinoids/.

[178] Ministry of Agriculture, Food and Rural Affairs. (2014). *Pollinator Health: A Proposal for Enhancing Pollinator Health and Reducing the Use of Neonicotinoid Pesticides in Ontario.* November 25. Retrieved January 14, 2015 at http://www.ebr.gov.on.ca/ERS-WEB-External/displaynoticecontent.do?noticeId=MTIzOTE5&statusId=MTg2NDA3.

[179] Metrolinx. (2008). *Costs of Road Congestion in the Greater Toronto and Hamilton Area; Impact and Cost-Benefit Analysis of the Metrolinx Draft Regioinal Transportation Plan*. P. 1. Retrieved January 19, 2015 at http://www.metrolinx.com/en/regionalplanning/costsofcongestion/ISP_08-015_Cost_of_Congestion_report_1128081.pdf.

[180] Metrolinx. (2008). *The Big Move: Transforming Transportation in the Greater Toronto and Hamilton Area.* P. 68. Retrieved January 19, 2015 at http://www.metrolinx.com/thebigmove/Docs/big_move/TheBigMove_020109.pdf.

[181] Transit Investment Strategy Advisory Panel. (2013). *Making The Move: Choices and Consequences.* Retrieved January 14, 2015 at http://www.mto.gov.on.ca/english/news/transit-reports/TISAP%20Report%20Dec10_Report%20Full%20x.pdf

[182] Mowat, D., Gardner, C., Mckeown, D., and Tran, N. (2014). *Improving Health by Design in the Greater Toronto-Hamilton Area*. Retrieved January 14, 2015 at https://www.peelregion.ca/health/resources/healthbydesign/pdf/moh-report.pdf.

[183] Ontario Office of the Premier. (2014). *Moving Ontario Forward With Large New Investment.* Retrieved January 19, 2015 at http://news.ontario.ca/opo/en/2014/04/moving-ontario-forward-with-large-new-investment.html.