Creating a Healthier Society

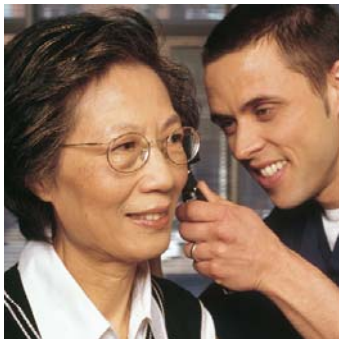
RNAO's Challenge to Ontario's Political Parties: Building Medicare's next stage, focusing on prevention

MAY 2007









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

Speaking out for health. Speaking out for nursing.

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Preface

Courage, my friends; 'tis not too late to build a better world.

Tommy Douglas

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses wherever they practise in Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the health-care system, and influenced decisions that affect nurses and the public they serve. We believe health is a resource for everyday living and health care a universal human right.

RNAO's Strategic Directions

- RNAO influences public policy that strengthens Medicare and impacts on the determinants of health.
- RNAO speaks out on emerging issues that impact on health, health care and nursing.
- RNAO advances nursing as a vital, significant and critical contributor to health.
- RNAO influences the public to achieve greater engagement in health care.
- RNAO inspires every RN and undergraduate basic nursing student to be a member.

It is in the context of our mandate that we share RNAO's key policy priorities for the upcoming provincial election that will take place on October 10th, 2007. RNAO has chosen to focus on public policies aimed at decreasing health inequities. We know that if implemented, these policies would lead to improved health outcomes for Ontarians, and a more just and prosperous society for all.

Summary of RNAO's Positions

What Keeps Us Healthy and What Makes Us Sick: Focus on Social Determinants of Health

1. Increase minimum wage to $10 per hour in 2007 and adjust it for inflation annually.

2. Review the *Employment Standards Act* to improve protection of vulnerable workers.

3. Ensure that the government enforces the *Employment Standards Act* by monitoring compliance, sanctioning employers who break the law, and collecting unpaid wages owed to workers.

4. Raise social assistance rates to allow people to meet their needs and live in dignity. Increase Ontario Works rates by 35 per cent and then index those rates to inflation. Increase Ontario Disability Support Plan rates by 20 per cent and then index them to inflation.

5. Improve the administration and service delivery of social assistance programs so that clients receive timely, respectful assistance that meets their needs.

6. Implement a comprehensive community-based housing strategy that includes:
   a. Capital subsidies to build new affordable housing or renovate existing housing stock that is substandard.
   b. Rent supplements to ensure affordable housing for low and moderate income households.
   c. Supportive community-based housing and services for those with physical, cognitive and/or mental health needs.

7. Maintain an Ontario Child Benefit that raises the living standard of all low-income families with children under 18 years of age.

8. Enhance resiliency by stabilizing and enhancing Healthy Babies, Healthy Children and Best Start program funding in the non-profit sector.

What Keeps Us Healthy and What Makes Us Sick: Environment and Human Health

9. Shift energy policy toward energy conservation.

10. Commit to regulations terminating all coal burning at Ontario's power plants by 2009.

11. Cancel plans for the construction of new nuclear plants in Ontario.

12. Increase reliance on small and large scale renewable energy sources.

13. Commit to phasing in a carbon tax and other environmental taxes and regulations.

14. Create a Pollution and Cancer Prevention Act to:
    a. Immediately require companies using or releasing large quantities of toxic substances to develop pollution prevention plans that would lead to the use of safer substitutes for toxins and a significant reduction in the generation and use of toxic substances.
    b. Increase public awareness of sources of toxins by creating a publicly accessible database of toxic releases.
    c. Require the labelling of products containing carcinogens, mutagens, and reproductive toxins.
    d. Establish funding and a technical support office to assist companies and workers in their efforts to reduce or eliminate the production and use of toxins, help citizen groups monitor pollution prevention plans, and collect and report annually on use of toxins.

15. Collaborate with partners such as the Canadian Cancer Society to develop and implement a comprehensive strategy to reduce environmental, household, and occupational carcinogens.

16. Commit to protecting Ontarians from pesticides by enacting legislation that will:
    a. Ban non-essential uses of pesticides.
    b. Ban the display and sale of pesticides for non-essential uses.
    c. Ban the sale of pesticide-fertilizer mixes.

Strengthen Medicare: Access to Health-Care Services

17. Recommit to the *Canada Health Act* and to the principle of a single-tier health care system.

18. Enforce the *Commitment to the Future of Medicare Act* to prevent for-profit clinics from delivering medically necessary health-care services in Ontario.

19. Uphold the ban on user fees for all necessary health services, acknowledging them as barriers to access.

20. Incorporate into any new health-care legislation a governing principle of not-for-profit delivery.

21. Reject signing onto the Trade, Investment and Labour Mobility Agreement (TILMA) and other similar agreements that limit the government's ability to regulate in the public interest.

22. Establish an immediate and indefinite moratorium on Infrastructure Ontario's AFP projects in the hospital sector. Do not approve or announce any additional AFP projects and transform any AFP projects that have not been finalized to traditional government finance and procurement methods.

23. Prohibit any AFP projects that are going ahead from including contracts for operation of services.

24. Assume a leadership role in expanding Medicare to include a national Pharmacare program.

Strengthen Medicare: Focus on Community Care

25. Fund eight new nurse-led primary health care clinics.

26. Fund seven nurse-led clinics that will provide chronic disease management.

27. Increase home care expenditures by 30 per cent by 2010 to support persons with chronic conditions and/or older persons to remain active members of our communities. Ensure all new RFPs specify a first right-of-refusal for non-profit agencies.

Strengthen Medicare: Nursing Workforce as a Priority

28. Commit to increasing Ontario's RN workforce by 9,000 FTEs by 2010.

29. Commit to continue the 70 per cent full-time employment strategy for all RNs, with the goal of achieving this target in all health-care sectors by 2010. This commitment should be backed up by increased targeted, conditional funding in the hospital sector, and the introduction of targeted, conditional funding into the long-term care and home care sectors.

30. Commit to continued funding for a full-time employment guarantee for all new RN graduates who wish to work full time.

31. Commit to the 80/20 strategy to offer full-time registered nurses working in all sectors, age 55 and over, the opportunity to spend 80 per cent of their

time on direct patient care, and the other 20 per cent on mentorship of new graduates and other professional development activities.

32. Equalize remuneration and working conditions for RNs working in acute care, primary care/family practice, home care, and long-term care sectors.

33. Enact the College of Nurses of Ontario's proposed legislative changes to the *Nursing Act* and regulations that will incorporate Acute Care Nurse Practitioners into the Extended Class. Enable all RN(EC)s to fully serve the public by eliminating the legislative requirement for consultation and providing for open prescribing for diagnostic tests and pharmaceuticals within their scope of practice.

34. Fund 150 new NP Primary Health Care positions across health-care settings, including nurse-led clinics, community health centres, family health teams, ERs, and other outpatient settings, in each of the next four years.

35. Equalize remuneration and working conditions for Primary Health Care NPs working in nurse-led clinics, community health centres, and family health teams.

36. Fund 50 new RN(EC) positions across all other streams of practice, including NP Acute Care Adult, NP Acute Care Paediatric, and NP Anaesthesia, in each of the next four years.

37. Provide base funding for expanded practice nurses such as nurse endoscopists and Registered Nurse First Assists.

38. Continue to invest in nursing faculty by providing financial support to increase the number of students enrolled in nursing PhD programs, paying tuition for nursing faculty enrolled in PhD programs, and support enrolment in Masters nursing programs.

39. Double the value of operating grants per full-time equivalent undergraduate nursing student.

40. Implement a provincially coordinated system for practice education -- a system that will efficiently coordinate placements for a broad range of health disciplines and programs.

41. Provide support for Nurse Practitioner education at the graduate level.

42. Ensure that government and those health organizations funded by the government do not engage in international recruitment of nurses and other health professionals.

43. Ensure that internationally educated nurses who make Ontario their new home face no systemic barriers to practice their profession.

44. Establish permanent funding for existing upgrading and bridging programs for internationally educated nurses who make Ontario their new home.

Increase Fiscal Capacity: Government Revenues and Expenditures are Social Choices

45. Increase tax revenues to ensure that there is sufficient fiscal capacity to enhance the health of Ontarians through increased social spending.

46. Phase in a carbon tax and other environmental taxes to achieve environmental objectives, and use revenues to support the social programs and services most needed by at risk populations.

47. Reverse the regressive tax cuts implemented by the previous Ontario government, which have had a negative impact on Ontario's fiscal capacity, the health of our cities, and the social fabric of our society.

What Keeps Us Healthy and What Makes Us Sick: Focus on Social Determinants of Health

Health is a measure of the degree to which the society delivers a good life to its citizens.
Sir Michael Marmot, Chair of the Commission on Social Determinants of Health[1]

A growing body of international,[2 3 4 5] national,[6 7 8 9] and provincial[10 11 12 13] research and policy analysis recognizes that health and life itself are a direct reflection of how we organize our societies. Large disparities in infant mortality, the burden of disease, and life expectancy between groups of people or populations are not random, but are socially determined.

Health inequities in Canada can be illustrated with examples involving Aboriginal status, poverty, and income inequality. Life expectancy at birth, on average, is five to 10 years less for First Nations and Inuit peoples than for all Canadians.[14] The economic and social status of Aboriginal Peoples is lower than that of non-Aboriginal Canadians on virtually every measure.[15] We are deeply concerned that Aboriginal People suffer a greater burden of disease and die earlier than other Canadians,[16] as do Canadians in lower income groups.[17] The infant mortality rate in Canada's poorest neighbourhoods in 1996 was two-thirds higher than that of the richest neighbourhood. There would have been 513 fewer infant deaths in 1996 if the rate for all of Canada had been as low as that of the richest neighbourhoods.[18] These findings on health disparity by neighbourhood income are of great concern as the gap between Canada's rich and poor is at a 30-year high, and growing.[19]

Why some people are healthy and others are not can be traced to key social determinants of health such as Aboriginal status, early childhood development, education, employment and working conditions, food security, health-care services, housing, income and its distribution, social safety nets, and social exclusion.[20] In contrast to a medical model that focuses on individual risk factors, our perspective is concerned with the social patterns and structures that shape people's chances to be healthy.[21]

Our next provincial government must be concerned with health equity and creating the conditions that allow all Ontarians to be healthy, both for moral and economic reasons. Health is a human right.[22 23 24] Canadians cherish the core values of equity, fairness, and solidarity on which our health-care system is premised.[25] Reducing health inequities would improve opportunities for the most disadvantaged, increase economic productivity, and decrease the use of health-care services, social services, and correctional services.[26]

Each day in our nursing practice, we see our clients struggle with compromised health and earlier death due to poverty and social exclusion. Recognizing the unequivocal evidence from the academic research and our own experience that material and social

deprivation harms health, we are dismayed that the most recent poverty statistics for 2002 and 2003 show that more than 1.7 million people live in poverty in our province.[27]

Meeting basic human needs for food, shelter, and dignity is essential for individuals, families, and society. RNAO is looking to the next provincial government to implement a comprehensive poverty strategy that would include the following elements.

Increase the Minimum Wage and Enforce Labour Standards

Approximately 200,000 people in Ontario earn the minimum wage and approximately 1.2 million workers earn less than $10 per hour.[28] Women, recent immigrants, people of colour, and less educated workers disproportionately earned poverty wages in Canada from 1980 to 2000.[29] Even with the increase in the minimum wage to $8 per hour in February 2007 and a proposed increase to $8.75 per hour in March 2008, working people earning the minimum wage are still far below the poverty line. The proposed increase in the minimum wage to $10.25 by 2010 in Ontario's 2007 Budget[30] is too gradual for people struggling in poverty today.

With 37 per cent of all jobs now being "non-standard" as part-time, temporary, contract, or self-employed work, many low-income families juggle multiple jobs with little security.[31] The Provincial Auditor of Ontario found in 2004[32] and 2006[33] that the Ministry of Labour fails to protect vulnerable workers by not adequately enforcing the *Employment Standards Act.* The *Employment Standards Act* must be strengthened to better protect vulnerable workers,[34] and the government of Ontario must better enforce these employment standards.

RNAO's Position:

- **Increase minimum wage to $10 per hour in 2007 and adjust it for inflation annually.**
- **Review the *Employment Standards Act* to improve protection of vulnerable workers.**
- **Ensure that the government enforces the *Employment Standards Act* by monitoring compliance, sanctioning employers who break the law, and collecting unpaid wages owed to workers.**

Increase Dangerously Low Social Assistance Rates

Ontario Works and Ontario Disability Support Plan benefits were drastically cut in 1995, and have fallen steadily relative to inflation since then.[35] The last five years in Ontario have recorded the lowest levels of welfare income on record since 1986, with recipients receiving only 34 per cent to 58 per cent of the poverty line.[36] Ontario's social assistance rates are so low that all recipients are at risk for compromised nutrition and ill health. Toronto Public Health's own 2006 calculation of the cost of the nutritious food basket, given the high cost of market rental accommodation in Toronto, concluded that "many

low and/or fixed income residents have to choose between paying the rent and buying food."[37] The Northwestern Health Unit notes that a family of four in the Kenora-Rainy River Districts who depend on Ontario Works as their income source would have to spend at least half of their total income on food.[38]

There is clear evidence that insufficient income support compromises health. An analysis of the 1996/1997 National Population Health Survey found that as income adequacy deteriorates, the risk of reporting food insufficiency increases.[39] Household food insufficiency is clearly linked with poorer reported and functional health, including higher odds of restricted activity, multiple chronic conditions, major depression, heart disease, diabetes, high blood pressure, and food allergies.[40] Infants and toddlers who experience food insecurity are at a greater risk for poor health, growth problems, and hospitalization.[41] Food bank surveys[42] [43] and peer review literature[44] consistently report that access to milk products, fruits, and vegetables are constrained in low income households. Even hypothetically, average monthly incomes for households in Toronto supported by welfare cannot afford a nutritious diet.[45] Low-income single mothers compromise their own nutritional intake in order to feed their children.[46]

Social assistance rates were increased by three per cent in March 2005, and by another two per cent in November 2006. While a step in the right direction, even with these increases, social assistance rates will be lower, in inflation-adjusted terms, than they were in 2003.[47] The estimated 676,500 Ontarians receiving social assistance[48] need sufficient resources so that they can live in health and in dignity. The scheduled increase in social assistance rates by two per cent in November 2008, while welcome, is insufficient.

The Auditor General of Ontario,[49] the Ombudsman of Ontario,[50] and the Street Health Community Nursing Foundation[51] have all documented deficiencies in the administration and service delivery of the Ontario Disability Support Program (ODSP) that adversely affect clients. Increasing access to ODSP by addressing barriers within the disability support system would provide significant benefit to Ontario's most vulnerable people, including those who are homeless. As our Street Health colleagues point out, improving access to ODSP for disabled homeless people will decrease homelessness, improve health outcomes, and decrease demand on the shelter and health-care systems.[52]

RNAO's Position:

- **Raise social assistance rates to allow people to meet their needs and live in dignity. Increase Ontario Works rates by 35 per cent and then index those rates to inflation. Increase Ontario Disability Support Plan rates by 20 per cent and then index them to inflation.**
- **Improve the administration and service delivery of social assistance programs so that clients receive timely, respectful assistance that meets their needs.**

Increase Affordable Housing

With rent increases for many tenants outpacing inflation, an all-time record number of 64,864 tenant households faced eviction in Ontario in 2005 because they couldn't pay their rent.[53] Insufficient affordable housing for low and moderate income households reflected in long waiting lists,[54] and physically deteriorating,[55] aging rental stock[56] have created an urgent need for the next provincial government to take action on affordable housing. Those who currently rely on community-based affordable housing include some of the most vulnerable members of our society, such as women and children fleeing violence and abuse, developmentally disabled individuals, and people living with mental or physical illness.

Providing social housing is much more cost-effective than the alternatives, as these average monthly costs indicate: social housing ($199.92); shelter bed ($1,932); provincial jail ($4,333); and hospital bed ($10,900).[57] Even more compelling is the human cost of having more than two million Ontarians currently forced to live in homes that are unaffordable,[58] substandard, or both.[59]

People who are homeless are sicker and have higher death rates than the general population. A study of men using homeless shelters in Toronto found mortality rates 8.3 times and 3.7 times higher than rates among men in the general population aged 18-24 and 24-44 respectively.[60] Homeless women aged 18-44 years were 10 times more likely to die than women in the general population of Toronto.[61] While the dangers to health are most obvious with homelessness, there is also clear evidence that housing policies have direct health impacts. Children living in families with access to subsidized housing were better nourished than comparable low-income families.[62] [63] Resources spent on housing rather than other essentials such as food compromise the health and well being of low-income Ontarians.

RNAO's Position:

- **Implement a comprehensive community-based housing strategy that includes:**
    - **Capital subsidies to build new affordable housing or renovate existing housing stock that is substandard.**
    - **Rent supplements to ensure affordable housing for low and moderate income households.**
    - **Supportive community-based housing and services for those with physical, cognitive and/or mental health needs.**

Implement Health and Social Policies that Support Children

We ask all parties to implement health and social policies with a life-course perspective. Biological and developmental factors, exposure to risk factors such as poverty, and early life experiences all profoundly influence children's health. These effects are cumulative, so that optimal early childhood development is essential not only for the well-being of the

individual as a child but it is also critical for long-term health into adulthood.[64] [65] Negative consequences of poor early childhood development can include restricted brain development; reduced language development, capacity to communicate, and literacy; and poorer mental and physical health throughout life.[66]

The most recent child poverty statistics show that the child poverty rate for Ontario has increased from 16.1 per cent in 2003 to 17.4 per cent in 2004. Nurses are concerned about child poverty and social exclusion because the evidence is clear: children living in poverty are in danger. In one of the largest studies into social class inequalities in childhood mortality and morbidity, it was found that children in the United Kingdom born into the lowest socio-economic group have a 40 per cent increased chance of dying in their first 10 years compared with children born into the highest group.[67] Loss of social assistance benefits due to welfare reform in the United States has been linked with increased food insecurity and increased health problems requiring hospitalization among children aged 36 months or younger.[68] Although Ontario data linking socioeconomic status directly with health outcomes is lacking, overwhelming evidence from other jurisdictions has generated strong consensus among public health leaders at the national,[69] provincial,[70] and local levels[71] that addressing child poverty is essential for child health and development.

The Ontario Child Benefit (OCB) announced in the 2007 provincial budget is a step forward in addressing child poverty in Ontario. This new benefit will go to low-income families with children between the ages of 0 to 18 years, and include both those working and those on social assistance. Low income families who are waged will receive a maximum benefit of $50/child/month in 2008, increasing to $92/child/month in 2011. Due to restructuring of social assistance rates, however, low income families receiving social assistance will only receive a net benefit of $50/child/month when the OCB is fully implemented in 2011.[72] Ontario's registered nurses are calling on all political parties to build on the progress made in this budget. The OCB should be increased, and social assistance rates should be restructured only to the extent that the net support is the same for all low-income families with children regardless of where their parents get their income.

In addition to adequate and equitable income, children need effective parenting, families, and supportive community environments to ensure healthy child development.[73] Family strengthening programs and early detection and intervention programs with outreach are two examples of interventions that can foster social inclusion and support parenting. Prenatal and early childhood home visits by public health nurses, for example, were found to reduce child abuse and neglect, use of welfare, and criminal behaviour on the part of single, low-income mothers for up to 15 years after the birth of the first child.[74]

Additionally, adolescents born to women who received home visits from nurses had reduced incidence of criminal and antisocial behaviour, including fewer behavioural problems related to alcohol and other drugs.[75] Supportive community environments can include access to reliable and integrated education, as well as health, social, and recreational services and 'child friendly' spaces and systems.[76]

Investing in universal, inclusive, and accessible early education and child care services, such as the Healthy Babies, Healthy Children and Best Start programs, helps to foster resiliency that will have life-long benefits. Quality early learning and child care programs are associated with decreased incidence of obesity, smoking, and abuse or neglect. These programs also have with long-term benefits such as improved educational outcomes, increased employment retention, and decreased poverty and reliance on social assistance.[77] The entire family benefits as parents whose children participate in quality early learning and child care programs enjoy decreased stress.[78]

RNAO's Position:

- **Maintain an Ontario Child Benefit that raises the living standard of all low-income families with children under 18 years of age.**
- **Enhance resiliency by stabilizing and enhancing Healthy Babies, Healthy Children and Best Start program funding in the non-profit sector.**

What Keeps Us Healthy and What Makes Us Sick: Environment and Human Health

Nurses know that the environment is a major determinant of health, and people flourish best when they live in clean, green, liveable environments. People are not only healthier but also happier in such settings. Ontarians can do much more to build these environments, and the time to start is now.

Evidence linking the environment to health outcomes is well known. The World Health Organization (WHO) estimates that environmental factors account for 24 per cent of the world's burden of disease and 23 per cent of all deaths.[79] While the costs are higher in developing countries, environmental factors have a significant impact on the incidence of many diseases across the globe. In developed regions, environmental factors accounted for 17 per cent of deaths.[80] In these regions, environment plays a more significant role in chronic diseases such as lung cancer (30 per cent).[81]

These adverse health impacts are well recognized. For example, Environment Canada states that "asthma, lung cancer, cardiovascular disease, allergies and many other human health problems have been linked to poor air quality."[82] The international and Canadian evidence shows that these impacts are disproportionately born by lower-income people.[83] [84] [85] [86] [87] [88] Environmental protection is not only a matter of health but also a matter of social justice.

Like all Canadians, registered nurses have become increasingly concerned about climate change and the impact of environmental toxins on the health of their families. We can safely say that "we are what we eat and what we breathe." In this platform, nurses focus on building healthier environments through cleaner air, and through reducing toxins in the environment and in our food.

Promote Clean Green Electricity and Address Climate Change

Our electrical power production often comes with a price: pollution and climate change through greenhouse gases. In particular, coal-fired power generation is a major contributor to smog, mercury pollution, and greenhouse gases.

Climate change is very much in evidence, and the public fears an environmental catastrophe and the associated human costs. Even now, climate change is causing a variety of health impacts, with the marginalized and vulnerable most affected. These include the impacts on health from extreme weather events such as Hurricane Katrina. Increasing instances of destructive wind storms, heat waves, droughts, wildfires, coastal floods, heavy ice storms, retreating glaciers and thinning Arctic ice cause direct and indirect risk to life and health.

Many of the mechanisms that produce global warming also exacerbate air pollution, which has a range of adverse health effects. The Ontario Medical Association has estimated the annual cost of air pollution in Ontario at more than 5,800 premature deaths, more than 16,000 hospital admissions, almost 60,000 hospital visits, and more than 29,000 minor illnesses.[89] Many of these costs will be associated directly or indirectly with energy production and energy use.

Effectively addressing these health and environmental impacts requires a renewed commitment to implementing policies that will address climate change. For Ontario, an important first step would be to promptly complete the phase-out of coal-fired power generation. This will contribute to reducing pollution, mercury releases, and climate change. Ontario could make up any power gap by a combination of increased conservation strategies, more renewable energy such as wind power, and by converting the coal plants to natural gas.

The Ontario Clean Air Alliance has estimated the total incremental cost of a phase-out for 2010 would result in very small additional residential electricity rate rises of 0.7 to 0.8 per cent in 2010 and 0.5 per cent for 2011 to 2029. For large industrial customers, the rise would be marginally higher: 0.9 to 1.0 per cent for 2010, and 0.6 per cent for 2011 to 2029.[90] When all costs of electricity generation are included (financial, health and environmental), the phase-out would save $1.7 billion per year.[91] A small investment in phasing out coal will bring very large benefits.

The government must very carefully consider alternatives to the dirty power produced by coal. It must first focus on energy conservation, including moving to more energy efficient homes, offices, manufacturing facilities and vehicles. Urban re-design, greater accommodation for walking and cycling, and enhanced public transit would save greatly on vehicle demand for energy. This would not only reduce greenhouse gas emissions, but also reduce toxic emissions and make our cities more liveable.

There are a range of safer alternative sources of power, heating and cooling. For example, there is considerable scope to increase the use of hydro,[92] solar and wind power

in Ontario. Earth energy offers a safe and much cleaner alternative for heating and cooling.[93] Many of these safer alternatives would become more economically viable if the de facto subsidy on fossil fuels was removed.[94] There is also potential to increase co-generation of heat and power, and this offers one way of saving on energy and greenhouse gas emissions. A report for the Ontario Ministry of Energy concluded that Ontario could produce well over half of its peak power consumption this way.[95] Ontario's energy strategy should also include switching from coal to much cleaner and more efficient natural gas at coal plants, which would give Ontario its needed electrical surge capacity without having to rely on coal.[96]

RNAO is opposed to one alternative -- an expansion of nuclear power. Nuclear power has proven to be extraordinarily expensive. The Ontario Clean Air Alliance has estimated that the cost of greenhouse gas saved would be $29.76 per tonne for a new nuclear reactor, versus $18.85 for wind power and $4.11 for natural gas plants.[97] Furthermore, nuclear power plants present radiation risks and produce large amounts of radioactive waste that must be stored in perpetuity (and no solution for such storage has been found).

One tool for cleaning up the environment is little-used in North America: green taxes. Ontario and Canada lag behind other OECD countries in the use of environmental taxes (only the US makes less use of environmentally related taxes than Canada).[98] Outside of the US, OECD countries are about twice as reliant on environmentally-related taxes as is Canada, so international experience suggests there is considerable scope for more aggressive use of green taxes, and support for green taxes in Canada has grown.[99] [100] The experience of these jurisdictions can help Ontario shape an effective policy involving phased introduction of taxes and subsidies. The introduction of a carbon tax would work to reduce greenhouse gas emissions. It has been implemented in a number of countries, and Quebec has committed to a carbon tax.[101]

Revenue raised from green taxes is available for a variety of purposes, including: subsidies to environmentally beneficial activities; paying for the costs of pollution; transitional assistance to industries and workers negatively affected by these taxes; subsidies to low-income families or individuals who would be disproportionately affected by these taxes; and, increases in general revenue, allowing expanded government programs.

RNAO's Position:

- **Shift energy policy toward energy conservation.**
- **Commit to regulations terminating all coal burning at Ontario's power plants by 2009.**
- **Cancel plans for the construction of new nuclear plants in Ontario.**
- **Increase reliance on small and large scale renewable energy sources.**
- **Commit to phasing in a carbon tax and other environmental taxes and regulations.**

Protect Ontarians from Toxics and Pollution

Chronic conditions such as asthma, cancer, developmental disabilities, and birth defects have become the primary causes of illness and death in children in industrialized countries, and there is growing expert recognition that chemicals in the environment are partly responsible for these trends.[102] In 2005, 2006, and 2007, Environmental Defence reported tests showing that Canadians, including children, had many chemicals that are known or suspected health hazards present in their bodies. These included: chemicals that cause reproductive disorders; hormone disruptors; neurotoxins; and, those associated with respiratory illnesses. The tests found that test subjects were heavily polluted; they had in their blood on average about half of all the many tested chemicals.[103] [104] [105] [106]

There is a great urgency to act, and to act decisively, to protect the health of Ontarians and their children. Large margins of safety must be built in to accommodate for the much greater vulnerability of children to toxins. Children are exposed to more toxins per body weight, absorb ingested substances differently, have developed fewer protections against toxins, face additional risks while undergoing development, face higher exposures due to activity and behaviour; and have much more time to develop disease from toxins.[107] [108] [109] [110] [111] The precautionary principle dictates that we insist on proof of safety prior to use, rather than waiting for proof of harm. RNAO supports the creation of a Pollution and Cancer Prevention Act to address this concern. [112]

RNAO's Position

- **Create a Pollution and Cancer Prevention Act to:**
    - **Immediately require companies using or releasing large quantities of toxic substances to develop pollution prevention plans that would lead to the use of safer substitutes for toxins and a significant reduction in the generation and use of toxic substances.**
    - **Increase public awareness of sources of toxins by creating a publicly accessible database of toxic releases.**
    - **Require the labelling of products containing carcinogens, mutagens, and reproductive toxins.**
    - **Establish funding and a technical support office to assist companies and workers in their efforts to reduce or eliminate the production and use of toxins, help citizens' groups monitor pollution prevention plans, and collect and report annually on use of toxins.**
- **Collaborate with partners such as the Canadian Cancer Society to develop and implement a comprehensive strategy to reduce environmental, household, and occupational carcinogens.**

Ban Non-Essential Use of Pesticides

The public has grown increasingly aware and concerned about one specific class of toxins: chemical pesticides. Seventy-one per cent of Ontarians support a province-wide

ban on most lawn and garden pesticides, similar to that enjoyed by Quebec citizens.[113] Polling shows strong support for the ban that extends across all political parties, age groups, and genders. There are many epidemiological and laboratory studies linking a range of health problems to pesticide exposure. The problems include: cancer, birth defects, reproductive damage, neurological and developmental toxicity, immunotoxicity, and endocrine disruption.[114] [115] The risk to health comes not only from active ingredients, but also from so-called inert substances.[116] [117] [118] Finally, synergistic and cumulative effects can heighten the health damage due to pesticides.[119] [120]We are concerned that the existing controls provided by Canada's national pesticide regulatory system are not adequate, particularly in protecting children from the special risks that pesticides pose to them.

RNAO's Position

- **Commit to protecting Ontarians from pesticides by enacting legislation that will:**
  - **Ban non-essential uses of pesticides.**
  - **Ban the display and sale of pesticides for non-essential uses.**
  - **Ban the sale of pesticide-fertilizer mixes.**

Strengthen Medicare: Access to Health-Care Services

Protect Medicare

Under the *Canada Health Act*, essential physician and hospital services are part of the cost-efficient single-payer system. This system offers universal access to health care that would otherwise be unavailable to many low-income people, and also removes a major source of anxiety and risk of bankruptcy.[121] Before Medicare, Canadians had a very different experience when they faced major health problems, and those who had that experience do not want to go back. Medicare must be protected and expanded.

Listen to the Evidence on Two-Tier Health Care

Research has shown that in addition to the obvious advantage of equal access, a single-tier system shortens wait times and saves money in several ways. For example, OECD countries with parallel private hospital systems proved to have larger and longer public wait lists than countries with a single-payer system.[122] A UK study found the result also held for regions as it held for countries.[123] Parallel private systems do not increase the number of health-care practitioners; rather, practitioners are split into two systems. This, in turn, creates an incentive for doctors to lengthen waiting lists in the public system.[124]

There are enormous savings to a single-payer system. Unlike their American

counterparts, Canadian providers only deal with one payer, and remain secure in the knowledge that they will be paid for insured services. In 1999, administrative costs in the US were $1,059 per capita as compared to $307 per capita in Canada.[125] If these costs were streamlined to Canadian levels, far more than enough money would have been saved to provide full insurance coverage for all of the 41.2 million Americans who were uninsured in 2001.[126] Overhead costs for Canada's Medicare system were 1.3 per cent as compared to 13.2 per cent for Canadian private insurers.[127]

RNAO's Position:

- **Recommit to the *Canada Health Act* and to the principle of a single-tier health care system.**
- **Enforce the *Commitment to the Future of Medicare Act* to prevent for-profit clinics from delivering medically necessary health-care services in Ontario.**
- **Uphold the ban on user fees for all necessary health services, acknowledging them as barriers to access.**

Act on the Evidence on Not-For-Profit Delivery of Health Care

In Ontario, health-care professionals work in both the not-for-profit sector (including most hospitals) and the for-profit sector (including some home care agencies and some long-term care facilities). RNAO supports all workers regardless of the sector in which they find employment. However, as a policy matter, RNAO remains an advocate of not-for-profit delivery based on evidence regarding cost and outcome.

There is considerable evidence on the differences of cost and outcomes between for-profit and not-for-profit delivery across sectors. Studies show that the quality of care in for-profit institutions is lower.[128] [129] [130] [131] [132]The most conclusive evidence comes from systematic reviews and meta-analyses of all available peer-reviewed literature on for-profit vs. not-for-profit health care, which found higher patient mortality rates in for-profit as compared to non-profit centres.[133] [134] Furthermore, research finds no trade-off on cost: a systematic review and meta-analysis of all available peer-reviewed literature in the *Canadian Medical Association Journal* concluded that for-profit hospitals charge a statistically significant 19 per cent more than not-for-profit hospitals.[135]

Canadian evidence, available from the long-term care sector, found that staffing levels were higher in not-for-profit facilities than in for-profit facilities,[136] and health outcomes were better in not-for-profit facilities.[137] [138] As one set of researchers concluded, differences in staffing were likely to result in the observed differences in health outcomes.[139] A review of North American nursing home studies between 1990 and 2002 similarly concluded that for-profit homes appeared to deliver poorer quality care in a number of process and outcome areas.[140]

To protect and expand Medicare, we need to protect government's ability to regulate and make policies on the provision of health-care services. The Trade, Investment and Labour

Mobility Agreement (TILMA) between British Columbia and Alberta that comes into force this year will severely restrict governments' ability to make policies in the public interest. Since the health sector is not exempted from the agreement, it could severely restrict governments' abilities to regulate the health sector in the public interest and to regulate for-profit delivery.[141] We are concerned that other provinces are being urged to sign onto this agreement.[142]

RNAO's Position:

- **Incorporate into any new health-care legislation a governing principle of not-for-profit delivery.**
- **Reject signing onto the Trade, Investment and Labour Mobility Agreement (TILMA) and other similar agreements that limit the government's ability to regulate in the public interest.**

Reject P3s

The Ontario government has implemented a program of alternative financing and procurement (AFPs) for hospitals and other public infrastructure. These AFPs are forms of public-private partnerships (P3s) that roll together complex contracts to finance, design, build and operate public facilities like hospitals. The government position is that AFPs are not P3s because they will remain publicly owned and controlled. However, they will be privately financed and partially operated by parallel private administrations. Many of the problems associated with P3s arise from private financing and operation. A decision in December 2006 to exclude from AFPs "soft facility management services" such as laundry and housekeeping reduces some of the immediate risk to staff and clients, but still carries the conflict of interest and inefficiency of running parallel private and public administrations.

Studies show that costs of P3s tend to be higher, and frequently, the quality of the service is reported to be poor[143] [144] [145] [146] [147]. Moreover, there are serious concerns about P3s' lack of transparency and public accountability since sensitive financial and project information remains confidential, and thus there is no way to verify the claims regarding the financial and risk gains from the AFP. Much of the purported cost advantages of P3s can be attributed to the use of high discount rates to calculate the present value of future government payments to the private contractor[148]. The evidence also shows that risk transfer is both unclear and comes at a high cost (about a 30 per cent increase).[149] In the AFP contract for Hôpital Montfort, for example, much of the risk of delays in construction was not transferred to the contractor but remained with the Ontario government.[150]

RNAO's Position:

- **Establish an immediate and indefinite moratorium on Infrastructure Ontario's AFP projects in the hospital sector. Do not approve or announce any additional AFP projects and transform any AFP projects that have not been finalized to traditional government finance and procurement methods.**

- **Prohibit any AFP projects that are going ahead from including contracts for operation of services.**

Expand Medicare: Time for a National Pharmacare Program

Increasing and improving health-care access, equity, and sustainability requires an expansion of Medicare, rather than a retreat to two-tier health care or for-profit delivery. A number of factors, including shorter length of hospital stay, an aging population, and cost structures call for an expansion of Medicare to include a national Pharmacare program.

Drugs are the second largest and fastest growing category of health expenditures in Canada, after hospital care.[151] Since 1997, calls for a pan-Canadian Pharmacare program have accelerated, including high-profile recommendations such as those arising out of the Romanow Commission. Such a program would provide equal access to prescription drugs across the country and keep the rising cost of prescription drugs in check. Progress, tentative as it may be, has been made on a national Pharmacare plan by the Federal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy, which was created out of the 2003 First Ministers' Accord on Health Care Renewal. RNAO is looking to the next government to build on this momentum and commit to participating in a national Pharmacare plan.

RNAO's Position:

- **Assume a leadership role in expanding Medicare to include a national pharmacare program.**

Strengthen Medicare: Focus on Community Care

Accelerate Primary Health Care Reform

In Ontario, many Ontarians who live in under-serviced areas, or who are without a family physician, face continued difficulties in accessing primary care. Working collaboratively with other health-care providers, registered nurses are well suited to provide a point of entry to health promotion and disease prevention as well as curative, rehabilitative, and supportive services.

Focus on Chronic Disease Management

As Ontario's population ages, the incidence of chronic illness increases. By age 65, 77 per cent of Canadian men and 85 per cent of women have at least one chronic condition.[152] Not surprisingly, people with chronic diseases, such as diabetes, heart disease, or emphysema, use the majority of health-care resources. [153]

Chronic disease is currently managed within an illness model often characterized by frequent emergency department visits and hospital readmissions with long lengths of stay. [154] This 'illness model' is focused on diagnosis, treatment and cure. While this approach is appropriate for acute illnesses, such as heart attack or stroke, it is not well suited to the management of chronic disease.

In transitioning from an illness orientation to a wellness orientation, prevention becomes the new priority at all points along the continuum of care. A large number of studies show that the benefits of this model in managing chronic illness include:

- Decreased health-care utilization, including fewer emergency department visits, fewer hospital readmissions, and decreased length of stay; [155] [156]
- Improved quality of life for patients; [157]
- Improved quality of care; [158]
- Improved patient satisfaction; [159] and,
- Improved health-care provider satisfaction. [160]

Nurses are well positioned to manage and deliver care to patients with chronic disease. The nursing model has a holistic approach that addresses the needs of patients and families across a continuum from diagnosis and management to caregiver and family support and end-of-life decision making. The success of nurse-led clinics in a variety of settings provides strong evidence of the benefits of having nurses provide chronic care. [161] [162] When compared with outpatient and inpatient care, nurse-led clinics for the management of chronic disease have been found to be more cost effective, result in higher patient satisfaction, fewer deaths, improvements in care and patient lifestyle, increased access to care, and reduced wait times. [163] [164]

Improved and equal access to home care will facilitate aging in place. Strategies are required to support persons with chronic conditions and/or older persons to age in place and exercise choice in how they live. RNAO has repeatedly urged for the repeal of competitive bidding. Though it continues, we are asking all parties to implement, at a minimum, a first right-of-refusal for non-profit agencies in all new RFPs.

RNAO's Position

- **Fund eight new nurse-led primary health care clinics.**
- **Fund seven nurse-led clinics that will provide chronic disease management.**
- **Increase home care expenditures by 30 per cent by 2010 to support persons with chronic conditions and/or older persons to remain active members of our communities. Ensure all new RFPs specify a first right-of-refusal for non-profit agencies.**

Strengthen Medicare: Nursing Workforce as a Priority

Ontario's RN workforce is aging. In 2006, RNs' average age was 45.6 years.[165] Twenty-three per cent of the Ontario nursing workforce is over the age of 55, and therefore able to retire and begin collecting a pension under the provisions of the *Pension Benefits Act.*[166] In the face of an aging nursing workforce, efforts are required to retain the current workforce; absorb and retain new graduates; attract more individuals to nursing; and, reduce workloads.

Nurses suffer from high rates of injury and illness. Female nurses are more likely to experience chronic conditions than the employed female workforce as a whole.[167] Nurses aged 55 or older who have health-related absences averaged more time off than younger nurses.[168]

Nurses have the knowledge and ability to play a pivotal role in all health-care settings. To address the shortage in health human resources, improve access to care, and maintain sustainability, it is imperative that nurses be able to work to their full scope of practice. This will require a number of interrelated changes to the legislative and regulatory environment, funding mechanisms, financial incentives, and practice environments.

As well, the combination of the need to move to a preventive model of health-care delivery and the aging workforce will require a range of nursing health human resource strategies, including: more flexible schedules; increasing the share of RNs working full-time; programs for new graduates and senior nurses; and, equalizing remuneration and working conditions across the home care, long-term care and acute care sectors. It will also require a commitment on the part of the next government to hire more RNs.

Increase Ontario's RN Workforce by 9,000 FTEs by 2010

Since 2003, progress has been made to increase the RN workforce in Ontario. However, Ontario's nurse to population ratio continues to lag behind that of the rest of Canada. Further progress on increasing the share of RNs working full-time and employment of new graduates will improve the quality of Ontarians' health care. To bring the nurse-to-population ratio up to the equivalent of the rest of Canada would require employment of almost 14,000 more RNs.[169] The current government has proved that meeting commitments to increasing the number of nurses is possible. To make progress toward closing this gap, we are asking all parties to commit to increase the RN workforce by 9,000 FTEs. These RNs must be employed in all roles and all practice sectors across Ontario.

RNAO's Position

- **Commit to increasing Ontario's RN workforce by 9,000 FTEs by 2010.**

Commit to 70 Per Cent Full-Time Employment for All RNs

The evidence shows that higher proportions of full-time RN staff are significantly associated with lower mortality rates and improved patient behaviours. [170] [171] Excessive utilization of part-time and casual employment for RNs has been associated with decreased morale and disengagement among nurses, and lack of continuity of care for patients. [172] RNAO has recommended the 70 per cent solution since 2000, and the McGuinty government was the first to adopt this recommendation in 2003. The percentage of Ontario RNs employed full-time has been rising from a low of 50 per cent in 1998 to 61.6 per cent in 2006.[173] RNAO's 2005 survey, *The 70 Per Cent Solution*, found the strongest progress in full-time RN employment took place in the hospital sector, which had conditional, targeted funding.[174] Achieving 70 per cent full-time work across the nursing workforce will require an increased policy intervention. It will require more targeted, conditional funding for the hospital sector, and the introduction of such funding to the long-term care and home care sectors.

RNAO's Position

- **Commit to continue the 70 per cent full-time employment strategy for all RNs, with the goal of achieving this target in all health-care sectors by 2010. This commitment should be backed up by increased targeted, conditional funding in the hospital sector, and the introduction of targeted, conditional funding into the long-term care and home care sectors.**

Guarantee Full-Time Employment for All New RN Graduates

More than 94 per cent of young nurses surveyed for RNAO's *The 70 Per Cent Solution* indicated a strong preference for full-time employment, while only 38 per cent had it.[175] A recent survey of nursing graduates shows that 79.3 per cent want to work full-time, but it can take them up to two years to find a full-time job.[176] Full-time employment is essential for integrating newly acquired academic knowledge into actual practice knowledge and skills. New graduates with full-time employment, mentored by senior nurses, will better serve the needs of the public.

RNAO's Position

- **Commit to continued funding for a full-time employment guarantee for all new RN graduates who wish to work full time.**

Commit to 80/20 Program for RNs 55 Years and Older

The 80/20 program will provide full-time, experienced RNs with the opportunity to spend 80 per cent of their time in direct patient care and 20 per cent of their time in mentoring or other professional development activities. Preliminary analysis of the results of a research project implementing an 80/20 program for all nurses on a unit at University Health Network in Toronto showed positive economic and patient care outcomes:

overtime hours were reduced, sick time stayed low, and variable direct labour costs increases were not higher than those of the control unit. It also showed higher patient satisfaction and shorter length of stay.[177]

In an analysis of the Ministry of Health and Long Term Care late career program funding initiative, 30.2 per cent of respondents indicated that the program had an impact on their retirement plans. Those who indicated a change in their retirement plans said that having a break from nightshifts and from the physical demands and stress of their regular work could allow them to continue working for longer.[178]

RNAO's Position

- **Commit to the 80/20 strategy to offer full-time registered nurses working in all sectors, age 55 and over, the opportunity to spend 80 per cent of their time on direct patient care, and the other 20 per cent on mentorship of new graduates and other professional development activities.**

Equalize Remuneration Across Sectors

A shift from an illness-based model of care to a preventive one will require a shift of nursing services out of the hospital sector and into the community. However, remuneration and working conditions vary greatly between sectors, with superior working conditions and remuneration in the hospital sector. The impact of these differentials has been most evident in the home care sector. This sector has lost 27 per cent of its nursing workforce between 1998 and 2004, and saw an increase in the share of older nurses working in the sector.[179] To retain and attract RNs across all sectors, gaps in remuneration and working conditions must be addressed.

RNAO's Position

- **Equalize remuneration and working conditions for RNs working in acute care, primary care/family practice, home care, and long-term care sectors.**

Enhance Roles and Utilization of NPs

Nurse practitioners in both primary and acute care have been shown to supplement and complement other roles [180] and improve access to health services. However, many nurse practitioners are not being fully utilized, and, for a variety of reasons, are unable to practice to their full scope.[181] [182] [183]

Primary Health Care Nurse Practitioners (RN(EC)s) are registered nurses who are specialists in primary health care. They are experienced nurses with additional nursing education that enables them to provide safe, accessible, and comprehensive quality care to clients of all ages. [184]Acute Care Nurse Practitioners (ACNPs) practice collaboratively

with other health-care providers in a variety of settings and across the continuum of care. They provide advanced nursing care to acutely ill, complex and vulnerable populations. ACNPs can improve access to care and reduce waiting times. [185] Studies have demonstrated that ACNPs provide quality patient and family care, improve patient satisfaction, and are cost effective. [186]

In September 2006, the College of Nurses of Ontario proposed legislative changes for the regulation of Registered Nurses (Extended Class). These changes would integrate ACNPs into the Extended Class registration and enable all NPs to function autonomously without medical directives or delegation, creating four streams of RN(EC) practice: primary health care, acute care adult, acute care paediatrics, and anaesthesia. These changes will allow all NPs to practice to their full scope, increase access to health services, and strengthen patient safety. [187]

RNAO's Position:

- **Enact the College of Nurses of Ontario's proposed legislative changes to the *Nursing Act* and regulations that will incorporate Acute Care Nurse Practitioners into the Extended Class. Enable all RN(EC)s to fully serve the public by eliminating the legislative requirement for consultation and providing for open prescribing for diagnostic tests and pharmaceuticals within their scope of practice.**
- **Fund 150 new NP Primary Health Care positions across health-care settings, including nurse-led clinics, community health centres, family health teams, ERs, and other outpatient settings, in each of the next four years.**
- **Equalize remuneration and working conditions for Primary Health Care NPs working in nurse-led clinics, community health centres, and family health teams.**
- **Fund 50 new RN(EC) positions across all other streams of practice, including NP Acute Care Adult, NP Acute Care Paediatric, and NP Anaesthesia, in each of the next four years.**

Support Expanded Roles for RNs

Expanded roles for nurses maximize health-care resources and enhance access to services. Supporting these roles will help Ontario to keep more nurses in our health-care system and potentially act as a magnet for those considering a career in nursing.

Nurses in many European countries practice in a number of expanded roles and in a diversity of venues, including emergency departments and nurse-led clinics, to provide care and support for clients and their families. These services have been shown to achieve positive outcomes for clients and practitioners. [188]

Registered Nurse First Assists (RNFAs) are registered nurses with additional certification in surgical assistance. RNFAs work with the surgeon and operating room team to provide

safe patient care before, during, and following surgery. [189] Patient outcomes have shown to be positively impacted by implementation of the RNFA role indicated by decreased patient anxiety, facilitation of continuity of care,[190] and decreased surgery time and turnover time between cases. [191]

Colorectal cancer is the second leading cause of cancer death in Ontario and the leading cause of death amongst non-smokers. [192] It is one of the most curable and preventable cancers if detected early. Currently, only 10 per cent of Ontarians aged 50 to 74 are being screened for colorectal cancer. This number is far below that in other countries, including the UK and Australia. [193] Nurse endoscopists, who are registered nurses with extended specialized education, are able to perform flexible sigmoidoscopy, providing care that is safe and cost effective. [194] Utilizing these nurses would enhance Ontario's capacity to screen for colorectal cancer.

Ontario has provided some leadership in new roles for RNs, including Registered Nurse First Assists (RNFA) and nurse endoscopists. However, these roles are yet to become permanent, and episodic funding has created a movement of nurses in and out of roles leading to cancellations of services and delays in care. It is imperative that stable funding is allocated to ensure the security of these roles.

Utilizing the skills, ability and knowledge of registered nurses in different roles is a viable, practical option to providing care for the people of Ontario.

RNAO's Position:

- **Provide base funding for expanded practice nurses such as nurse endoscopists and Registered Nurse First Assists.**

Increase Nursing Enrolments

Significant numbers of new graduates are needed not only to meet the needs of a growing and aging population, but to replace the large number of nurses who are expected to retire in the coming years. The current government's long-standing commitment to funding 4,000 first-year seats in nursing programs is very important.[195] Given the growing need to increase the supply of nurses, that number must be increased in the future. However, there are constraints to educating more nurses: faculty; funding to support nursing education; and, access to practice education.

Nursing schools need more faculty to teach growing numbers of students, reflecting a province-wide problem in higher education where Ontario lags behind the rest of Canada and lags behind its own history with respect to faculty-to-student ratios.[196] [197] The 2005 Rae Review on post-secondary education cited reports that 11,000 new university faculty and 7,000 new college faculty would be needed by the end of the decade.[198] This need is particularly urgent in nursing.

Another constraint to expanding nursing enrolments is limited space. The Rae Review recommended that Ontario spend $540 million per year over ten years for post-secondary education on facility renewal ($200 million) and on new facilities and equipment ($340 million, including $40 million for instructional equipment in colleges).[199] The Council of Ontario Universities estimates that deferred maintenance costs now require an expenditure of $260 million per year.[200]

Practice education is a cornerstone of health profession/provider education. A coordinated system for placements requires the capacity for inter-professional placements, deployment of students in an emergency situation, and data analysis and reporting.

Primary health care nurse practitioner practice is advanced practice that requires educational preparation at the graduate level.[201] Moving to preparation at the graduate level will enhance support for nurse practitioners to achieve a high quality practice and patient safety. Continued evolution of education for all nurse practitioners is necessary to ensure consistency with national core competencies for nurse practitioners and existing standards in other jurisdictions. It will also support recruitment to the profession.

Addressing these pressing needs for nursing education will require government investment. Currently, for undergraduate nursing students the operating grant per full-time equivalent student is $7,858. For undergraduate medical students, an estimated $22,000 in base operating grants is provided for each full-time undergraduate enrolment. In an acknowledgement of the increased costs associated with increasing enrolments, the government is providing about $49,000 per FTE for the approximate 700 new first-year undergraduate medical spaces created since 2000 in 2006-07.[202] Doubling the value of the operating grants for nursing students would bring welcome resources, and begin to close the gap in support between nursing and medical education.

RNAO's Position

- **Continue to invest in nursing faculty by providing financial support to increase the number of students enrolled in nursing PhD programs, paying tuition for nursing faculty enrolled in PhD programs, and support enrolment in Masters nursing programs.**
- **Double the value of operating grants per full-time equivalent undergraduate nursing student.**
- **Implement a provincially coordinated system for practice education -- a system that will efficiently coordinate placements for a broad range of health disciplines and programs.**
- **Provide support for Nurse Practitioner education at the graduate level.**

Integrate Internationally Educated Nurses who Choose to Make Ontario Their Home

The exodus of skilled health professionals from areas with high unmet health needs has placed Africa at "the epicentre of the global health workforce crisis."[203] RNAO is mindful of our responsibility not to contribute to global health inequities[204] and of the human[205] and economic[206] costs of stripping vulnerable populations of access to health care due to migrating health professionals. For this reason, RNAO supports the World Health Organization,[207] the International Council of Nurses,[208] and the Canadian Policy Research Network[209] in calling for ethical international recruitment guidelines within the context of a responsible national and provincial health human resources strategy.

RNAO also acknowledges the right of individual nurses to migrate, and, therefore, that there should not be any systemic barriers to internationally educated nurses (IENs) with permanent status in Canada from practicing their profession and serving the public. IENs are an increasing share of the nursing workforce in Ontario. In 2005, IENs accounted for 34.1% of new RNs.[210] Recent research shows that IENs face challenges at all stages of the process of moving into practice in Ontario. These include: difficulties and delays completing the application process for licensure; required investments in upgrading and further education to become eligible to take the RN exams; difficulties writing the exam due to lack of familiarity with Ontario nursing culture and with exam formats; and integrating into the nursing workforce. As a result, pass rates for IENs were much lower than for nurses educated in Ontario.[211]

There are several existing programs that facilitate registration of IENs in Ontario. The CARE Centre for Internationally Educated Nurses has had success in assisting internationally trained nurses to prepare for qualifying exams once they have met their academic requirements. There are bridging programs at Mohawk College/McMaster University, Algonquin College/University of Ottawa, and York University. The Post-RN Bachelor of Science in Nursing Program at York offers a 20-month program for internationally trained RNs to more quickly meet current academic entry-to-practice requirements in Ontario. The first class graduated in December 2006. The program also offers an intensive ESL component created for health professionals.

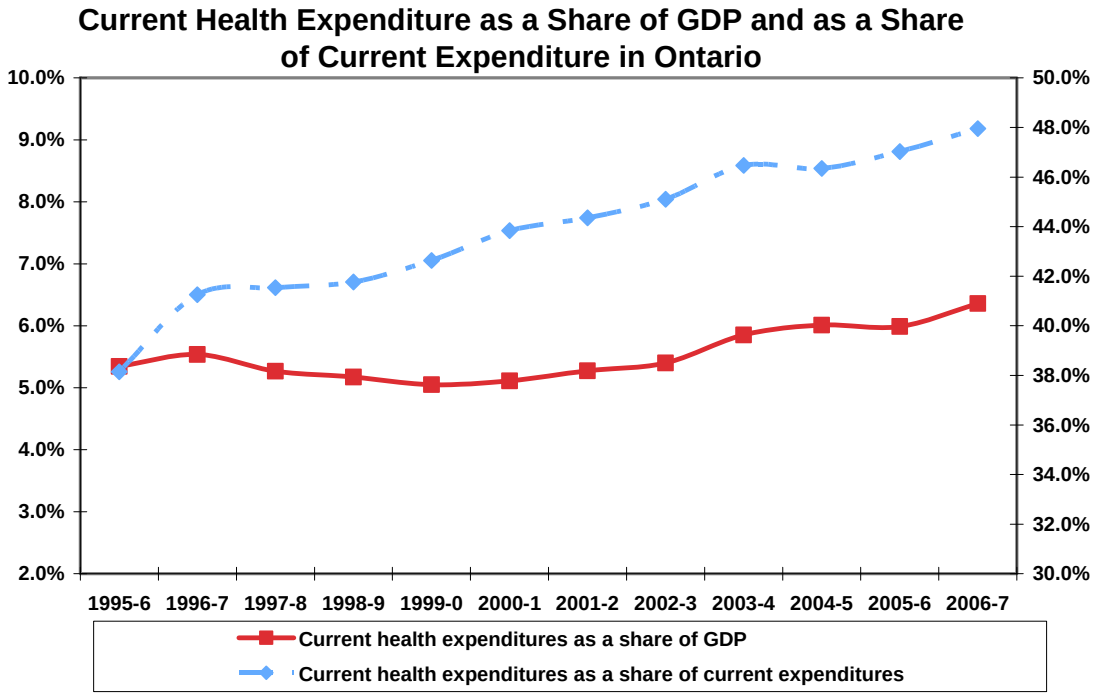
RNAO's Position

- **Ensure that government and those health organizations funded by the government do not engage in active international recruitment of nurses and other health professionals.**
- **Ensure that internationally educated nurses who make Ontario their new home face no systemic barriers to practice their profession.**
- **Establish permanent funding for existing upgrading and bridging programs for internationally educated nurses who make Ontario their new home.**

Increase Fiscal Capacity: Government Revenue and Expenditures are Social Choices

RNAO's proposed investments in the health of Ontarians and in nursing will, in the short run, result in an increase in government expenditures of $4 billion rising to $6.2 billion in the fourth year. This would constitute, in the first year, only 4.4 per cent of total 2007-08 expenditures.

There are those who would suggest that proposals to increase spending on health care are irresponsible, as health spending is taking up an increasing share of government expenditures. The chart below shows that provincial spending on health has moved in a narrow range between 5.2 and 6.5 per cent of GDP over the last 12 years. At the same time, the chart shows health spending taking up an increasing share of total program spending -- a dramatic increase from 38 per cent to 48 per cent.

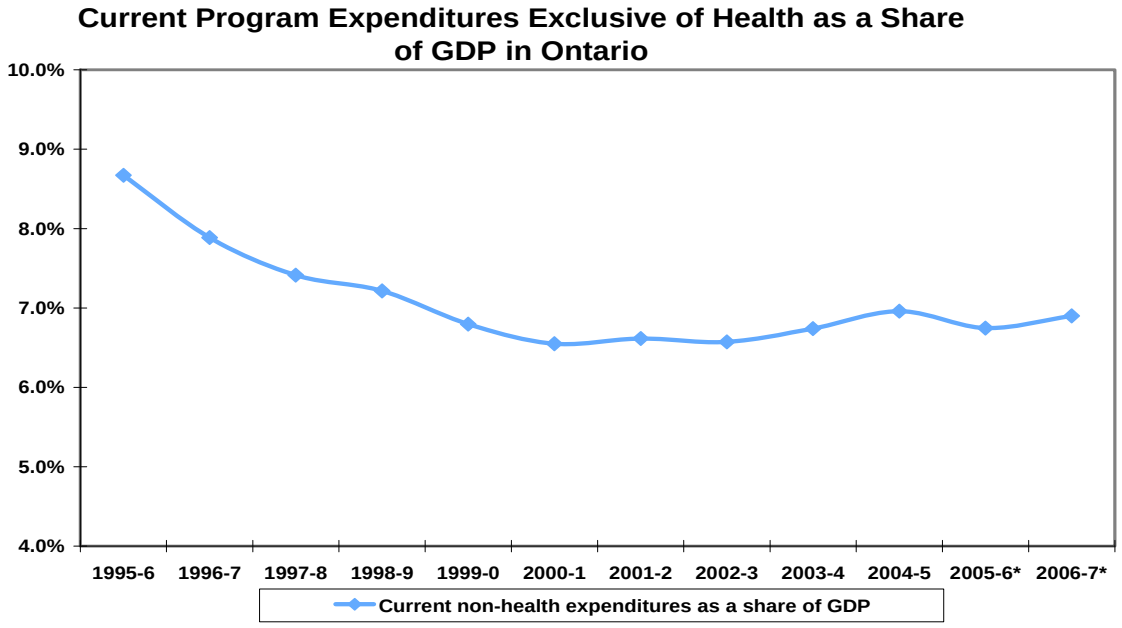


Source: Ontario Budgets and author's calculations

Arguments have been made that health care's increasing share of program spending is due to a number of complex issues from technological changes and poor cost control to demographics. In fact, the share of health care of total program expenditures reflects something much simpler – government policy choices. It reflects the previous government's public policy program of reducing taxes and public services. While the current government has made some progress in rebuilding Ontario's public services, those aforementioned tax cuts have left an enduring legacy. Ontario's fiscal capacity remains $15 billion behind where it would have been had those tax cuts not been implemented.[212]

Spending on Social Determinants of Health has Fallen

Chart 2 shows program spending exclusive of health care as a share of GDP. During the tenure of the previous government, spending on these program areas dropped sharply as a share of GDP – to a low of 6.5 per cent in 2000. While this ratio rose over this government's term, it remains at or below 7 per cent of GDP. Between 1995-96 and 2003-04, the previous government's deepest funding reductions were for social services, housing, and transfers to municipalities.[213] These program areas are the ones that have the largest impact on the health of Ontarians –as they alleviate poverty, provide adequate housing, contribute to public health programs and increase participation in our parks, schools, and community centres.



Source: Ontario Budgets and author's calculations

The health of Ontarians depends on an enhanced commitment to a reinvestment in public services. We are asking all parties to commit to the necessary increase in fiscal capacity.

RNAO's Position:

- **Increase tax revenues to ensure that there is sufficient fiscal capacity to enhance the health of Ontarians through increased social spending.**

- **Phase in a carbon tax and other environmental taxes to achieve environmental objectives, and use revenues to support the social programs and services most needed by at risk populations.**

- **Reverse the regressive tax cuts implemented by the previous Ontario government, which have had a negative impact on Ontario's fiscal capacity, the health of our cities, and the social fabric of our society.**

Platform Costs

	Annual cost $s Millions Year 1	Year 2	Year 3	Year 4
What Keeps Us Healthy and What Makes Us Sick: Focus on Social Determinants of Health				
Ontario Child Benefit	76	583	440	374
Increase Ontario Works and Ontario Disability support program	1,200	1,315	1,430	1,545
Increase Affordable Housing	1,310	1,310	1,310	1,310
Best Start and Healthy Babies, Healthy Children	600	750	900	1,200
Strengthen Medicare and Nursing: Focus on Community Care				
Increased numbers of Nurse Practitioners	29	59	92	128
15 nurse-led clinics	5	9	19	25
Increase in home care funding	172	352	552	574
Strengthen Medicare and Nursing: Nursing Workforce as a Priority				
70 per cent full time funding	68	138	216	225
80/20 Program	71	74	77	80
Increase employment of RNs in Ontario	77	157	247	257
Support for Internationally Educated Nurses	5	5	6	6
New Graduate Program	70	73	76	79
Equalizing RN wage rates across sectors	232	241	251	261
Support for Nursing Faculty	3	3	3	3
Increased funding for Nursing Education Programs	77	83	84	91
Base funding for roles in hospitals	3	5	9	12
Total	3,998	5,157	5,712	6,170

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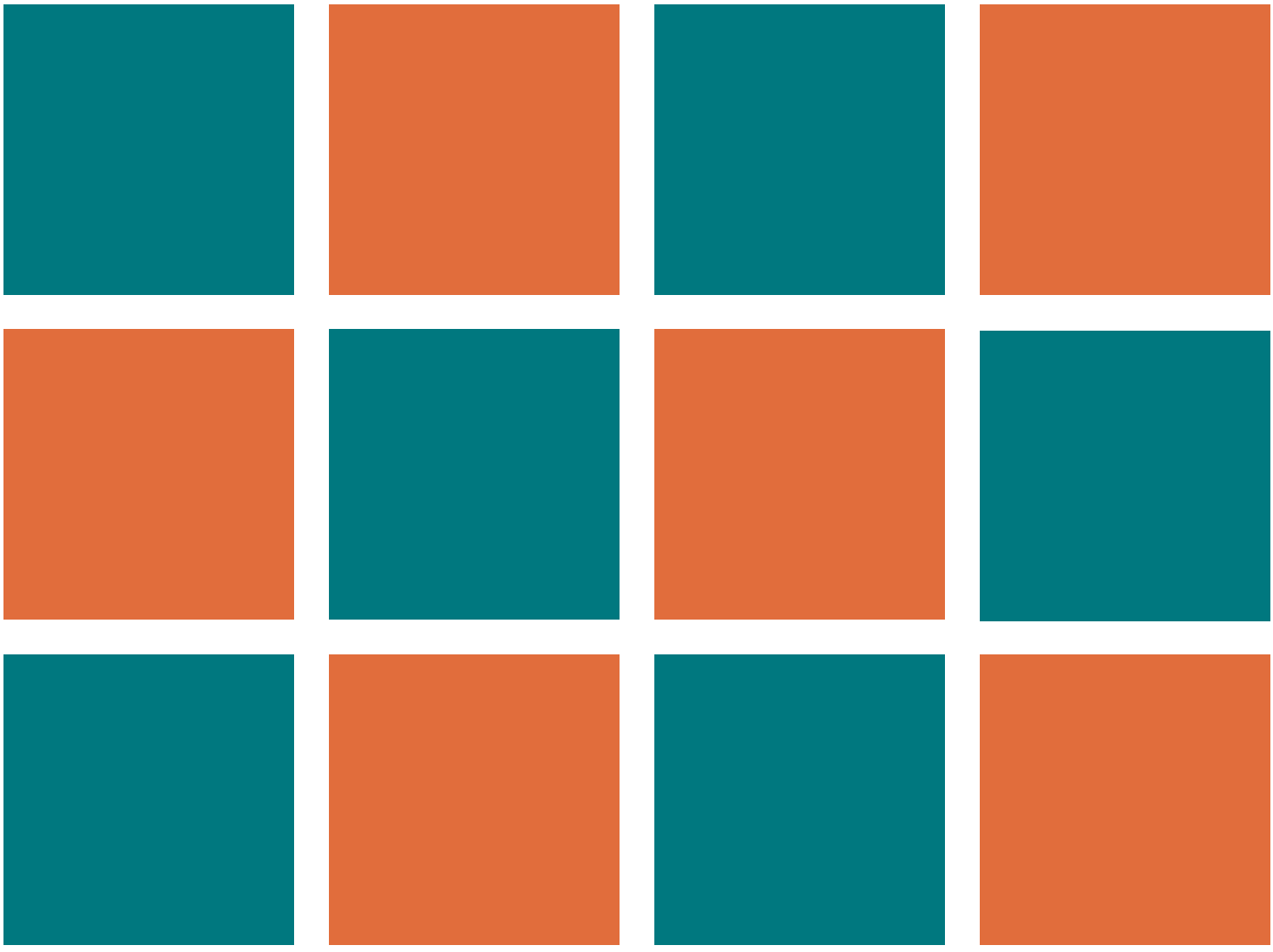

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