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

Submission to the Canadian Nurses Association National Expert Commission on Transforming the Health-Care System

Registered Nurses'
Association of Ontario

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RNAO Recommendations to the CNA National Expert Commission on Transforming the Health-Care System

- Address income inequality as a key determinant of mental and physical health, linked to lower life expectancy, greater exposure to environmental damage such as climate change and toxics, decreased educational performance, increased violence and decreased social mobility.

- Strengthen Canada's publicly-funded, not-for-profit health care system and reject efforts to commercialize or privatize health care delivery.

- Oppose the negotiation of comprehensive trade agreements that seek to undermine the ability of governments to regulate or implement programs in the public interest such as publicly-funded, not-for-profit health care.

- Support examples of successful innovations that are proven to produce better outcomes and value within the publicly-funded, not-for-profit system, such as the 80/20 program for late-career nurses, Registered Nurse First Assists and advance practice nurses, targeting 70 per cent full-time nurses in all sectors, new nurse graduate guarantee initiatives, long-term care best practice coordinators and all RNs and NPs working to full scope.

- Fully utilize nurse practitioners and RNs in primary care, community care, long-term care and acute care, including funding for innovations such as NP-led clinics as pioneered in Ontario, and other inter-professional primary care models.

- Guarantee all Canadians timely access to team-based primary care, within a strong primary health care system.

- Ensure nursing leadership in primary care sets the agenda on quality and accountability in primary care service provision, research, administration and governance.

- Increase investment in home care services, including homemaking and professional services, to support persons with chronic conditions and/or older persons so that they continue to remain active and vibrant members of our community.

- Provide incentives for collaboration of all community health care partners, including mental health and chronic disease management, in addition to home care services.

- Reject competitive bidding as a method of allocating funding for home care.

- Expand the publicly-funded, not-for-profit health care system to include a comprehensive national home care and pharmacare strategy, and a strategy for mental health and addictions.

The Registered Nurses' Association of Ontario (RNAO) is the professional organization representing registered nurses in Ontario. It is the strong, credible voice leading the nursing profession to influence and promote healthy public policy. We welcome the opportunity to contribute to the CNA National Expert Commission's vitally important and timely consultation with Canadians on transforming and strengthening our treasured publicly-funded, not-for-profit health care system.

A. Improving Health by Acting on the Social and Environmental Determinants of Health

According to the World Health Organization's Commission on Social Determinants of Health, "social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death."[1] The "new progressive"[2] global Occupy Movement has put the spotlight on growing economic inequalities that underpin vast power differentials that erode democratic processes so necessary for individual and collective health. Income inequality in Canada has increased over the last 20 years[3] and the increase in income inequality has been greater in Canada than in the United States since the mid-1990s.[4] The richest one per cent in Canada are taking more of the gains from economic growth than ever before in recorded history.[5] Understanding these trends is crucial as the evidence grows that the costs of inequality include worse mental and physical health, lower life expectancy, decreased educational performance, increased violence, and decreased social mobility.[6]

As health inequities are unfair, unacceptable, and largely avoidable, they are a shared responsibility that requires engagement of all sectors of government and all segments of society.[7] The voice of nursing must be aligned with the wisdom of social movements and public interest civil society organizations who are demanding "governments fulfill their obligations to act to guarantee social rights and state protection."[8] In particular, it is critical to address the clout of financial capital in the global economy by initiating and enforcing international tax mechanisms to control global speculation and eliminate tax havens.[9] Global trade agreements and regulations need to be refashioned to ensure equity-based social protection systems, including protecting publicly financed and publicly provided not-for-profit health systems.[10]

The Chief Medical Officer of Health of Ontario has called for the application of a "health lens to every program and policy" so that the health impacts and benefits of various decisions may be known.[11] [12] The Chief Public Health Office of Canada has emphasized the need to approach "problems from all sides with coordinated, multi-pronged, intersectoral action."[13] In addition to monitoring progress and holding governments accountable for action on the social determinants of health, it is also vital that health impact assessments be used "to document the ways in which unregulated and unaccountable transnational corporations and financial institutions constitute barriers to Health for All."[14]

The Registered Nurses' Association of Ontario's **Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Partie**s is grounded in the values of human rights in its pursuit of transformative change that seeks to improve health, the health care system, and access to nursing services.[15] One of the key principles articulated in that document is fairness and respect for our first peoples: "vibrant communities mean respect for the right of our first

peoples to self-determination and equitable access to resources, jobs, health care, clean water, good schools and safe housing."[16] Canada's nurses must find meaningful ways to support First Nations, Métis, and Inuit communities that continue to struggle with living conditions that are harmful to health and human dignity.[17] [18]

Evidence of the connection between the environment and health is well established. The World Health Organization estimates that environmental factors account for 24 per cent of the world's burden of disease and 23 per cent of all deaths.[19] Environment is estimated to play a larger part in some conditions, such as asthma (44 per cent).[20] Climate change itself affects human health, by contributing to extreme weather events, killer heat waves, poor air quality, and vector-, rodent-, food- and water -borne diseases. By fighting global warming, we are not merely protecting the environment – we are protecting the health of Ontarians. Creating vibrant communities means building healthier environments through cleaner air and water; creating good green jobs on a base of equity and environmental sustainability; getting serious about climate change; and reducing toxic substances and other pollutants in the environment, in our workplaces, in our consumer products, and in our food and water.

As the principle of environmental justice reminds us, the costs of environmental damage and climate change are disproportionately borne by lower income people.[21] This is particularly true at the global level with climate change; it is the most vulnerable people in developing countries that are at greatest risk of inequity. These are the people who did the least to cause global warming. Human-generated greenhouse gases that further global warming are likely to exacerbate droughts in sub-Saharan Africa and threaten a "catastrophic reversal in human development."[22] When confronting the social and environmental determinants of health in Ontario, we must consider the impact on our most vulnerable populations, particularly Aboriginal people. Social justice, clean air and clean water all must be recognized as human rights and the starting point if we are to be serious in improving individual, community and population health.

B. Publicly Funded and Not-For-Profit Health-Care Delivery are Non-Negotiable

There is widespread support among Canadians for our publicly funded, not-for-profit health care system, with recent polling showing that 94 per cent of Canadians support public, not private for-profit, solutions. This is up about ten per cent from a similar poll one year ago, indicating growing support as governments engage in re-negotiating the 2004 Health Accord.[23] Any doubts that publicly-funded not-for-profit health care provides better care and better value are quickly allayed by a look south of the border.

Commercialization of health care in the United States has not served its population well. There were 49.9 million Americans (16.3 per cent of the U.S. population) without any health insurance in 2010[24] while the U.S. was still the outlier nation in terms of health expenditures among OECD countries. Total health spending accounted for 17.4 per cent of GDP in the United States in 2009 compared with the average of 9.5 per cent in OECD countries and 11.4 per cent for Canada.[25] In terms of total health spending per capita, the United States with $7,960 USD (adjusted for purchasing power parity) spent more than twice the OECD average of $3,223 USD in 2009.[26] Total health spending in Canada accounted for 11.4 per cent of GDP in 2009, with spending of $4,363 USD per capita.[27] The OECD estimated that Canada's health share of GDP had dropped to 11.3 per cent in 2010.[28]

Robert Evans provides strong evidence that market approaches to health care reform have a "redistributive agenda" that is both more costly for health care systems as a whole and privileges those who are healthy and wealthy.[29] "Any shift from public to private financing, by whatever means, will necessarily transfer costs from those with higher to those with lower incomes, and from the healthy to the ill."[30] Private insurance[31 32] and medical savings accounts[33 34] are two examples of non-public financing common in the United States that would increase inequities in health outcomes and in access and quality of health care while costing more.

It is critical that nurses remain attentive to these power dynamics as well as to language that signals support for privatized, for-profit entrepreneurial health care. For example, persistent calls for for-profit financing and delivery of certain health services are often cloaked as "innovation" and "patient choice". Flirting with for-profit health care must be rejected, in the strongest possible terms based as thorough review of the evidence shows that for-profit delivery produces worse patient outcomes, and is more expensive than not-for-profit delivery.

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."[35] Private contracting in the U.S. Medicare program for seniors through the Medicare health maintenance organization (HMO) contracting program is a cautionary tale in that it evolved into a multi-billion dollar subsidy for HMOs who often cherry-pick the healthiest clients while refusing those most acutely and expensively ill.[36] The experience of public-private competition in the United States is that for-profit "firms carve out the profitable niches, leaving a financially depleted public sector responsible for the unprofitable patients and services."[37]

Considerable evidence is available on quality of care differences between for-profit and not-for-profit delivery across sectors. Studies show that the quality of care in for-profit institutions is lower.[38 39 40 41 42] |The most conclusive evidence comes from systematic reviews and meta-analyses of peer-reviewed literature on for-profit versus not-for-profit health care, which found higher patient mortality rates in for-profit as compared to not-for-profit centres.[43 44 45] One compelling example is that patients attending for-profit dialysis had eight per cent higher death rates than those who received care at non-profit facilities. This translates into an estimated 2,000 premature deaths each year in the United States linked to for-profit dialysis.[46] Furthermore, worse health outcomes have also come with higher costs: a systematic review and meta-analysis of peer-reviewed literature concluded that for-profit hospitals charged a statistically significant 19 per cent more than not-for-profit hospitals.[47]

Canadian evidence from the long-term care sector has found that staffing levels were higher in not-for-profit facilities than in for-profit facilities,[48] and health outcomes were better in not-for-profit facilities.[49 50] Differences in staffing were likely to result in the observed differences in health outcomes.[51] 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.[52] A systematic review and meta-analysis published in 2009 confirmed that the evidence suggests that, on average, not-for-profit nursing homes deliver higher quality care than for-profit nursing homes.[53] This meta-analysis estimated that pressure

ulcers in 600 of 7,000 residents with pressure ulcers in Canada and 7,000 of 80,000 residents with pressure ulcers in the United States are attributable to for-profit ownership.[54]
The research evidence is clear – Canadians will benefit most from strengthening the public financing and not-for-profit delivery of health services. This is precisely why the RNAO joins many other civil society groups in opposing comprehensive trade agreements that are inevitably negotiated behind closed doors and seek to undermine the ability of governments to regulate or implement programs in the public interest such as health care.

The above does not mean that systemic changes and innovations are not necessary and achievable, but these are best accomplished through strengthening our health care system. Michael Rachlis has identified many success stories in the public, not-for-profit system in improving clinical services, reducing wait times and decreasing costs.[55] [56] [57]

C. Innovation in the Not-for-Profit System: Innovative Models of Care Delivery, Quality and Technology

Given the changing health care needs of Canadians, as well as the growing complexity and fractured nature of our current health care system, innovative solutions are called for, within the context of not-for-profit delivery.

According to a September, 2011 World Health Organization report, 89 per cent of all deaths in Canada result from non-communicable diseases (ie. diabetes, respiratory diseases, cancers, and cardiovascular diseases).[58] Continuing to fund and manage health care services primarily structured to treat communicable diseases and acute episodes of illness rather than preventing and treating chronic and non-communicable diseases will perpetuate ineffective, inefficient and costly care. While the need to increase public funding of health care services that would assist in the care of chronic diseases (ie. home care, pharmacare, and diagnostic equipment including MRIs), remains, new and innovative service delivery options for already insured services do not require additional spending.[59] Restructuring to achieve high quality care will in fact strengthen our treasured health care system, in part by improving access and controlling costs.[60] We must spend better and and smarter, instead of focusing on cost reduction."[61]

Scaling up Validates Innovative Models of Care Delivery

Working together in high-functioning inter-professional teams reorients the system to focus on the person receiving care.[62]Current examples of successful innovations that produce better outcomes and value that should be replicated nationally include: 1) Nurse Practitioner-led clinics,[63] [64] 2) Registered Nurse First Assistants,[65] 3) the 80/20 principle for innovative professional development,[66] 4) targeting 70 per cent full-time nurses in all sectors; 5) new nurse graduate guarantee initiatives [67] 6) LTC Best Practice Coordinators[68] 7) defining and integrating APN role and responsibilities[69] and 8) all RNs and NPs working to full scope.

For example, RNAO has long campaigned for 70 per cent full-time employment for all nurses.[70] Full-time RNs increased from a low of 50 per cent in 1998 to 67.9 per cent in 2011 (68.2 per cent if nurse practitioners are included). [71] This dramatic progress has resulted in better retention, better quality of patient care, and more people wanting to enter the profession. Moreover, employing full-time instead of casual agency nurses ensures the continuity of care,

continuity of caregiver and workforce stability that is associated with lower mortality rates and improved patient behaviours. [72] [73] [74]

Full Utilization of RNs and NPs

In August, 2011, landmark legislation was proclaimed that enables Ontario's NPs to maximize their potential within the acute care system. Legislation and complementary regulations in the *Public Hospitals Act* support NPs to autonomously treat and discharge hospital inpatients. As of July 1, 2012, NPs will also be authorized to admit patients into hospital.

Other groundbreaking enhancement to NPs, RNs and RPNs scope of practice in Ontario includes:

- Nurse practitioners can autonomously prescribe medications appropriate to patient care, rather than from a pre-determined list
- A restrictive list of laboratory tests that NPs are authorized to prescribe has been removed
- NPs are authorized to set and cast fractures of bones and dislocations of joints.
- NPs are enabled to dispense, compound and sell medications in certain situations
- RNs and RPNs will be able to receive patient care orders from NPs

Enabling NPs to provide these services not only improves hospital quality measures, patient safety, cost-effectiveness and patient flow, it also nurtures an equitable, collaborative professional paradigm that motes excellent value within the not-for-profit system.

In November, 2011, the RNAO announced the creation of a task force to recommend ways to maximize utilization of primary care/family practice nurses. There are currently 4,285 family practice nurses in Ontario, of whom 2,873 are RNs and 1,412 are registered practical nurses. To bring about transformational change in Ontario's primary care system, the doors must be opened to utilize all health care professionals to their maximum scope of practice. For example, family practice nurses are ideally positioned to coordinate care at home, conduct "house calls", and assume a navigating role. By leveraging their central role, family practice/ nurses can help build a primary health care system that promotes health equity and addresses root causes of health disparities, including addressing the social and environmental determinants of health. Since 2002, some primary care RNs in the UK have been functioning in an expanded role as independent nurse prescribers. Increasing access to needed medications and maximizing the skills of all health professionals are two reasons the British government championed this expanded role. Independent nurse prescribers are "first level" registered nurses who have completed a specialized certification training course. They are responsible and accountable for patient assessments and clinical management, including prescribing. In some jurisdictions, the nurse prescriber must work in partnership with a mentor for a specified period of time before working autonomously in the role. Independent nurse prescribers do not work from a formulary list of permitted medications but rather are authorized to prescribe any medication appropriate for patient care within their competence, knowledge and skill. In an evaluation published in 2010, nurse prescribing was found to be safe and clinically appropriate and widely accepted by patients.[75]

Technology Serves to Improve Quality of Care

Information technologies that improve the efficiency of administration, documentation and reporting may free up time and resources that can be used to enhance service delivery.[76] Assistive technology can improve workforce capacity and client independence. [77] Both serve to reduce costs (goods, services and time), while improving quality of care. New strides in point of care information technology should focus on coordinating care while reducing the proportion of time nurses spend on documentation. Assistive technology, such as hand-washing reminders, and weightless transfer devices, should reduce morbidity in nurses who are disproportionately prone to illness and injury.[78] Nurse fatigue may also be minimized by technological enhancements to workplaces that incorporate best practice design principles to optimize lighting, reduce noise and interruptions, improve lines of sight, and reduce walking distances.

Better Care and Better Value in Primary Care

At its best, primary care is a person-oriented entry point to the health care system which fits within the bounds of a strong primary health system. It may encompass health promotion, primary and secondary disease prevention and health maintenance and restoration across the life span.[79] [80] [81] [82] In Canada, however, primary care is often framed by disease-oriented models of care and dominated by family physicians.[83] [84] Federal policy in the form of the *Canada Health Act* constructs and reinforces this system by guaranteeing funding for family physicians, but no other health or community services, outside of the hospital setting.

Canadians need equitable and timely access to primary care services that will seamlessly address physical, mental and social health needs. This includes access to a variety of health care providers, community supports, and treatments and medications. Such a system ideally builds from teams of nurses and other health care providers collaborating with individuals and communities to provide safe, timely, relevant, accessible and efficient services.[85] [86] [87] As of 2012, Ontario will have 26 functioning NP-led clinics across the province, joining Community Health Centres and other inter-professional models in providing access to high quality primary care for thousands of people.

Thousands of Canadian Registered Nurses and Registered Practical Nurses play varied and critical roles as system navigators, health promoters, clinicians, advocates, collaborators and educators in primary care.[88] In some places, the primary care nursing role has the potential to be strengthened significantly through leadership and increased recognition of the immense opportunities this nursing role provides for the health care system as a whole. As partnerships between primary care and public health increase, RNs are particularly well equipped, with a client-centered, population health perspective to show the way as leaders, researchers, administrators and front line providers in primary care across the province.

Home care – **It's Time!**

High quality home care keeps our communities vibrant by allowing people with acute and chronic health conditions to remain independent, active and involved. The home has become a principal site for efficient health care delivery across Ontario and Canada. Home care provides

critical support services, from post-hospitalization follow-up to homemaking and personal care.[89]

However, as people are being discharged from acute care settings "quicker and sicker", access to care that was until recently provided in hospitals and assured under the *Canada Health Act* is being eroded.[90] A Canadian home care strategy is critical. It must balance individual and family self-reliance with guarantees for the provision of core health care services including access to registered nurses. Advances in treatments and technology, limited resources, decreased length of hospital stay, increased day surgery treatment and changes in expectation have significantly increased the care requirements of today's community client. [91] [92] Direct and indirect health care costs, such as wound care supplies and lost wages secondary to caregiving responsibilities are being passed from the public sector to individual patients and families.[93] Wages for professionals and formal (paid) caregivers in the home care sector remain low when compared with the hospital setting but nonetheless we are seeing increasing volumes and complexity of nursing care provided in the home. [94] Home care policy must take into account the importance of nursing workforce stability for continuity of care and patient safety, in addition to adequate funding all the services required to keep people well in their homes.

Use of competitive bidding in the home care sector is antithetical to client-centred care as it inevitably leads to contracts awarded on the basis of price rather than quality. Ontario is the only province relying exclusively on competitive bidding, and home care is the only health sector in Ontario where direct care is contracted out. It is not a model that should be replicated in other jurisdictions. As Ontario's Auditor General has noted in several reports, the suggested benefits of a competitive model have never been realized while many unintended consequences have left Ontario with an ailing and debilitated home care sector.[95] [96]Within a competitive bidding system, for-profit agencies have edged out not-for-profit organizations who have historically offered higher wages, more stable working conditions, superior quality of care and more transparent accountability structures.[97] [98]

National Pharmacare Program

As with home care, increasing and improving access to health care, equity and sustainability requires an expansion of the publicly-funded, not-for-profit system to cover the cost of pharmaceuticals. In 2009, spending on drugs accounted for 16.4 per cent ($30 billion) of health expenditures in Canada.[99] The share of health care spending on drugs has nearly doubled over the last 30 years and now makes up the second largest proportion of health care spending, after hospital care.[100] With drugs being a major driver of health care costs, priority should be given to a standardized, national, publicly funded and publicly controlled pharmacare program covering essential drugs. Since 1997,[101] calls for a pan-Canadian pharmacare program have accelerated, including high-profile recommendations such as those arising out of the Romanow Commission.[102] [103] [104] Such a program would provide equal access to prescription drugs across the country and keep the rising cost of prescription drugs in check.

Access to Mental Health and Addiction Services

Tackling mental health and addictions issues is vital for the health of individuals, families, and communities. It is estimated that at least 60 per cent of individuals diagnosed with a mental illness also have addictions. Mental health and addictions account for nearly 12 per cent of the

overall burden of disease, yet a province such as Ontario consistently spends only five per cent of the provincial health budget on mental health and addictions.

In its report *Every Door is the Right Door,*[105] the Ontario government points out that in total, including lost productivity, law enforcement, and disability claims, drug costs, and employee assistance claims, mental health and addictions cost Ontario at least $39 billion per year. Every dollar spent on mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs.

A mental health strategy must be developed that is delivered at the individual's preferred location, with special consideration for: members of Aboriginal communities; older adults tackling new and ongoing mental health and addictions challenges; people from racialized communities; new Canadians; people with disabilities; discharged members of the Canadian Forces, especially those who were in combat roles; children and youth requiring increased and enhanced mental health and addictions services; and, inmates in correctional facilities and rehabilitated ex-convicts.

People facing mental health and addictions challenges must receive respectful, equitable, appropriate, and seamless client-centered access to health and social services. Stigma in perceptions, attitudes, and actions needs to be addressed.

D. What do we need from nurses, other health professionals, governments and the public **to address the challenges that we're facing?**

As the CNA National Expert Commission heard in a Toronto focus group[106], economic anxiety is increasing while public awareness of economic inequality and health inequities remains low, despite the "Occupy" movement beginning to shine a light on the growing gap separating the top one per cent and the vast majority of Canadians. Nurses were reminded by focus group participants of the tremendous support and credibility they have as a profession, and the potential influence that over 266,000 registered nurses can have as a force for change.[107] To meet the most pressing health challenges that Canada faces, it is critical that Canada's nurses work together with civil society groups, health professionals that share the same commitment to equity, and the public, especially those who have been marginalized, to transform government and other societal structures in order to build a more just society. The Final Report of the Commission on Social Determinants of Health,[108] the Rio Political Declaration on Social Determinants of Health,[109] and the Rio Declaration by Public Interest Civil Society Organizations and Social Movements[110] provides a strong framework for action to decrease health inequities.

Conclusion

The RNAO appreciates the opportunity to have input into the important and historic work of the CNA's National Expert Commission.

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