

**SUBMISSION**

**ON**

***2011 PRE-BUDGET CONSULTATIONS***

**TO**

**STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS**

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## **Summary of ONA Priority Recommendations for 2011 Budget**

ONA proposes the following recommendations for priority action in the 2011 budget.

1. Fund policies that create and protect RN positions, particularly in the hospital sector, and focus on retention initiatives, such as funding for late-career and mid-career nursing initiatives. We urge the government to adopt a policy to retain full-time equivalent RN positions (including current RN vacancies) employed in hospitals while implementing initiatives to make significant progress to move toward the non-Ontario RN to population ratio.
2. Provide annualized dedicated funding for late-career nursing initiatives, instead of approval in late fall, which does not allow sufficient time for employers to utilize the funds prior to the end of the fiscal year.
3. Expand additional bridging seats from RPN education programs to RN education programs.
4. Increase additional second-level entry RN programs, such as the two-year post-graduate program at the University of Toronto.
5. Direct hospitals to comply with regulation 965 under the *Public Hospitals Act*, specifying every hospital must put in place a functioning Fiscal Advisory Committee and shall make recommendations to the board regarding operations and staffing in the hospital. Informed consultations with FACs must take place prior to any further RN reductions being considered, and staff nurse input must be included in decision-making related to administrative, financial, operational and planning matters in hospitals.
6. Continue progress toward a culture of safety in the healthcare sector by way of funding for healthy work environments directed to improve RN staffing and reduce patient workloads for RNs, which will reduce the costs to the healthcare system of illness and injury of nurses.
7. Fund a regulated minimum staffing standard in long-term care homes at an average level of 3.5 *worked* hours of nursing and personal care per resident per day (including .68 RN hours).
8. Enhance funding for mandated public health programs and implement accountability measures for Boards of Health.
9. Implement a policy of wage parity for home care nurses.
10. Postpone corporate tax cuts.

## Introduction

The Ontario Nurses' Association (ONA) is the union representing 55,000 registered nurses (RNs) and allied health professionals and more than 12,000 nursing student affiliates providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

ONA welcomes this opportunity to provide the Standing Committee on Finance and Economic Affairs with priorities for the 2011 Ontario budget.

Government restraints on healthcare funding and, in particular, hospital global budgets, have resulted in thousands of RN job cuts and extensive restructuring of healthcare services throughout the province. Our submission reviews research showing RNs are the best value for our healthcare system, outlines the implications of RN job cuts for quality patient care, assesses the current per capita level of health care and hospital funding in Ontario relative to other jurisdictions, including an assessment of the significant cost drivers in the system, and provides recommendations for funding improvements to protect and to value RN-delivered patient care in Ontario.

The current cuts to hospital RN jobs and clinical services are a result of hospitals receiving base funding less than the actual costs of inflation over the past three years. The base hospital funding increase for 2008-09 was 2.4%, 2.1% in 2009-10, and this year (2010-11) it is 1.5%. The problem with funding hospitals less than the rate of inflation is that hospitals are forced to balance their budgets and they are not allowed to run deficits, which results in hospitals reducing budgeted RN positions as the "quick fix" to balancing budgets.

Bill 8 – *the Commitment to the Future of Medicare Act* – provided for mandatory accountability agreements between hospitals and local health integration networks (LHINs). The Hospital/LHIN Accountability Agreements contain the requirement for hospitals to balance their budgets. The government gave the LHINs the power to force hospitals to balance their budgets and to eliminate their deficits even when it means cutting RN jobs and vital patient care services.

The consequences of three years of underfunding hospitals, and the LHINs forcing balanced hospital budgets, are now becoming clear – significantly fewer RN jobs and less access to vital patient services in local hospitals across the province.

What has happened so far is extensive rationing of hospital services in many areas, including layoffs for RN staff and not replacing RN positions when they become vacant. For RNs, this has amounted to the elimination of over 2500 RN full-time equivalent positions. For our patients, this has meant the loss of 1950 hours of care for every direct care RN position eliminated, and over 4.3 million hours of RN patient care cut since the spring of 2009.

Our submission is that Ontarians do not want their hospitals to balance their budgets at the expense of RNs and quality patient care. Rather, healthcare funding policies are required that ensure that our patients are able to access the quality care they require, particularly care delivered by RNs.

### **RNs are the Best Value for Quality Patient Care**

In 2010, 93,916 RNs reported employment in nursing in Ontario.<sup>1</sup> The ratio of RNs to 100,000 of population, however, remains the second lowest in Canada.<sup>2</sup> Ontario has 644 RNs per 100,000 population compared to Canada's average of 689 and the non-Ontario average of 717. This means more than 9,000 additional RNs are currently required just to reach the non-Ontario average ratio.

In addition, the nursing workforce in Ontario continues to age. There are now 27,258 RNs aged 55 plus or more than 29 per cent of Ontario's employed RN workforce that is eligible to retire in the coming years.<sup>3</sup>

Taken together, Ontario has fewer RNs per population than other provinces and has an aging nursing workforce. It is our contention that these factors mean that government healthcare funding policies must be reconsidered if there are to be sufficient numbers of RNs to deliver quality patient care. However, current government healthcare funding policies have resulted in exactly the opposite result – significant reductions in RN positions and reduced hours of RN care.

It is time to value the invaluable contribution that RNs make to our healthcare system and to quality patient care.

Extensive research evidence shows improved outcomes for patients with *more* hours of nursing care.<sup>4</sup> Adding one patient to a nurse's average caseload in acute care hospitals is associated with a 7 per cent increase in failure to rescue (complications), a 7 per cent increase in patient mortality, a 23 per cent increase in nurse burnout, and a 15 per cent increase in job dissatisfaction.<sup>5</sup>

RN staffing is associated with a range of better patient outcomes: reduced hospital-based mortality, hospital-acquired pneumonia, unplanned extubation, failure to rescue, nosocomial bloodstream infections, and length of stay.<sup>6</sup>

In Ontario, however, healthcare funding policies have resulted in the elimination of more than 4.3 million hours of RN care from hospitals solely as a cost-saving measure by hospitals to balance their budgets, without any attention to research evidence on the value of RNs for better patient outcomes and as the best value for money.

One study by Needleman et al.<sup>7</sup> balanced the costs of increasing nurse staffing in United States hospitals with the associated cost savings that might be achieved by reducing adverse outcomes and length of hospital stays, and avoiding patient deaths. They concluded that raising the proportion of nursing hours supplied by RNs resulted in improved patient outcomes and reduced the costs associated with longer hospital stays and adverse outcomes compared to other options for hospital patient care staffing.

A further study<sup>8</sup> has shown that improved patient care from additional RN staffing that prevents nosocomial complications, mitigates complications through early intervention, and leads to more rapid patient recovery, creates medical savings and shows the economic value of professional RN staffing.<sup>9</sup> Estimates from this study suggest that adding 133,000 full-time equivalent RNs to the acute care hospital workforce<sup>10</sup> in the U.S. would save lives,<sup>11</sup> and the productivity value to the economy of total deaths averted is equivalent to more than \$1.3-billion per year, or \$9,900 per additional RN per year. Medical savings is estimated at \$6.1-billion, or \$46,000 per additional RN per year. Combining medical savings with increased productivity, the estimates of economic value averages \$57,700 for each additional RN.

The research evidence confirms that RNs provide the best clinical value and the best economic value for patient care.

We know from the research literature that *fewer* RNs and *fewer* RN hours will result in more patient complications and higher mortality rates for patients and higher costs for our healthcare system. RN staffing models are the best overall value for positive patient outcomes and for our healthcare system.

We turn now to consider healthcare funding policies to improve RN staffing levels to protect quality patient care.

### **Healthcare Funding Policies to Protect Quality Patient Care**

The fact is that the level of funding for health care in Ontario is quite low relative to other provinces on a per capita basis. Healthcare funding per capita in Ontario is essentially *tied for second lowest* in the country and would require \$174 more per person or \$2.3 billion to reach the non-Ontario average rate of per capita funding for health care.<sup>12</sup>

Hospital funding per capita in Ontario remains the *second lowest* per capita funding in the country.<sup>13</sup> In 2010, Ontario hospitals were funded \$262 *less* per person than the non-Ontario average.<sup>14</sup> This means that it would take \$3.5 billion to bring Ontario up to the average of what other provincial governments spend to fund hospitals.<sup>15</sup>

On the other hand, Ontario spends more than any other province on physicians. Physician expenditures per capita in 2010 in Ontario were \$862 compared to the non-Ontario rate of \$670 or \$2.5 billion more than other provincial governments spend on physicians.<sup>16</sup>

Moreover, Ontario also spends more than any other province on drugs. Drug expenditures per capital in 2010 in Ontario were \$346 compared to the non-Ontario rate of \$285 or \$809 million more than other provincial governments spend on drugs.

Taken together, spending on physicians and drugs in 2010 was significantly more than spent by other provincial governments, and almost equates to the \$3.5 billion that Ontario hospitals are underfunded compared to other provinces.

Clearly, hospital funding has been hardest hit as a result of government restraints, and RNs have been the most affected.

Government spending on physicians and drugs, on the other hand, remain much higher relative to what other provincial governments spend. Continuing to undervalue the contribution RNs make to our healthcare system and to patient care makes no sense given the research evidence that RNs provide the best value for money, dollar for dollar.

Furthermore, the government's current plan is to cut Ontario's Corporate Income Tax, which means reduced revenue available to fund public health care, to fund hospitals and to fund patient care provided by RNs. Ontario's corporate income tax rate fell from 14 per cent to 12 per cent on July 1, 2010. It will fall to 10 per cent over the next three years. The total cost of the Corporate Income Tax cut when fully phased in will be \$2.4 billion annually, according to *Ontario's Tax Plan for Jobs and Growth*, the government's blueprint. It is becoming clear that these corporate tax cuts must be postponed to a later date.<sup>17</sup>

A majority of Ontarians, in fact, would pay *higher* taxes to support high quality public health care.<sup>18</sup> Further, this recent poll indicates that more Ontarians want the government to make health care a high priority, would protect this funding envelope from cuts, and believe health care is government's most important service. Ontarians (90%) also agree that reducing the number of nurses would really hurt the quality of the healthcare system.<sup>19</sup>

We respectfully submit that, based on an extensive body of research evidence, healthcare funding policies must focus on creating and protecting RN positions, particularly in the hospital sector, and focus on targeted retention initiatives, such as late-career and mid-career nursing initiatives, amongst other funding priorities to educate new RNs.

We recommend the government provide annualized dedicated funding for late-career nursing initiatives, instead of approval in late fall, which does not allow sufficient time for employers to utilize the funds prior to the end of the fiscal year.

We also urge the government to adopt an overall funding policy to retain current full-time equivalent RN positions (including current RN vacancies) employed in hospitals, while implementing initiatives to make significant progress moving toward the non-Ontario RN per population ratio.

Further, we submit that part of the solution to achieving progress is to provide additional bridging seats from RPN education programs to RN education programs. A further component of achieving progress is to increase second-level entry RN programs such as the two-year post-graduate program at the University of Toronto.

We also recommend a policy be adopted that actively consults with nurses regarding the impacts on patient care prior to any planned nursing and clinical service reductions being contemplated or implemented.

The *Public Hospitals Act*<sup>20</sup> currently provides for each hospital to put in place a Fiscal Advisory Committee (FAC), and that staff nurses are represented. Hospital FACs are mandated to make recommendations to the hospital board “with respect to the operation, use and staffing of the hospital.”<sup>21</sup>

Hospitals are not complying with these requirements. We urge the government to take action to ensure that hospitals are in compliance with existing legislative requirements related to setting up functioning FACs in every hospital and that each FAC is consulted and makes recommendations to hospital boards regarding nurse staffing decisions and clinical service reductions, and that hospitals provide for the participation of “staff nurses in decision-making related to administrative, financial, operational and planning matters in the hospital.”<sup>22</sup>

### **Long-Term Care Sector**

New long-term care regulations fail to include mandated staffing and care standards, and instead have included voluntary staffing plans that are a *lower* requirement than that which previously mandated the long-term care sector to ensure there was sufficient staffing to provide the nursing care required by the residents.<sup>23</sup>

There is also an extensive literature<sup>24</sup> on the relationship between higher RN staffing levels in long-term care homes and improved quality of care outcomes for residents. The current government policy to address staffing issues in long-term care homes, however, is to implement *voluntary* staffing committees to address staffing within existing funding rather than to reinstate *mandatory* staffing levels and care standards.

A recent critique of this policy of voluntary staffing concludes that this voluntary approach to staffing in long-term care homes in the U.S. has not resulted in improved nurse staffing despite increasing acuity of residents and the payment of billions of dollars.<sup>25</sup> The authors recommend “the best way to achieve appropriate staffing levels is to require them by law and to enforce the standards.”

The current approach adopted by the Minister of Health and Long-Term Care, which relies on overall per diem increases in funding to improve staffing and care levels for residents of long-term care facilities, has failed to improve staffing in long-term care homes.

ONA continues to call for a regulated staffing standard of an average level of 3.5 hours of nursing and personal care per resident per day, including .68 RN hours that is in line with resident acuity and the staffing recommendations in the research literature.

### **Home Care Sector**

Current government policy is to move Alternate Level of Care patients out of acute care hospitals and into community care, as appropriate. ONA continues to call for implementation of previous recommendations<sup>26</sup> for wage parity in the home care sector as part of the government’s strategy to shift appropriate hospital care into the community. Additionally, we believe that any resumption of a policy of competitive bidding in home care will also not achieve the government’s objectives.

The available evidence from the experience of this sector shows that home care workers, including nurses, have experienced high levels of stress and burnout.<sup>27</sup>

Indeed, a recent study has found that the implementation of managed competition resulted in decreased levels of job satisfaction and a greater propensity to leave among home care workers.<sup>28</sup>

An additional study has shown that in a five-year period, from 1996 to 2001, three non-profit agencies lost 52 per cent of their employees. Many nurses sought employment in the hospital sector.<sup>29</sup>

Evidence also exists that managed competition has resulted in workloads that have increased as providers make more client visits per day, that there is less organizational and peer support provided, and that there is a greater emphasis on the business side of providing care than on the provision of care.<sup>30</sup>

There is also mounting recent evidence of patients being unable to access the home care they require.<sup>31</sup> This situation of rising demands for home care services requires funding attention.

### **Public Health Sector**

Public health nurses continue to raise concerns regarding reduced funding for mandated public health programs. This policy seems counterintuitive since we know that keeping people healthier at an earlier stage will assist with reducing the overall costs of acute care at a later stage.

Funding for the healthy babies, healthy children (HBHC) program, in particular, has been frozen at the same level as 2007-2008 funding. This funding freeze has resulted in reductions in public health nurse positions in a number of public health units. Research shows that the HBHC program allows more children in Ontario to get a healthier start in life.<sup>32</sup>

A recent survey of public health nurses concludes that public health nurses need a combination of factors to succeed: sound government policy, supportive organizational culture and good management practices.<sup>33</sup>

In the 2011 budget, we urge enhanced funding for mandated public health programs and strict accountability requirements for boards of health.

### **Continue Progress towards a Culture of Safety in the Healthcare Sector**

We urge the government to continue to take action to reduce the rate of injury and illness for nurses. The relationship between workload, understaffing and the lack of safe working conditions leading to nursing injury and illness is now well documented.<sup>34</sup> Fewer nurses as a result of absenteeism from injury and illness means less care delivered to patients in our communities.

The most urgent need this year is for continued funding of healthy work environment policies to improve RN staffing and reduce nurse-patient workloads.

Recent research<sup>35</sup> conducted with healthcare workers in Ottawa hospitals highlights the importance of taking action now: almost three in five healthcare workers experience role overload, resulting in absenteeism, lower productivity and high turnover.

The most problematic stressors in the study include understaffing, increased complexity of the work, and a culture of health care related to meeting wait times and the impacts of ongoing restructuring.

Nurses and their patients pay a steep price for these high levels of work overload. There are more nurses being injured or becoming ill, resulting in rising rates of absenteeism and overtime.

A recent Canadian study<sup>36</sup> found that the cost of nurse absenteeism is estimated at \$15.5-million per week.

In addition, the equivalent of almost 12,000 full-time nursing positions worked overtime at an estimated cost per week of \$18-million.<sup>37</sup> This is the cost to be paid when fewer nurses are in the system, but these costs are better spent on retention and recruitment initiatives.

## **Conclusion**

We thank the Standing Committee for the opportunity to provide priorities for the 2011 budget from the perspective of Ontario's front-line registered nurses.

Our submission reviews an extensive body of research showing RNs are the best value for our healthcare system and for quality patient care. We outline the serious implications of RN job cuts for quality patient care. We assess the current lower per capita level of healthcare and hospital funding in Ontario relative to other jurisdictions, and we provide evidence of physician and drug expenditures that are significantly higher in Ontario than other provincial governments spend. Our recommendations for funding improvements will protect and will value RN-delivered patient care in Ontario.

Improved RN staffing is shown to result in improved patient outcomes. Less RN care is linked to higher rates of complications and mortality for patients. It also leads to a wide-range of health and safety issues for nurses and higher costs for our healthcare system. It is time to change our approach to valuing the invaluable contribution of RNs to our healthcare system.

## **Endnotes**

<sup>1</sup> College of Nurses of Ontario. *Membership Statistics*, 2010.

<sup>2</sup> Canadian Institute for Health Information (CIHI). *Regulated Nurses: Canadian Trends, 2005 to 2009*.

<sup>3</sup> College of Nurses of Ontario. *Membership Statistics*, 2010.

<sup>4</sup> See the literature cited in Tourangeau, Anne E. et al., "Impact of hospital nursing on 30-day mortality for acute medical patients." *Journal of Advanced Nursing* 57(1):33, 2007.

<sup>5</sup> See Aiken et al. "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction." *Journal of the American Medical Association* 288(16): 1987-1993, 2002.

<sup>6</sup> See, for example, Needleman, et al. "Nurse-staffing levels and the quality of care in hospital." *New England Journal of Medicine* 346(22): 1715-1722, 2002

<sup>7</sup> Needleman, J., et al. "Nurse staffing in hospitals: Is there a business case for quality?" *Health Affairs* 25(1): 204-211, 2006.

<sup>8</sup> Dall, Timothy M. et al. "The Economic Value of Professional Nursing," *Medical Care* 47(1):97-104, 2009.

<sup>9</sup> The term "economic value of professional nursing" in this study refers to a monetary assessment of the value of incremental changes in nurse staffing that result in improved quality of patient care. This definition emphasizes the changes in nurse staffing that affect medical costs due to the impact on patient outcomes. Improved patient care that prevents or mitigates complications creates medical savings. Reduced lengths of recovery and mortality rates have national productivity implications.

<sup>10</sup> More than 2.4-million registered nurses (RNs) are employed in nursing in the U.S. (56 per cent in hospitals). See Dall et al.

<sup>11</sup> The addition of 133,000 RNs is estimated to save 5,900 lives per year. The additional nurse staffing would decrease hospital days by 3.6-million. More rapid recovery translates into increased national productivity, conservatively estimated at \$231-million per year or \$1,700 per additional RN per year. See Dall et al.

<sup>12</sup> CIHI. *National Health Expenditure Database*, 2010. See also, OHA, "The Changing Face of Ontario Healthcare, Provincial Government Spending Comparisons." Health Finance and Research Unit, November 2010.

<sup>13</sup> CIHI. *National Health Expenditure Database*, 2010. Only Quebec per capita funding for hospitals is lower than Ontario hospitals that are at \$1,291 per capita compared to the non-Ontario average of \$1,553. All other provinces are close to or above the non-Ontario average.

<sup>14</sup> OHA. 2010.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> See, for example, Editorial, "Lower Corporate Taxes No Cure-All," *Toronto Star*, January 31, 2011.

<sup>18</sup> HOOPP Media Release, "Ontarians ready to pay more to sustain healthcare – as long as healthcare workers are supported," December 1, 2010.

<sup>19</sup> Ibid.

<sup>20</sup> See Regulation 965.

<sup>21</sup> S. 5(2).

<sup>22</sup> See Reg. 965, S. 4(f).

<sup>23</sup> Section 60 (6) in Regulation 832 to the *Nursing Homes Act* provides that a licensee of a nursing home shall ensure that there is a sufficient number of registered nurses, registered practical nurses and health care aides on duty in the home at all times to provide the nursing care required by the residents of the home (O. Reg. 340/96, s. 4).

<sup>24</sup> See, for example, Bostick, Jane E. et al. "Systematic Review of Studies of Staffing and Quality in Nursing Homes." *J Am Med Dir Assoc* July 2006: 366-376. For Canadian evidence, see McGregor,

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Margaret J, and Lisa A. Ronald, "Residential Long-Term Care for Canadian Seniors: Nonprofit, For-Profit or Does it Matter?" *IRRP Study*, No. 14, January 2011. See also College of Nurses of Ontario, *Supporting Quality Nursing Care in the Long-Term Care Sector*. May 2006.

<sup>25</sup> Edelman, Toby S., and Charlene Harrington, "An Analysis of the Shirlee Sharkey Report on Long-Term Care Homes Human Resources Issues in Ontario." December 18, 2009. Research commissioned by the Ontario Health Coalition.

<sup>26</sup> See Joint Provincial Nursing Committee. "Stabilizing Nursing Human Resources in Home Nursing Services." Recommendations to the Minister of Health from the Community Wage Disparity Working Group, July 14, 2000.

<sup>27</sup> See Denton, Margaret et al. *Organizational Change and the Health and Well-Being of Home Care Workers*. Study prepared for Research Advisory Council, Workplace Safety and Insurance Board of Ontario. See also Margaret Denton et al. "Job Stress and Job Dissatisfaction of Home Care Workers in the Context of Health Care Restructuring." *International Journal of Health Services* 32(2): 2002, pp. 327-357.

<sup>28</sup> See Denton, Margaret et al., "Market-Modelled Home Care: Impact on Job Satisfaction and Propensity to Leave." *Canadian Public Policy* Vol. XXXIII, 2007.

<sup>29</sup> See Denton, M. et al., "Where have all the Home Care Workers Gone?" in *Health Services Restructuring in Canada: New Evidence and New Directions*, ed. by C. Beach et al. Kingston: Queen's University, 2006.

<sup>30</sup> Denton et al., 2007.

<sup>31</sup> See recent media coverage. Moira Welsh and Theresa Boyle. "Home-care services can't keep up, audit finds," Toronto Star, December 6, 2010. Denis Davy. "Private home care on the rise," The Hamilton Spectator, November 16, 2010. See also 2010 Annual Report of the Auditor General of Ontario, Chapter 3, "Home Care Services."

<sup>32</sup> See research summarized at:

[www.health.gov.on.ca/english/public/pub/ministry\\_reports/healthy\\_babies\\_report/hbabies\\_report.html](http://www.health.gov.on.ca/english/public/pub/ministry_reports/healthy_babies_report/hbabies_report.html).

<sup>33</sup> Underwood, Jane M. et al. "Building Community and Public Health Nursing Capacity: A Synthesis Report of the National Community Health Nursing Study," *Canadian Journal of Public Health* 100(5): October, 2009.

<sup>34</sup> Statistics Canada. *Findings from the 2005 National Survey of the Work and Health of Nurses, December 2006*.

<sup>35</sup> See Duxbury, Linda et al. *The Etiology and Reduction of Role Overload in Canada's Health Care Sector*. Study funded by the Ontario Workplace Safety and Insurance Board.

<sup>36</sup> Informetrica limited. *Trends in Own Illness or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses*, June 2009. Study commissioned by the Canadian Federation of Nurses Unions.

<sup>37</sup> Informetrica Limited, June 2009.