ONTARIO NURSES' ASSOCIATION

SUBMISSION

on

2021 PRE-BUDGET CONSULTATIONS

to

Minister of Finance

January 26, 2021

ONTARIO NURSES' ASSOCIATON
85 Grenville Street, Suite 400
Toronto, ON M5S 3A2
Phone: (416) 964-8833
Web site: www.ona.org

Summary of ONA Recommendations for 2021 Ontario Budget

ONA's submission to the 2021 Ontario pre-budget consultation builds on the recommendations laid out in our 2020 submission, all of which hold true today:

1. On the SARS Commission recommendations:
   - Fully implement – and appropriately fund where necessary – the precautionary principle in all health-care facilities.
   - Stockpile 3 months of supply of Personal Protective Equipment (PPE) for all health- care facilities in the province.
   - Empower the Ministry of Labour (MOL) inspectors to properly investigate allegations of violations to the *Occupational Health and Safety Act.*
2. On the shortage of Registered Nurses:
   - Launch a robust recruitment strategy to bridge the Registered Nurse (RN) care gap. For Ontario to reach the average RN staffing ratio in Canada, the province needs to hire at least 20,000 net new RNs to enable the appropriate staffing of hospitals and in other sectors.
   - Repeal Bill 124, legislation that freezes public sector wages and violates constitutional rights of unionized nurses, as part of a broader strategy to improve retention and recruitment of RNs.
   - Launch a provincially funded COVID fund for all sectors to provide compensation for lost wages due to illness and/or self-isolation of RNs and health-care professionals. The fund should also be used to supplement the lost income of all front-line health-care workers in long-term care and elsewhere who were forced to select only one workplace and lost income as a result.
3. In hospitals:
   - Permanently raise the annual funding escalator for Ontario hospitals and acute care facilities by a minimum of 5.2 percent to meet estimated annual increases in cost pressures, pre-pandemic, with binding targets to eliminate hallway health care.
4. In public health:
   - Permanently reverse the announced 2019 cuts and provincially fund public health programs and services at 100 percent to ensure consistent service provision and resilience to outbreaks throughout the province. Develop a clear plan to ensure the recruitment and retention of front-line public health nurses.
5. In long-term care:
   - Launch systemic change in Ontario's long-term care sector by immediately increasing the funding to ensure a minimum of four (4) hours of direct care per resident per day, with RN care comprising 20 per cent. In addition, there should be at least (1) Nurse Practitioner for every 120 residents. As well, it is time to rapidly accelerate the phase out of "for profit" long-term care homes and immediately restore the annual Resident Quality Inspections (RQIs) in all the LTC homes.
6. In home care:
   - Protect and expand the jobs of care coordinators in the transition from Local Health Integration Networks (LHINs) to Ontario Health Teams (OHTs) to improve the continuity of care for patients in home care.
   - Restore the Patient Bill of Rights to legislation and repeal the sections of Bill 175 that open the door to increased service delivery by for-profit home care agencies.
   - End the practice of competitive bidding among for-profit home care providers, which rewards employers who pay home care nurses and other workers less and weaken working conditions.

7. Repeal Bill 195 that allows employers to strip RNs of hard-won and constitutional contract rights outside of a state of emergency, risking to further demoralize the workforce of front-line heroes.
8. Tackle head on the growing epidemic of violence in health-care settings by improving staffing levels and fully implementing the recommendations in the *Workplace Violence Prevention in Health-care Progress Report.*

I. Introduction

The Ontario Nurses' Association (ONA) is the union representing 68,000 registered nurses (RNs) and health-care professionals, as well as 18,000 nursing student affiliates, providing care in hospitals, long-term care facilities, public health, the community, including home care, clinics and industry.

In one short year, the COVID-19 pandemic has indelibly altered the landscape of health care in Ontario. Despite this, the issues at the heart of the crisis in our health-care system remain largely the same now as they were one year ago. Pre-existing cracks and weaknesses in the system were overwhelmed by the new pathogen that spread mercilessly through society, exacerbating the tragedy. Meanwhile, these cracks and weakness have not been fixed.

ONA welcomes the opportunity to provide the Standing Committee on Finance and Economic Affairs with recommendations from the perspective of front-line nurses and health-care professionals with respect to our priorities for the 2021 Ontario budget.

In honour of the 200th anniversary of the birth of Florence Nightingale, the World Health Assembly declared – prior to the year's commencement – that 2020 would be recognized as the *International Year of the Nurse and Midwife*.[1] Without a doubt, 2020 quickly became the year of the nurse and other health-care professionals as these heroes provided the last line of defence against a pandemic ravaging societies and health-care systems. It was their courage, compassion and dedication, in the face of unfathomable adversity, that brought light to an otherwise grim year.

It is our hope that the government will learn important lessons from the pandemic; chief among them that Ontario cannot afford to return to the status quo of chronic underfunding and understaffing, which blighted the health-care system before the pandemic struck. Budget 2021 must lay the groundwork for a relaunch of the entire Ontario health-care system based on the principles of sustainable and adequate public funding, a robust workforce of RNs and other health-care professionals and a phase-out of the corrosive profit-driven delivery of care, which monumentally failed Ontarians during the COVID-19 pandemic.

Unfortunately, much of what was true in January 2020 remains true to this day. The core issues affecting health care one year ago have not been systemically fixed. Successive governments have failed to act: Ontario still has the lowest RN-to-population ratio in Canada. Nothing has been done to lock-in sustainable funding for hospitals over the medium and long term. New wage restraint rules and statutory overrides of union contracts now make it more difficult to attract and retain nurses to the province. Health-care restructuring has created unprecedented uncertainty for nurses and health-care professionals across many sectors.

Hospitals across Ontario have been running major deficits during the pandemic, despite provincial funding bursts, leaving many concerned about possible cashflow issues in 2021.[2]

Put quite simply, Ontario can – and must – do better.

Amidst the severe crisis of the COVID-19 pandemic, opportunity emerges to change course and rebuild the Ontario health-care system from the ground up with a strong foundation of sustainable public funding, a robust workforce of registered nurses and health-care professionals and a phase out of profit-driven care.

The province also has additional tax revenue sources that could be mustered for this cause. Ontario's personal income tax is equivalent to 9.9 percent of labour income, compared to the 11.7 percent share in the rest of the country. And its corporate income tax revenue is 11.8 percent in Ontario, compared to the 12.2 percent share in the rest of the country.[3] By asking those who can afford it to pay a little more, Ontario can maintain its public health-care system, and improve and expand it.

Without the courage, compassion and stamina of Ontario's RNs and health-care professionals, who have bravely held together an underfunded system during an unprecedented pandemic, the tragedy in Ontario would have been far worse. We owe them all a great debt. The government owes them a better future.

II. Full funding and implementation of the SARS Commission recommendations

As the Ontario government picks through the avalanche of lessons from the COVID-19 pandemic, we must not lose sight of the lessons learned from the previous near-miss pandemic: SARS. Ontario was the North American front line against SARS in 2003 and much was gleaned from this dress rehearsal.

Indeed, Justice Archie Campbell's Inquiry into Ontario's handling of the virus provided a blueprint for the province's pandemic preparations.

Unfortunately, many of the crucial recommendations authored by Justice Campbell and his commission in 2006 were not effectively implemented in the intervening years, leaving Ontario unnecessarily vulnerable to the next outbreak in 2020.[4]

In our submission to Ontario's Long-term Care COVID-19 Commission, ONA presented our recommendations for immediate action to help mitigate the ongoing tragedy in the LTC sector on the basis of the SARS Commission recommendations.[5] These recommendations can and should be applied broadly to the entire health-care system, as well:

1. The precautionary principle, established by the SARS Commission as a fundamental aspect of worker health and safety, must guide the development, implementation and monitoring of measures, procedures, guidelines, processes and systems to ensure worker health and safety.
2. Empower the Ministry of Labour, Training and Skills Development (MLTSD) inspectors to properly investigate allegations of *Occupational Health and Safety Act* (OHSA) violations and unsafe workplaces, as recommended by the SARS Commission:
    - This should include a proactive inspection blitz in LTC homes and other health-care settings, including unannounced inspections (Note: The SARS commission recommended that "in any future infectious disease outbreak, the MOL take a proactive approach throughout the outbreak to ensure that health-care workers are protected in a manner that is consistent with worker safety laws, regulations, guidelines and best practices.")
3. Stockpile a three (3) month supply of PPE, for every health care facility in the province, including gloves, gowns, goggles, face shields, surgical masks and NIOSH-approved fit-tested N95 respirators (or equivalent or better). This is a standard policy in Hong Kong, which also dealt with SARS and has had enormous success in curbing the spread of the COVID-19.
    - Ensure that PPE is readily accessible to all relevant health-care professionals and staff in the health-care facilities who would need them.
    - Ensure fit-testing for all staff for NIOSH-approved N95s and other respirators.
4. Facilities should provide weekly updates on supply of PPE during a pandemic to the Joint Health and Safety Committee and the workplace trade unions.

The COVID-19 pandemic has taught us that we can never be caught unprepared again. Moreover, the government of Ontario must commit to elevating the importance of the precautionary principle in all pandemic preparations for the future and to investing in the resources needed to effectively apply it, should the time come.

III. Registered Nurse Shortage

A focus on the nursing workforce is crucial now more than ever as Ontario plans for the period of pandemic recovery. The year 2019 marked the fourth year in a row that Ontario had the lowest RN ratio per 100,000 population in the country.[6] ONA has consistently urged the government to develop a funded plan to close the RN care gap, as part of its strategy to address hallway health care. For Ontario to reach the average RN staffing ratio in Canada, the province needs to hire at least an additional 20,000 RNs.[7]

The latest comparable provincial data available from the Canadian Institute for Health Information (CIHI) on RNs in Canada shows that Ontario had just 725 RNs per 100,000 Ontarians, well below the Canadian average. Newfoundland and Labrador, by contrast, has the best ratio with 1,098 RNs per 100,000 residents.[9] As the pandemic drags on, there is reason to be concerned that a higher number of RNs and health-care professionals could exit their workplaces from accumulated burnout and declining morale.

Data from the College of Nurses of Ontario shows that the RN share of all nursing employment is declining – from 76.3 percent in 2003 to 65.7 percent in 2019. ONA has consistently raised that the replacement of RNs with Registered Practical Nurses (RPNs), combined with population growth and more demand from more complex, unstable patients, is creating a shortage of RNs.[8]

Further, a health human resources strategy for Ontario will also be needed to plan to replace RNs currently approaching retirement age. In 2019, there were 27,271 RNs aged 55-plus, or 25.6 per cent of Ontario's employed RN workforce, eligible to retire in the coming years. That is one-fourth of employed RNs who could retire in the coming years, potentially further aggravating the already severe shortage.[9]

The Ontario Auditor General's 2016 Annual Report[10] provided strong evidence for the need to improve RN staffing in our hospitals. The Auditor General found that RN patient assignment is heavier in Ontario than what international best practices recommend. As the Auditor's report notes, comprehensive research shows "that every extra patient, beyond four, that is added to a nurse's workload results in a seven per cent increased risk of death."[11]

For instance, research indicates that RN staffing is positively correlated with a range of improved patient outcomes: reduced hospital-based mortality, fewer cases of hospital-acquired pneumonia,

unplanned extubation, failure to rescue, nosocomial bloodstream infections; and shorter lengths of stay.[12]

RN staffing also provides savings to the health-care system as a whole. Multiple peer-reviewed studies, using costing models, have found that improved RN staffing levels reduces the number of interventions and treatments related to avoidable adverse events.

As an example, one study has demonstrated that higher RN staffing decreases the odds of readmission of medical/surgical patients by nearly 50 per cent and reduces post-discharge emergency department visits.[13] A further study[14] concluded that raising the proportion of RN hours 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.

Yet another study[15] demonstrated that patient care improved 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.[16] Further, a study[17] to determine the costs and savings associated with the prevention of adverse events by critical care RNs found annual savings from prevented adverse events (such as near misses) ranged from $2.2 million to $13.2 million, while RN staffing costs for the same time period amounted to $1.36 million. This study concluded that although RN critical care staffing costs are significant, the potential savings associated with preventing adverse events is far greater.

The evidence is clear that the addition of RN staffing would result not only in safer patient care but also in measurable cost savings for Ontario hospitals and the provincial treasury.

The 2021 budget is an opportunity for this government to change the course of history in Ontario and begin laying the foundations for a sustainable and resilient RN workforce in the coming years and decades. If ever their vital contribution to society had been overlooked, the COVID-19 pandemic deservedly brought these heroes back into the spotlight. Without them, our system would have failed.

Nurses provide the best care they can under the working conditions they face. They care deeply, they are committed to their patients, but the status quo is not adequate for safe patient care.

IV. Hospital Sector

The challenges facing the hospital sector in Ontario were widely known across this province before the pandemic struck. Few Ontarians are unaware of hallway health care, overcrowding and understaffing in hospitals. And once COVID-19 arrived, few Ontarians were left unaware of the vital role that hospitals play in keeping us all safe.

Ontario nurses have been sounding the alarm bells for years now regarding an emerging critical state in our hospitals, which seems to deteriorate year after year. The root causes are no mystery. Years and years of underfunding by provincial governments has left hospital administration budgets squeezed and unsustainable. Provincial funding has failed to keep up with population growth, aging, new infrastructure needs and inflationary costs.[18] Ontario's per capita program spending is already the lowest in Canada – in 2017 Ontario spent $3,903 per person on health-care which is $487 per person lower than the average of the rest of Canada.[19] Ontarians need a provincial budget in 2021 that commits to long-term, sustainable escalators in hospital funding to ensure hospitals have the funds needed for a robust recovery from the pandemic.

Despite significant one-time emergency investments by the province to shore-up the beleaguered Ontario hospitals during the first and second waves of the virus, hospitals have been running out of cash. In October 2020, the Ontario Hospital Association announced some hospitals were opening new lines of credit or redeploying capital funds to pay for the "king's ransom" in pandemic-related costs. Worse still, some facilities may eventually run out of cash for payroll.[20] Meanwhile, surgeries continue to be deferred and patients transferred in desperate bids by hospitals to preserve enough beds for COVID patients. Budget 2021 must provide the emergency funding to guarantee no hospital will run out of cash during the pandemic, even in the most extreme scenarios.

Despite these challenges, our valiant ONA members go beyond the call of duty every day and night to deliver quality care to Ontarians during some of the most trying times imaginable. But Ontarians can only expect so much from health-care workers being asked to do more with less.

Somehow, amidst the unfathomable crisis facing the health-care system this year, some hospitals proceeded with major layoffs of RNs. Over the course of 2020, ONA tallied the elimination of 63 net full-time and part-time RNs through hospitals that make up the University Hospital Network. And, with the second wave of the pandemic imminent, Southlake Regional Health Centre in Newmarket, Ontario, opted to eliminate 77 full-time and part-time RN positions in September 2020.

This hospital already faced nine charges by the Ministry of Labour for violations of the *Occupational Health and Safety Act* and has faced severe RN shortages in recent years. Layoffs likes these defy logic and common sense in a year like 2020. While the hospital management has jurisdiction over human resources decisions, the provincial government can set standards and provide adequate funding. Ultimately, the provincial government ought to commit in Budget 2021 to restoring lost RN positions in hospitals across the province as a first and immediate step towards reducing the overall and growing shortage.

In our 2020 pre-budget submission, ONA brought to the attention of the provincial government the increasingly dire circumstances in hospitals across the province, running overcapacity, underfunded and understaffed. All of these bear repeating in this year's submission. Here are some of the highlights:

- A 2019 Ontario Hospital Association (OHA) report read:
  "Attempts to squeeze out any more perceived hospital inefficiencies – with existing system structure and capacity – will likely worsen hallway health-care. The very real risk is that access to hospital care will become even more difficult and wait times will continue to rise."

- Ontario has the lowest hospital expenditure per capita of any province in Canada. Internationally, Ontario is tied with Mexico for the fewest number acute care beds per capita.

- From 2012 to 2019, total funding for Ontario hospitals rose by 5.4 percent (less than 1 percent per year), while the average total rise in other provinces was 12.9 percent. The same report finds that hospital bed capacity has been relatively flat since 1999, despite a province-wide population increase of 27 percent.[21]

- In one Brampton hospital, overcapacity in some cases runs at over 500 percent.[22] Other hospitals across Ontario frequently run at well over 100 percent capacity, including in Markham, Hamilton, Sudbury and Ottawa.[23]

These conditions in hospitals cannot be the "normal" to which Ontario returns. They are dangerous and a betrayal of the RNs and other hospital heroes who fought COVID on the front lines. The government owes it to hospital workers to begin laying the foundations in Budget 2021 for sustainable funding tied to cost inflation and other cost pressures over the medium and long-term. We cannot go back to how things were for many years.

The independent Financial Accountability Office of Ontario estimated in 2017 that in order to keep up with normal cost pressures (population growth, aging, inflation, and wage growth), Ontario hospitals would require at least 5.3 percent annual increases in funding over the subsequent five

years.[24] The Ontario government failed to meet even this standard, as evidenced by the total funding increases between 2012 and 2019.

However, at the December 2019 Council of the Federation, Premier Doug Ford joined with other provinces in demanding federal health transfers to the provinces be raised by 5.2 percent each year to meet cost pressures, consistent with an independent assessment by the Conference Board of Canada.

ONA believes that if the Ontario government asks the federal government for a 5.2 percent annual increase in funding, it is appropriate for the provincial government to deliver at least the same annual escalator to hospitals.

V. Public Health and Public Health Nurses

The COVID-19 pandemic has proven the critical value of public health and public health nurses. From contact tracing, to public education, to infection control and now the vaccination roll-out, the vital work of public health nurses has never been more apparent in the everyday life of Ontarians from all walks of life. We owe them a great debt.

Beyond COVID-19, public health nurses also do countless other jobs preventing disease and supporting the health and wellbeing of Ontarians. Every day, public health nurses work to prevent outbreaks of infectious diseases; ensure that students are vaccinated; improve people's health through teaching healthy eating habits and smoking cessation programs; give the best possible start to newborn babies and their moms and supports mothers learning to breastfeed; make our communities safer with sexual health counseling and testing; and provide the only place that some of the most vulnerable people living in Ontario can get access to primary care.

In addition, the ongoing opioid crisis is of major importance to public health. This crisis already has cost the people of Ontario enormously and has been exacerbated during the pandemic. What we know is that local responses are important and look very different for communities' right across the province. Without a strong and independent local lens in public health, the fear is that certain populations will have limited or no access to public health services.

Most people do not see the infections and poor health outcomes that public health nurses work so diligently to prevent. Their work is upstream health-care – preventing, today, illnesses that are

completely avoidable tomorrow. As one of ONA's public health leaders aptly stated, "when we do our job well, it's invisible."

In 2019, on the eve of the pandemic, the Ontario government announced sweeping cuts to public health programs across Ontario. While new, temporary, injections of funding have been made in the context of the pandemic, the government has not committed to a complete reversal of the previously planned yearly cuts.

ONA vociferously opposed the provincial funding cuts for public health services in 2019, arguing, among other things, that it would weaken the province's ability to respond quickly to new communicable diseases. This prediction proved to be correct. The funding cuts to the municipal boards of health simply downloaded the cost pressures to jurisdictions with more limited revenue tools.

Furthermore, Ontarians overwhelmingly oppose these cuts. A poll conducted by Environics Research in May 2019 found that 70 percent of Ontarians surveyed said they "strongly oppose" the province's cuts to public health.[25]

We urge the province to increase its funding for public health programs to 100 percent to ensure consistent service provision everywhere throughout the province. Access to public health services in our communities saves lives and reduces hallway health care.

Budget cuts were also handed down to Public Health Ontario in 2019, contributing, in some reports, to an exodus of senior staff from the agency in the months leading up to the outbreak of COVID-19. Ironically, Public Health Ontario was established as an independent agency following the SARS outbreak in 2003.[26] The weakening of Public Health Ontario expertise on the eve of the pandemic was a mistake and a reminder that public health should never be shortchanged again.

In Budget 2019, the government announced its intention to restructure Ontario's public health units – an announcement that came as a complete surprise to all public health units and their boards of health as they were not consulted. The restructuring process has been put on hold during the pandemic, and it is unclear if the government will relaunch them once the pandemic stabilizes permanently.

Without clarity regarding future plans, we believe it is important to reiterate the concerns we expressed last year in our pre-budget submission. We are concerned about the consequences that will flow from the government's massive restructuring of public health, especially as it relates to funding, retention of public health nurses and locally-based service delivery for marginalized and vulnerable populations across Ontario. Prior to the pandemic, restructuring was creating unprecedented uncertainty for our members. Questions such as the status of their jobs, their bargaining agents, working conditions, wages, benefits and contracts all were unanswered. If the government chooses to move forward once again with restructuring post-pandemic, the fragility of the public health sector must be prioritized and unnecessary instability avoided.

Shockingly, the raging pandemic does not seem to have stopped some public health units from issuing pink slips to public health nurses. And this comes after some other public health units laid off public health nurses in the months leading up to the pandemic. Health units such as Windsor Essex and Haldimand Norfolk are two in particular that proceeded with layoffs in 2020, despite a bare-bone nursing workforce. The $50 million investment by the provincial government at the start of the 2020-21 school year to hire 500 (then 625) school nurses employed by health units was an important step. However, by December 2020, many of the health units had not provided evidence that all nurses hired to fill these positions amounted to net new staff. This raises the question about whether some of the health units are simply pocketing the school nurse funding without adding to their overall public health nurse workforce. The government should take measures in Budget 2021 to ensure that these funds are effectively deployed to hire 625 net new public health nurses in public health units across Ontario.

VI. Care Coordinators and Home Care

ONA represents thousands of workers, including care coordinators and direct care teams who play a vital role in the continuum of home care for patients. The year 2019 saw the announced creation by the provincial government of 24 new Ontario Health Teams (OHTs) to replace the pre-existing Local Health Integration Networks (LHINs). As ONA has communicated to the government on many occasions, it is essential that the positions of care coordinators be enhanced, not cut during this health-care restructuring process. If the government is serious about addressing the crisis of hallway health care and meaningfully improving the quality and continuum of care at home, nothing less than the protection and enhancement of these jobs in the new OHTs is required.

Care coordinators provide the essential care required for patients to successfully leave hospital and to maintain a healthy and stable life at home. Their work to assess needs and deliver the resources required, as their primary responsibilities, gives patients the dignity and support they need to choose to live at home and stay out of hospital or successful recuperate after a hospital stay. In the years prior to the pandemic, a growing number of hospital beds were being occupied by alternate level of care (ALC) patients. Care coordinators play a key role in unlocking those beds by ensuring a successful transfer of patients back to their homes. In addition to the monetary savings for the system as a whole, home care also underpins a dignified living for our elderly and acute patients of all ages. Quality home care is an ethical imperative to which every Ontarian should be entitled when they need it. To this end, it is vital that the government commit to protecting and expanding in Budget 2021 the jobs of care coordinators through the restructuring process.

In 2020, the government adopted Bill 175, legislation that paved the way to the complete restructuring of home care to the Ontario Health Teams. ONA raised many objections to Bill 175 along the way, on the basis of numerous concerns. Chief among them is our concern about the stability of care coordinator jobs within the new system – something the legislation failed to guarantee. We also raised concerns about the weakening of accountability mechanisms within the legislation, in particular the removal of the Patient Bill of Rights from statute with only the promise to download this important document to the regulations. While we understand the need for government to update legislation governing certain sectors from time to time, this measure effectively weakens accountability without justification. Moving important legal provisions and safeguards such as a Bill of Rights from statute to regulation downgrades their importance and allows amendments to be made without public input, consultation and in camera.

Bill 175 also opens the door to privatization and a growth in the footprint of profit-making in the home care sector. In particular, the legislation facilitates the expansion of for-profit Health Service Providers (HSPs) to manage care coordination. This means an expansion of the market for home care corporations, rewarding companies with a history of lower pay, working conditions and quality of care. Shifting care coordination to private corporations also risks two outcomes. First, care coordinators may opt to exit the care coordination field if working conditions, contracts and pensions are jeopardized. Second, shifting the assessment work of care coordinators to the for-profit home care agencies creates the conditions for the emergency of a costly conflict of interest. Empowering a profit-making service provider to order the services they themselves provide, and then charge the government or the client, removes a check on the system and exposes it to abuse. Budget 2021 should repeal these provisions in Bill 175.

In our pre-budget submission last year, ONA recommended an end to the practice of competitive bidding among for-profit home care providers. We reasoned that this system rewards home care employers who pay home care nurses and other health-care professionals, in particular PSWs, less, offer fewer full-time positions and weaken working conditions. If this reality was true one year ago, it is now beyond contention. The COVID-19 pandemic has exposed the fragility and danger of the for-profit system, as underpaid, part-time care workers are forced to piece together shifts, while employers also use temporary staffing agencies, at LTC homes and for staffing by home care providers. This porous system accelerated the deadly spread of the virus through the various components of the health-care system, infecting lower income care workers and clients and residents alike. The race-to-the-bottom system of care provision in home care, like in long-term care, is not only ethically wrong, it is also a danger to public health. Budget 2021 must be the dawn of a new day for home care workers where working conditions, pay and job security, including permanent full-time positions, is strengthened.

VII. Systemic Change in Long-Term Care

The scale of the devastation in Ontario's long-term care setting will not soon be forgotten. Wave one and wave two of the pandemic have been equally merciless and whatever lessons the government learned – or should have learned – from wave one, failed to mitigate the effects of the second wave. As of January 12, 2021, 3,063 residents have died from the virus in LTCs across Ontario as well as 10 health-care workers. Cumulatively, 12,700 residents had been infected and nearly 5,000 health-care workers.[27] Not only tragic, these numbers are also shameful given the alarm bells already ringing about the vulnerability of the sector prior to the arrival of COVID-19. Indeed, the story of the collapse of the long-term care sector during the COVID-19 pandemic is nothing short of a chronicle of a tale foretold.

For years, health-care professionals and their trade unions, health experts, family associations, commissions of inquiry, coroner's inquests/reports, legislative committees and ministerial reports had been saying the same things: the LTC sector is understaffed, underfunded, excessively profit-driven and in dire need of an overhaul to raise standards for residents and workers alike.[28]

In the year preceding the COVID-19 tragedy, two important and high-profile government reports issued stark warnings about the deprived state of the sector. The first, was the final report of Commissioner Eileen Gillese's *Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System* (dated July 31, 2019).[29]

This report further recognized that the chronic problems of recruitment and retention of RNs in long-term care has caused serious RN staffing shortages and safety issues. As part of her recommendations, Commissioner Gillese directed the Ministry to conduct a study on the appropriate staffing levels in long-term care homes and table the report in the legislation by July 31, 2020. The findings of this study have since been released and they point to the same root causes of the crisis, among them, staffing shortages, poor working conditions, underfunding and a culture of unmotivated management.[30]

The Financial Accountability Office (FAO) issued a second report, titled *Long-Term Care Homes Program: A Review of the Plan to Create 15,000 New Long-Term Care Beds in Ontario* (dated October 30, 2019). In it, the FAO stated that the pressures and challenges facing this sector were on track to get worse, not better.[31] Rapid growth rate in the number of Ontarians aged 75 and older will outpace the growth rate of long-term care beds. The province needed an additional 70,000 – new beds by 2033 to *maintain* the wait list at a staggering and unacceptable 36,900 individuals.[32]

While the government has promised 15,000 new LTC beds and, since the pandemic started, has ramped up efforts to break ground on them, nurses know that building capacity in long-term care is about more than beds. It is also about a shortage of qualified staff, mainly nurses and PSWs.

That is why ONA is urging the government to immediately increase the funding per home to ensure a minimum of four (4) hours of direct care per resident per day, with RN care comprising 20 per cent. In addition, there should be at least (1) Nurse Practitioner for every 120 residents given the acuity of residents. As well, it is time to rapidly accelerate the phase out of "for profit" long-term care homes and immediately restore the annual Resident Quality Inspections (RQIs) in all the LTC homes. Sadly, it has taken over 3,000 deaths for the government to make the issue of care hours a priority. And, while we acknowledge it is a necessary first step, the five-year timeline[33] for the government's implementation of this vital measure is too slow. Extraordinary measures need to be taken as soon as possible to raise the hours of direct care for LTC patients to avert further avoidable tragedy.

ONA represents RNs in more than 314 long-term care facilities across Ontario. We have been outspoken advocates for improvements in this sector for decades – particularly on understaffing and underfunding. We have long called for more RNs, more RPNs and improved funding. We also advocate for the phasing-out of privatization in this sector.

Indeed, these were some of the recommendations we included in our pre-budget submission in 2020, before COVID-19 struck, turning the cracks in the system into vast chasms.

There's little doubt that the current provincial government inherited an unsustainable situation from the previous government, with little over 600 additional LTC beds built between 2011 and 2018.[34] However, the government also contributed to a deterioration in the quality of care in the 18 months leading up to the pandemic. According to the interim report of the LTC commission, Resident Quality Inspections (RQIs) of LTC homes were slashed from over 600 in 2017, to 329 in 2018 (the year the current government was elected), and down to 27 in 2019, the year before the pandemic. Incomprehensibly, during the months in which the pandemic raged – killing thousands – the provincial government only conducted 11 RQIs. Ironically, the RQIs were launched by the Ministry of Health and Long-Term Care in 2013 to help identify systemic issues in homes with a commitment to conducting one per home per year. ONA firmly recommends the provincial government commit in Budget 2021 to re-establishing annual RQIs in all LTC homes with firm compliance mechanisms for all findings.

The pandemic has caused untold suffering to the RNs, PSWs and health-care professionals who have bravely worked in LTC, and across all health-care sectors, on the front line for months saving, and striving to save, countless lives. However, so many of our health-care heroes have seen their earnings impacted by the pandemic, because of absences due to illness or self-isolation or a one worker one workplace policy, in the interest of curbing the spread of the deadly disease. Unlike in the 2003 SARS crisis, the government has not yet set up a fund dedicated to compensating these health-care heroes for lost wages incurred while doing everything right. ONA demands that this be addressed in Budget 2021, with the launch of a COVID Fund, modelled off of the 2003 predecessor fund during SARS.

The role of profit in the LTC sector bears enormous guilt in the story of the tragedy of the COVID-19 pandemic. Overall, the data points to overall higher mortality and morbidity rates within for-profit LTC homes, the vast majority of which are owned by large chains such as Sienna, Rykka, Southbridge, Chartwell, Revera and Extendicare.[35] According to one report, as of December 2020, per 100 beds, Southbridge lost 9 residents, Rykka lost 8.6 residents, Sienna homes lost 6.5, and Chartwell 4.6. The overall industry average is 3.7 resident deaths per 100 beds. Non-profit homes averaged 2.8 resident deaths per 100 beds and municipal homes averaged 1.4.[36]

If the systemic failure of the for-profit homes to save lives and protect the health of their residents and employees is not enough of a scandal, then surely their diversion of precious dollars away from the front lines and towards shareholder profits is unconscionable. While hundreds of residents died and hundreds of millions in government funding was received, two chains in particular – Extendicare and Sienna – paid out a total of $74 million to shareholders in 2020.[37]

ONA is appalled that these corporations would choose to divert $74 million during an unprecedented and deadly crisis away from their residents' and staff needs to line the pockets of investors. This fact alone speaks to the depravity within the for-profit LTC system and requires urgent action. For years, and based on disturbing mortality and morbidity data in the years preceding the pandemic, ONA has called for a phase-out in for-profit LTC care. Never has this been more needed and more urgent.

The Ford government has spoken repeatedly during the pandemic about putting an iron-ring around the long-term care sector. But, as the second wave of the pandemic proves, the much-touted iron-ring has been in name only. Pre-existing weaknesses combined with the ineffective application of the iron-ring have failed to meaningfully protect LTC residents and workers throughout the entire chronology of the pandemic. The compounding failures and tragedies in the LTC sector point to the need for a systemic overhaul, one that raises staffing levels, hires more full-time RNs, increases funding, improves direct care hours, adequately compensates staff and phases out dangerous profit-making. The provincial government owes it to the memory of the 3,000 plus residents and 10 plus health-care workers who have died thus far in the LTC sector to do nothing less.

VIII. Ending Violence in Health Care

In our pre-budget submission last year, ONA raised concerns about the alarming levels of violence rising in hospitals and other health-care settings. In the intervening year, these concerns have not dissipated and have gone unaddressed by the government. Violence is a symptom of a health-care system under-resourced and under stress. This is unacceptable. Prior to the pandemic, violent incidents causing lost-time injuries for nurses in Ontario have risen 27 percent in a recent four-year span.[38]

For health-care workers overall, the rate of increase in violence-related lost-time claims is three times the rate of increase for police and correctional service officers, combined.[39]

ONA's position is crystal clear: violence is not part of the job. Moreover, the government will not successfully improve safe patient care without guaranteeing safe working conditions for staff. In January 2020, after considerable advocacy from ONA's bargaining unit, the Ministry of Labour charged Southlake Regional Health Centre in Newmarket Ontario with nine safety violations of the Occupational Health and Safety Act.[40] But, it should have never gotten this far.

And neither are these incidents isolated to one of a handful of hospitals. ONA's members report internally that violent incidents occur on a daily basis across the province. ONA members far too often say that they go to work wondering how long it will be until the next violent attack takes place. These conditions of work contribute to burnout and mental illness among our members and are unsustainable for the health-care system overall. Although no data exists yet, it is safe to say that the pandemic has only exacerbated these conditions.

And so, ONA reiterates our recommendations from last year's pre-budget. It is crucial that the Ontario government confront the chronic understaffing in health-care settings across the province by fully implementing the recommendations from the 2017 Workplace Violence Prevention in Health-care Progress Report. Regrettably, according to the 2019 Auditor General report, as few as 10 percent of the recommendations had been fully implemented in the last three years. No update was included in the 2020 Auditor General report.

Ontario owes so much to our front-line RNs and health-care professionals as they continue to risk their health to save lives every day. As the province builds towards a new normal in health care, guaranteeing the health and safety, including mitigation of workplace violence, of the health-care heroes ought to be a top priority.

IX. Wage Fairness and Charter Rights

The COVID-19 pandemic has pushed RNs and health-care professionals to the brink. Their heroic work, risking everything, has saved countless lives and our health-care system. Notwithstanding this, the provincial government bafflingly imposed two pieces of legislation in 2019-2020 that overrode the Constitutional Charter rights of unionized nurses, Bill 124, *Protecting a Sustainable Public Sector for Future Generations Act, 2019* and Bill 195, *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*. The former bill also imposes the wage cap for RNs, which amounts to a wage cut in inflationary terms.

As working conditions for Ontario's nurses continue to deteriorate due to the COVID-19 pandemic, underfunding, understaffing, and RN shortages, it is vital that compensation in our province remain competitive. Without competitive wages and benefits, Ontario runs the risk of under-recruiting RNs and losing practicing RNs who choose to leave the workforce altogether.

Without competitive wages and a respect for worker's rights, the RN shortage threatens to worsen, adding further pressure to working conditions and affecting patient care.

The Ontario government has repeatedly called RNs and health-care professionals "heroes" during this pandemic. Yet, in practice rights are being trampled and wages being effectively cut. If the Ontario government is serious about honouring the bravery and sacrifice of health care heroes, then surely these bills express the opposite. In Budget 2021, we demand that the provincial government reverse the unconstitutional provisions of these bills and remove the wage cap to allow free and unfettered collective bargaining to take place. Similarly, emergency orders that override collective agreement rights, outside of an actual declared emergency, must be rescinded.

X. Conclusion

The Ontario Nurses' Association and our 68,000 members are frustrated and angry that the government has not taken the actions necessary to update directives to include precautions for airborne transmission of COVID-19. If nurses and health-care professionals cannot rely on the government to protect their health and well-being, Ontario's patients will suffer as a result from the growing shortage of health human resources.

Action must be taken now to rebuild the capacity necessary in our public health-care system to ensure quality care and to replenish the supply of nurses and health-care professionals to deliver that care. The pandemic has been an extreme wake up call.

We now implore the government to take action in response to ensure the future of our precious public health-care system, including ensuring a sustainable supply of nurses and health-care professionals.

Endnotes:

[1] World Health Organization. (2020). *2020 – Year of the Nurse and Midwife.* Retrieved from https://www.who.int/campaigns/year-of-the-nurse-and-the-midwife-2020 .
[2] CTV News. (2020). *Ontario hospitals face 'unprecedented' financial pressure, need funding: OHA.* Retrieved from https://toronto.ctvnews.ca/ontario-hospitals-face-unprecedented-financial-pressure-need-funding-oha-1.5168546?cache=.
[3] Financial Accountability Office of Ontario (FAO). (2019). *Comparing Ontario's Fiscal Position with Other Provinces.* Retrieved from https://www.fao-on.org/en/Blog/Publications/inter-prov-comparisons-feb-2019.
[4] CFNU. (2020). *A Time of Fear*. Retrieved from https://www.atimeoffear.com/.
[5] ONA. (2020). *Recommendations for Ontario's Long-Term Care COVID-19 Commission.* Retrieved from https://www.ona.org/wp-content/uploads/ona_recommendationsltccommission_20201021.pdf.
[6] Canadian Institute for Health Information (CIHI). (2020). *Nursing in Canada, 2019*/ Retrieved from https://www.cihi.ca/sites/default/files/document/nursing-report-2019-en-web.pdf.
[7] Canadian Institute for Health Information (CIHI). (2018). *Nursing in Canada, 2018*. Retrieved from https://secure.cihi.ca/free_products/regulated-nurses-2018-report-en-web.pdf. (ONA calculations based on CIHI data as CIHI no longer reports nurse to population ratios.)
[8] College of Nurses of Ontario. Data Query Tool – *Member Demographics Tool*, 2017 – 2019. ONA calculations.
[9] College of Nurses of Ontario. Data Query Tool – *Member Demographics Tool*, 2017 – 2019. ONA calculations.
[10] Office of the Auditor General of Ontario (AG). (2016). *Annual Report*. Retrieved from http://www.auditor.on.ca/en/content/annualreports/arbyyear/ar2016.html
[11] Ibid.
[12] Needleman, et al. (2002). Nurse-staffing levels and the quality of care in hospital. *New England Journal of Medicine* 346(22): 1715-1722.
[13] Weiss, M.E., et al. (2011). Quality and cost analysis of nurse staffing, discharge preparation, and post discharge utilization. *Health Services Research* 46(5): 1473-1494.
[14] Needleman, J., et al. (2006). Nurse staffing in hospitals: Is there a business case for quality? *Health Affairs* 25(1): 204-211.
[15] Dall, Timothy M. et al. (2009). The Economic Value of Professional Nursing. *Medical Care* 47(1):97-104.
[16] 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 of mitigates complications creates medical savings. Reduced lengths of recovery and mortality rates have national productivity implications.
[17] Rothschild, J.M., et al. (2009). The costs and savings associated with prevention of adverse events by critical care nurses. *Journal of Critical Care* 24(3).
[18] Ontario Hospital Association (OHA). (2019). *Ontario Hospitals – Leaders in Efficiency*. Retrieved from https://www.oha.com/Documents/Ontario%20Hospitals%20-%20Leaders%20in%20Efficiency.pdf.
[19] ONA calculations. Source: Weighted average based on Statistics Canada data for agreements covering 500+ employees.
[20] CTV News. (2020). *Ontario hospitals face 'unprecedented' financial pressure, need funding: OHA.* Retrieved from https://toronto.ctvnews.ca/ontario-hospitals-face-unprecedented-financial-pressure-need-funding-oha-1.5168546.
[21] OHA (2019).
[22] Marychuk, Mary. (2019). NDP to force vote for new Brampton hospital after 'shocking' statistics show Peel Memorial operates well over capacity. *BramptonGardian.com.* Retrieved from https://www.bramptonguardian.com/news-story/9673220-ndp-to-force-vote-for-new-brampton-hospital-after-shocking- statistics-show-peel-memorial-operates-well-over-capacity/.
[23] Staff. (2019). HSN was overcapacity every month over the last year. *Sudbury.com.* Retrieved from https://www.sudbury.com/local-news/hsn-was-overcapacity-every-month-over-the-last-year-1831545.
[24] OHA. (2019.
[25] CBC News. (2019). Majority of Ontarians oppose province's cuts to public health, new poll suggests. Retrieved from https://www.cbc.ca/news/canada/toronto/poll-ontarians-oppose-provincial-public-health-cuts-1.5142867.
[26] National Post. (2020). *Public Health Ontario suffered exodus of senior leaders and budget cuts before the COVID-19 pandemic struck.* Retrieved from https://nationalpost.com/news/canada/covid-19-public-health-ontario-budget-cuts.
[27] Public Health Ontario. (2021). *COVID-19 in Ontario: January 15, 2020 to January 12, 2021.* Retrieved from https://files.ontario.ca/moh-covid-19-report-en-2021-01-13.pdf.
[28] RNAO. (2020). *Long-Term Care Systemic Failings: Two Decades of Staffing and Funding Recommendations*. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_LTC_System_Failings_June_2020_1.pdf.
[29] Gillese, Hon. E. (2019). *The Long-Term Care Homes Public Inquiry Final Report Volume 1.* Retrieved from http://longtermcareinquiry.ca/wp-content/uploads/LTCI_Final_Report_Volume1_e.pdf.
[30] Ministry of Long-Term Care. (2020). *Long-Term Care Staffing Study*. Retrieved from https://www.ontario.ca/page/long-term-care-staffing-study#section-4.
[31]FAO (2019). *Long-Term Care Homes Program.*

[32] Ibid.
[33] Office of the Premier of Ontario. (2020). *Province Increasing Direct Care for Long-Term Care Residents to Four Hours per Day*. Retrieved from https://news.ontario.ca/en/release/59030/province-increasing-direct-care-for-long-term-care-residents-to-four-hours-per-day.
[34] Office of the Premier of Ontario. (2020). *Ontario Unveils New Innovative Approach to Building Long-Term Care Homes Faster*. Retrieved from https://news.ontario.ca/en/release/57690/ontario-unveils-new-innovative-approach-to-building-long-term-care-homes-faster.
[35] CBC Marketplace. (2020). *Ont. Nursing homes have had 22 years to do safety upgrades. COVID-19 reveals deadly cost of delay.* Retrieved from https://www.cbc.ca/news/health/covid-19-coronavirus-long-term-care-homes-ontario-1.5604009.
[36] CBC Marketplace. (2020). *Three nursing home chains have the highest COVID-19 death rates in Ontario, data analysis finds.* Retrieved from https://www.cbc.ca/news/canada/nursing-homes-covid-19-death-rates-ontario-1.5846080.
[37] CBC Toronto. (2020). *2 Ontario LTC operators got $157M in COVID-19 aid, they also paid $74M to shareholders.* Retrieved from https://www.cbc.ca/news/canada/toronto/big-spend-long-term-care-aid-dividends-1.5832941.
[38] Ontario Nurses' Association. (2019). *Workplace Violence and Harassment A Guide for ONA Members.* Retrieved from https://www.ona.org/wp-content/uploads/ona_guide_workplaceviolenceandharassment.pdf.
[39] Association of Workers' Compensation Boards of Canada (AWCBC). (2017). AWCBC Statistics. 2015 Injury Statistics across Canada. Retrieved from http://awcbc.org/?page_id=14.
[40] YorkRegion.com. (2020). *Newmarket's Southlake Hospital Charged*. Retrieved from https://www.yorkregion.com/news-story/9812448-newmarket-s-southlake-hospital-charged-after-nurse-security-guard-attacked/.