Standing Committee on Finance (FINA)
Pre-budget consultations 2012

Canadian Federation of Nurses Unions

Responses

1. Economic Recovery and Growth

Given the current climate of federal and global fiscal restraint, what specific federal measures do you feel are needed for a sustained economic recovery and enhanced economic growth in Canada?

The Canadian Federation of Nurses Unions (CFNU) represents 156,000 nurses, working in hospitals, homes, residential long-term care facilities and in communities across the country. Our submission to the pre-budget 2013 consultation is premised on the axiom that health is wealth and a healthy economy, now and in the future, is dependent on a healthy population. The CFNU is concerned about the impact of the economic downturn and the ongoing effects of unemployment, underemployment, poverty and income inequality on population health. Poverty costs Canada an estimated $72 billion to $86 billion per year, about five to six percent of our GDP.[1] As noted in the final report of the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities, Federal Poverty Reduction Plan: Working in Partnership Towards Reducing Poverty in Canada, efforts and investments to tackle poverty can be "highly profitable, since it is recognized that reducing poverty leads to reduced costs for health care, the criminal justice system, social programs and so on, and increases the economic contribution of a part of the population whose talents are not currently being exploited to their full potential."[2] Recommendation 1: Initiate and implement a national poverty reduction and prevention strategy shared by the federal, provincial, territorial, aboriginal and municipal governments, engaging business and civil society, as recommended in the 2010 report of the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities, Federal Poverty Reduction Plan: Working in Partnership Towards Reducing Poverty in Canada. Reduced access to essential medicine is one of the ways in which poverty and joblessness affect health. Pharmaceuticals are an increasingly important aspect of health care, yet, eight percent of Canadians cannot fill a prescription due to cost. A quarter of Canadians do not have any drug coverage at all.[3] Out of pocket expenses vary considerably across the country. In an example of a patient with congestive heart failure, out-of-pocket costs for a prescription burden of $1283 varied between $74 and $1332 across the provinces.[4] A national pharmacare plan also would bend the cost curve for Canadians. In a study by Marc-André Gagnon, an Assistant Professor at the School of Public Policy and Administration at Carleton University, it was estimated that a national pharmacare plan could provide savings of over $10 billion dollars.[5] Canadian employers, for example, spend over $10 billion annually, providing drug insurance[6] for the 58% of Canadian workers who have employment-based coverage.[7] A national pharmacare program could eliminate or greatly reduce this cost to the private sector, freeing up funds for growth. A national pharmacare plan is a spending program that pays for itself. Recommendation 2: Work with the provinces and territories to develop a national pharmacare program based on: the principles of universal and equitable access for all Canadians; improved safety and appropriate use; and cost controls to ensure value for money and sustainability, as recommended by the Standing Senate Committee on Social Affairs, Science and Technology 2012 report, Time for Transformative Change: A Review of the 2004 Health Accord. The first two recommendations above: tackling poverty and introducing a national pharmacare program are up-front investments that will provide substantial and direct economic returns down the road. To assist the government in making these and other investments to improve the health of the economy and society, the CFNU recommends that the federal government support the creation of a financial

transaction tax (FTT). A global financial transactions tax could raise billions in revenue, perhaps up to $650 billion,[8] assisting governments to reduce poverty and increase global stability.[9] One report estimates that a small financial transactions tax applied in Canada could generate approximately $3.5 billion annually (assuming a fifty percent reduction in high frequency, non-productive trading).[10] Recommendation 3: Work towards the adoption of a Financial Transactions Tax, as supported by 74% of Canadians in a recent poll undertaken by the International Trade Union Confederation.[11]

Sources 1 Laurie, Nathan. (2008) The Cost of Poverty: An Analysis of the Economic Cost of Poverty. Ontario Association of Food Banks. 2 House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities. (2010). Federal Poverty Reduction Plan: Working in Partnership Towards Reducing Poverty in Canada. 3 Statistics Canada. (2004) Joint Canada/United States Survey of Health, 2002–03; The Commonwealth Fund. (2007) International Health Policy Survey in Seven Countries. Author. 4 Demers, V. et al. (2008) Comparison of Provincial Prescription Drug Plans and the Impact on Patients' Annual Drug Expenditures. Canadian Medical Association Journal: 178(4). 5 Gagnon, Marc-André (2010). The Economic Case for Universal Pharmacare. Ottawa: Canadian Centre for Policy Alternatives 6 Stevenson, Helen. (2011) An End to Blank Cheques: Getting More Value Out of Employer Drug Plans. The Reformulary Group. 7 Canadian Health Coalition. (2008). Life Before Pharmacare. Canadian Centre for Policy Alternatives. 8 Schulmeister, Stephan. (2011). Implementation of a General Financial Transactions Tax. Austrian Institute of Economic Research. 9 Leading Group on Innovative Financing for Development. (2010). Globalizing Solidarity: The Case for Financial Levies. 10 Sanger, Toby. (2011). Fair Shares: How Banks, Brokers and the Financial Industry Can Pay Fairer Taxes. Canadian Centre for Policy Alternatives. 11 International Trade Union Confederation. (2012). ITUC Global Poll 2012 – How Banks Can Contribute to Society. Author.

2. Job Creation

As Canadian companies face pressures resulting from such factors as uncertainty about the U.S. economic recovery, a sovereign debt crisis in Europe, and competition from a number of developed and developing countries, what specific federal actions do you believe should be taken to promote job creation in Canada, including that which occurs as a result of enhanced internal and international trade?

The health care sector is a significant employer in Canada and faces significant competition for health human resources internationally. There is also internal competition for health care workers.[12] Since 2006, the nursing workforce has grown by 9%, however, the ratio of nurses to population has still not returned to 1990s levels.[13] The nursing workforce is short 11,000 FTE (full-time equivalent) Registered Nurses (about 16,500 persons). Without intervention this shortage will increase to 60,000 FTE RNs (about 90,000 persons) by 2022.[14] The cost of this shortage in paid overtime alone is $660.3 million annually. The CFNU has identified three ways the federal government can assist provinces and territories to stabilize the nursing workforce at a level that ensures safe staffing for patients and workers: assisting in education and skills training for workers, data collection and analysis, and coordinating planning. Education and Skills Training Budget 2012 committed to the forgiveness of a portion of Canada Student Loans for new family physicians, nurse practitioners and nurses that practice in under-served rural or remote communities. Whereas this initiative is welcome, it does not go far enough. We encourage the federal government to extend this program to health care workers that have gone back to school to upgrade skills. For example, a personal care worker that is seeking to upgrade her skills to become a Licensed Practical Nurse (LPN), or an LPN seeking to become an RN, or an RN seeking to become a Nurse Practitioner could all benefit from this program, as financial cost is a common barrier to skills upgrading. Nursing research shows that a rich skill mix is associated with increased patient outcomes and decreased costs.[15] Through the Economic Action Plan, the Labour Market Agreements and Development Agreements and the Employment Insurance program, there has been much effort to

find better ways of helping people obtain and keep employment as productive members of the labour force. Under the current apprenticeship in trades program, apprentices are paid by their employer during periods of practical training. During the classroom portion of their training, apprentices are eligible for regular benefits under Part I of the EI Act. Depending on the regional and local priorities of the province or territory, the apprentice may receive EI Part II support to cover classroom-related expenses. A similar tiered-pathway or apprenticeship-like approach through modular education and laddered credentialing would provide health care students options to graduate into the workforce at various stages of training. This would be of particular value for engaging Aboriginal Canadians and internationally educated health care workers in skills upgrading.[16] Recommendation 4: Reduce the financial burden on health care workers seeking education or skills upgrading by creating an apprenticeship-like program through EI for health care workers and by extending student grants and loan-forgiveness programs. Data gathering and analysis There is an urgent need for ongoing data that is easily collectible, reportable and comparable across sectors and jurisdictions that relates numbers of nurses to workload, staff mix and patient acuity. Specifically, there is a need to develop pan-Canadian benchmarks and indicators related to the workplace: injury and violence rates, time to care, (freeing up caregivers' time for more direct patient care), and return-to-work (after injury or illness) efforts. The federal government should support the development of standardized patient information systems and workforce data collection systems to allow for integrated workforce planning, system-wide analysis of nursing workload and patient outcomes and interprovincial data sharing. Recommendation 5: Work with provinces and territories on the development and deployment of data indicators to track nursing workforce and workload, including undertaking regularly a National Survey of the Work and Health of Nurses, like the 2005 collaborative effort involving the Canadian Institute for Health Information, Health Canada and Statistics Canada. Coordination of health human resources planning There is an urgent need for pan-Canadian coordination. The federal government must work with the provinces and territories to improve labour market intelligence. In the first report of the Premiers Innovation Working Group, pan-Canadian coordination is noted as needed for the areas of shared workforce projections, dataset and analysis and sharing training capacity. The Canadian Federation of Nurses Unions has developed a checklist for strengthening health care in Canada. Our first recommendation addresses the necessity of engaging all stakeholders to best achieve results and we request that nurses, other health care workers, and patients/residents/clients and their advocates be fully engaged with governments in the planning and coordination of health human resources and system re-design efforts. Recommendation 6: Expand the work and membership of the Advisory Committee on Health Delivery and Human Resources (ACHDHR) to coordinate analysis, data collection, information sharing, action planning and consensus building. Sources 12 Health Care Innovation Working Group. (2012) From Innovation to Action: The First Report of the Health Care Innovation Working Group. Council of the Federation. 13 Canadian Institute for Health Information. (2011). Regulated Nurses: Canadian Trends, 2006 to 2010. Author. 14 Canadian Nurses Association (2009). Tested Solutions for Eliminating Canada's Registered Nurse Shortage. Ottawa: Author. 15 Canadian Nurses Association (2009). The Value of Registered Nurses. Factsheet. Ottawa: Author; and Canadian Nurses Association (2004). Nursing Staff Mix: A Literature Review. Ottawa: Author. 16 Health Council of Canada (2005). Summary report from meeting on Health Human Resources.

3. Demographic Change

What specific federal measures do you think should be implemented to help the country address the consequences of, and challenges associated with, the aging of the Canadian population and of skills shortages?

The aging of the population is sometimes presented as a policy and funding crisis. While changing needs from changing demographics require specific government interventions, the Canadian Federation of Nurses Unions wants to challenge the notion that the aging population represents a silver tsunami that will overwhelm government financing. Our recommendations for the last federal budget with respect to aging, call for planning to ensure adequate public services are available, rather than panic and support for more for-profit provision of services for seniors. Evidence abounds that for-profit financing and for-profit provision of elderly care leads to less access and worse health outcomes.[17] It is critical to remember that: - There is a steady trend towards better functional health for the elderly, which challenges assumptions of dependency.[18] Only seven percent of those over 65 in Canada live in institutions and only seven percent of those living in private homes need assistance with daily living. In other words, 86% of Canadians 65 years and older are not dependent on others for care. Only 18% lived with children or grandchildren compared to 60% of people aged 20-24 years of age.[19] - The majority of caregivers of frail elderly are themselves elderly. In 2007, there were one million caregivers over 65.[20] - Aging is not a major cost driver in health care spending. Aging accounts for only 0.8% of annual increases in spending over the past decade.[21] These statistics point to the need for a sober pan-Canadian approach to healthy aging, to caregiver support, and to respite, home and community, and long-term care for those who need more help. The patchwork of programs and public plans across the country leads to large variations in access to and quality of services for seniors, and in health outcomes. The investments beyond acute care will pay off for patients and for governments. Every day, an average of 14% of all acute hospital beds are used by patients who could be cared for safely in other settings.[22] The lack of investment across the continuum, results in overcapacity in the acute care sector, evidenced in unacceptable emergency room waits and nursing workloads. To plan for the changing demographics, the CFNU echoes the following recommendation from the 2009 Special Senate Committee on Aging.[23] Recommendation 7: That the federal, provincial, and territorial governments develop and implement a strategy for continuing care in Canada, which would integrate home, facility based long-term, respite and palliative care services. The strategy would establish clear targets and indicators in relation to access, quality and integration of these services and would require governments to report regularly to Canadians on results. Sources 17 See CUPE. (2009). Residential Long-Term Care in Canada: our Vision for Better Seniors Care. Author; Grignon, Michael and Nicole F. Bernier. (2012). Financing Long-Term Care in Canada. IRPP; and Deber, Raisa, B. (2002) Delivering Health Care Services: Public, Not-For-Profit, or Private? Royal Commission on the Future of Health Care. 18 Jacobzone, Stéphane. (1999) Aging and Care for Frail Elderly Persons: An Overview of International Perspectives. OECD, and World Health Organization. (2008). Demystifying the myths of aging. Denmark. Author. 19 Gilmour, H. and j. Park. (2005). Dependency, Chronic Conditions and Pain in Seniors Health Reports, Supplement, Vol.16. Statistics Canada. 20 Statistics Canada. (2006). A Portrait of Seniors in Canada. Author. 21 Canadian Institute for Health Information. (2011). Health Care Cost Drivers: The Facts. Author. 22 National Expert Commission. (2012) A nursing call to action. Canadian Nurses Association. 23 Special Senate Committee on Aging. (2009). Canada’s aging population: Seizing the opportunity. Senate of Canada.

4. Productivity

With labour market challenges arising in part as a result of the aging of Canada's population and an ongoing focus on the actions needed for competitiveness, what specific federal initiatives are needed in order to increase productivity in Canada?

There is a substantial body of evidence that investments in not-for-profit child care enhance productivity and retain workers. For example, in the province of Quebec, having a child care program that serves about half of Quebec children under the age of five, has allowed "an additional 70,000 women with young children to enter the labour force, a 3.8% increase in women's employment overall. The ripple effect of this increase in working mothers' employment contributed an additional $5.2 billion to the provincial economy and increased Quebec's GDP by 1.7%. Furthermore, the impact of working mothers' increased purchasing power and taxes paid, along with reduced social transfers, means that for every dollar Quebec invests in its child care system, the province currently recovers $1.05 and Ottawa recovers 44 cents – for an additional $700 million in federal revenue."[24] Speaking to an earlier section of this submission, child care is a big job creator: investing $1 million in childcare would create almost 40 jobs, at least 43% more jobs than the next highest industry and four times the number of jobs generated by $1 million in construction spending.[25] The creation of a national not-for-profit child care program should be an integral part of a national caregiver strategy, recognizing the burgeoning numbers of the so-called sandwich generation – those providing both elder and child care. Recommendation 8: Reinvest the Universal Childcare Benefit to create a national not-for-profit child care and early learning program. Chronic diseases are on the rise in Canada, including mental illness. Five hundred thousand people are off work every day as a result of mental illness, and mental illness costs the Canadian economy $51 billion a year.[26] Chronic diseases have been estimated to cost Canada $190 billion annually.[27] To tackle these health and productivity challenges, the Canadian Federation of Nurses Unions supports the Canadian Nurses Association National Expert Commission's call for reaching the top five among nations in regards to five key health outcomes. Recommendation 9: Work with all levels of government to fund and implement the Mental Health Commission of Canada's Mental Health Strategy. Recommendation 10: Work with all levels of government to achieve primary health care for all by, among other things, implementing the Senate Committee recommendation, that the federal government establish a Canadian Health Innovation Fund to identify and implement innovative and best-practice models in health-care delivery, and the dissemination of these examples across the health system. Healthy workplace initiatives have also been demonstrated to improve productivity by reducing absenteeism, improving retention and recruitment and overall organizational performance.[28] Recommendation 11: To enhance productivity in the workplace, the federal government should provide strategic leadership and policy development, knowledge development and dissemination, build partnerships and promote healthy workplaces. Sources 24 Pierre Fortin, Luc Godbout and Suzy St-Cerny. (2011). Economic Consequences of Quebec's Educational Childcare Policy. Powerpoint presentation from Early Years Economics Forum, Toronto. 25 Fairholm, R. (2009). Understanding and addressing workforce shortages in early childhood education and care (ECEC) project. Ottawa: Child Care Human Resources Sector Council. 26 Dewa, S. Carolyn, et al. (2010) "Examining the Comparative Incidence and Costs of Physical and Mental Health-Related Disabilities in an Employed Population", Journal for Occupational and Environmental Medicine. Volume 52, Number 7. 27 Public Health Agency of Canada. (2011). Backgrounder: United Nations NCD Summit 2011: Chronic diseases- most significant cause of death globally. Author. 28 Lowe, Graham S. (2003). Healthy Workplaces and Productivity: A Discussion Paper. Health Canada.

5. Other Challenges

With some Canadian individuals, businesses and communities facing particular challenges at this time, in your view, who is facing the most challenges, what are the challenges that are being faced and what specific federal actions are needed to address these challenges?

There is no question that First Nations, Inuit and Métis people face severe challenges, as evidenced in the large health gap between Aboriginal and non-Aboriginal Canadians. • The life expectancy of First Nations men is 7.4 years less than other Canadian men, and the life expectancy of First Nations women is 5.2 years less than other Canadian women.[29] For Inuit men and women, the gap is even greater, at 15 years.[30] • The infant mortality rate among First Nations is 6.4 deaths per 1,000 live births, 1.5 times that of other Canadians. The infant mortality rate for Inuit in Nunavik is 24.9 deaths per 1,000 live births.[31] • First Nations carry a disproportionate burden of infectious diseases with twenty times tuberculosis rates,[32] five times hepatitis A, and seven times chlamydia rates.[33] Tuberculosis rates for Inuit are 90 times higher, and chlamydia rates are 17 times higher in Nunavut than in the rest of Canada.[34] • One in three First Nations adults aged 50-59 have diabetes, and the frequency of diabetes among First Nations adults is nearly four times the Canadian average, with nearly 90% reporting adverse consequences such as vision problems, kidney malfunction, heart problems and problems with hands and feet.[35] The Canadian Federation of Nurses Unions supports the Assembly of First Nations' request for new investments in the Non-Insured Health Benefits Program to accommodate for population growth and a built in escalator to account for inflation, changes in health service utilization and changes in health status.[36] Recommendation 12: Ensure the sustainability of the Non-Insured Health Benefits Program and provide a funding escalator to reflect the actual costs of population growth and inflation. The demographic changes noted in the earlier section of this brief differ significantly when the First Nations, Inuit and Métis populations are isolated. The Aboriginal population is growing nearly six times faster than the non-Aboriginal population.[37] One fifth of the First Nations population is 19 years or younger, twice the proportion of young people as the aggregate Canadian population.[38] First Nations, Inuit and Métis people are the future workforce of Canada. Studies show that if we close the education and employment gap between First Nations and other Canadians, First Nations workers would add $400 billion to Canada's GDP by 2026 and Canada would save $115 billion in government expenditures. First Nations, Inuit and Métis Canadians are significantly under-represented in the field of nursing. The federal government can play a role in the identification and removal of barriers that may discourage or prevent Aboriginal workers from entering and remaining in nursing. Recommendation 13: Expand initiatives such as the Aboriginal Workforce Participation Initiative to support retention and recruitment of First Nations, Métis and Inuit nurses. Recommendation 14: Implement the recommendations of the final report of the National Panel on First Nation, Elementary and Secondary Education and increase funding for the post-secondary education of First Nations, Inuit and Métis people. 29 Health Canada. (2003). A Statistical Profile on the Health of First Nations in Canada for the Year 2000. First Nations & Inuit Health Branch. 30 Inuit Tapiriit Kanatami. (2009). Correspondence. 31 Health Canada. (2004). Health Sectoral Session Background Paper. Author. 32 Long, R. and Ellis, E. (Ed.). (2007). Canadian Tuberculosis Standards (Sixth Ediciton). Public Health Agency of Canada and Canadian Lung Association. 33 Gideon, V. (2005). First Nations Health: the Landscape. Powerpoint presentation given at the CFNU MP Breakfast, May 10, 2005. Assembly of First Nations. 34 Inuit Tapiriit Kanatami. (2009). Correspondence. 35 First Nations Information Governance Centre. (2010). Quick Facts. Author. 36 Assembly of First Nations. (2011). Structural Transformation & Critical Investments in First Nations on the Path to Shared Prosperity Pre-Budget Submisson. Author. 37 Statistics Canada. (2008). Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census. Author. 38 First Nations Information Governance Centre. (2010). Quick Facts. Author. 39 Atleo, Shawn. (2012). Speaking Notes, Calgary Chamber of Commerce. Assembly of First Nations.