RNAO 2026 Provincial Pre-budget Submission

Jan. 29, 2026

The Registered Nurses' Association of Ontario (RNAO) represents more than 57,250 registered nurses (RN), nurse practitioners (NP) and nursing students across the province. For nearly a century, the association has advocated for changes that strengthen the nursing profession and improve people's health. RNAO welcomes the opportunity to present the views of nurses on Ontario's spending priorities to the Ministry of Finance.

Introduction

Developments in the United States over the past year have created a far more uncertain context for Canadians. Long-standing assumptions about cooperation and reliability in our relationship with the U.S. can no longer be taken for granted. President Donald Trump's rhetoric and policy direction have raised serious concerns about economic stability, trade, and shared security. In Ontario, this uncertainty carries real fiscal and social consequences given our deep economic integration and reliance on stable cross-border relationships.

This changed context underscores the importance of clear, values-based public policy choices. In periods of external instability, provincial budgets are a primary tool for protecting people's health, wellbeing, and economic security. That protection depends not only on a strong, publicly funded health system, but also on sustained investments in the social and environmental conditions that keep communities healthy and resilient.

As policy choices in the United States move toward deregulation, reduced public investment and widening inequality, RNAO urges Ontario to pursue a deliberate alternative. This includes restoring and strengthening science-based climate mitigation and adaptation measures, reinforcing income supports and housing investments to address deep poverty and homelessness, and ensuring stable, adequate funding for Ontario's publicly funded health system. Public dollars must be directed toward public benefit, not investor-driven care models. Fiscal decisions should also reflect Ontario's commitment to inclusion, supporting newcomers and vulnerable communities as contributors to social and economic wellbeing. Nurses are ready to be fully utilized and actively engaged in delivering these priorities.

At a time when democratic norms are under strain elsewhere, Ontario's legislature has an opportunity to model stability, cooperation, and foresight. RNAO calls for a budget process that supports constructive debate, cross-party collaboration, and prudent long-term planning. By investing in people, public services, and democratic institutions, Ontario can strengthen its resilience and chart a confident path forward in an increasingly uncertain global environment.

Recommendation #		RNAO recommendation summary
1. Nursing		
1.1	Compensation	Increase nurses' compensation and address existing pay disparities within the health system
1.2	Internationally educated nurses (IEN)	Improve ability of IENs already residing in Canada to contribute to the workforce, while ensuring ethical workforce practices.

Recommendation #		RNAO recommendation summary
1.3	Nursing Graduate Guarantee	Strengthen mentorship and retention programs to attract nurses to the Ontario workforce.
1.4	Healthy workplaces for nurses and other health-care staff	Fund RNAO to expand the Best Practice Spotlight Organization® (BPSO®) Program and develop healthy workplace guidelines and resources for health settings.
1.5	Extern programs	Expand the hospital-focused nursing clinical extern program and LTC nursing extern pilot to include all community care sectors, ensuring scalability.
1.6	Nursing education (RNs)	Assuming BScN seat allocations of 600 for 2026–2027 and 700 for 2027–2028, implement a 5 per cent increase in each of the following two years to match the RN per capita ratio in rest of Canada by 2029.
1.7	Nursing education (NPs)	Increase the number of seats in NP programs, starting with 200 in 2026 with the goal of having 7,500 registered NPs in Ontario by 2029.
1.8	Nursing education – Equity, diversity and inclusion (EDI)	Include racism and discrimination as a mandatory topic in nursing, interprofessional and continuing education curricula. Require mandatory courses or workshops that include topics of cultural humility, anti-oppressive behaviors, anti-racism and trauma-informed care in orientation and continuing education programs.
1.9	NP residency programs	Introduce funding to develop paid post-graduate NP residency programs to support a retention and recruitment strategy for both new graduates and practicing NPs to improve access to specialized care for Ontarians.
1.10	Nursing faculty	Recruit and retain faculty for nursing programs and promote funding for PhD and DN students to support the nurse educator workforce.
1.11	Nursing – continuing education	Increase funding for continuing education, professional development, specialty certifications, and leadership training to strengthen evidence-based practice, improve health outcomes and enhance job satisfaction.
1.12	Funded educational stipends	Implement a standardized, provincially funded educational stipend for experienced and licensed nursing professionals completing mandatory immersive clinical placements required for credential advancement, including RPN-to-RN bridging students, nurse practitioner students and internationally educated nurses.
1.13	RN scope of practice - prescribing	Continue to provide funding to incentive the early integration of RN prescribing education into BScN curriculum. Provide tuition

Recommendation #		RNAO recommendation summary
		support for RN prescribing to prepare up to 20,000 RNs as prescribers over four years.
1.14	RN scope of practice	Expand RN scope of practice to authorize RNs to apply automated-external defibrillators (AED) and defibrillators in AED mode for in hospital cardiac arrests, and refer to interprofessional health care providers such as occupational therapists, physiotherapists and registered dietitians.
1.15	NP scope of practice	Expand NP scope of practice to authorize NPs to initiate additional legal forms, order additional forms of energy and diagnostic tests, and complete documents related to gender-affirming care.
1.16	Violence against health-care providers	Formalize existing workplace violence prevention guidelines as provincial requirements for health care employers, establishing minimum standards for risk assessments, training, mitigation, response and accountability measures, enforced through funding and oversight mechanisms.
1.17	Nursing agencies	Reduce reliance by addressing recruitment and retention strategies, and reform Ontario's approach to nursing to strengthen a stable, permanent workforce.
2. Care delivery		
2.1	Pharmacare	Finalize a pharmacare agreement with the federal government and collaborate on its expansion beyond diabetes and contraception.
2.2	Public health – Base funding	Ensure that Public Health Ontario has sustainable resources required to deliver on the agency's mandate effectively, including emergency preparedness, by shifting from reallocating one-time annual funding to base funding and indexing to inflation.
2.3	Public health – First Nation community wellness	Increase and sustain funding and resources to all First Nation communities to ensure their public health needs – as determined by the communities themselves – are met. Begin with doubling the number of Community Wellness Nurses – from 50 to 100 - in remote First Nation communities to provide public health services.
2.4	Primary care – Access	Attach the estimated 3 million Ontarians without a regular primary care provider to an NP or family doctor by 2029.
2.5	Home care funding	Permanently increase funding and transform home care delivery in Ontario by implementing a relational funding model that supports comprehensive home and community services.

Recommendation #		RNAO recommendation summary
2.6	Long-term care – Direct care and skill mix	Prioritize quality care from regulated health professionals by formalizing a Nursing Home Basic Care Guarantee to deliver safe, dignified, and client-centered care. Fund and maintain a standard of at least four hours of direct care daily per resident with a skill mix of 20 per cent RNs, 25 per cent registered practical nurses (RPNs), and 55 per cent personal support workers (PSWs).
2.7	Long-term care – Attending NPs	Ensure one attending NP as most responsible care provider in long-term care per 120 residents by 2029 – with an addition of at least 150 NPs during the upcoming fiscal year.
2.8	Long-term care – NPs as clinical directors	Fund NPs as clinical directors to ensure accessible, quality care for residents and optimized outcomes.
2.9	Long-term care – Funding formula	Ensure that LTC homes that decrease acuity (Case Mix Index, or CMI) due to evidence-based care retain all savings to reinvest in staffing and/or programs for residents.
2.10	Long-term care – Infection prevention and control	Ensure one infection prevention and control (IPAC) RN lead per 120 residents.
2.11	Long-term care – Embedding evidence-based guidelines into electronic medical records	Extend funding for RNAO's Clinical Pathways program for three years to support long-term care homes with embedding RNAO's best practice guidelines into their electronic medical record.
2.12	Retirement homes – Attending NPs	Fund attending NPs in 20 retirement homes in 2026 with outcome measurements, to improve access to primary care.
2.13	Hospitals – Backlog	Stop all funding to investor-driven, private for-profit clinics for surgeries, treatments and procedures. Ensure that publicly funded hospitals have the resources to clear backlogs of surgeries, treatments and procedures in safe and timely ways.
2.14	Hospitals – Surgical care	Increase the funding for an additional 500 RN First Assistant and 200 NP Anesthetists by 2029, starting with 200 RN First Assistant and 80 NP Anesthetists in the upcoming fiscal year.
2.15	Hospitals – Minimum nurse-patient ratios	Implement mandatory, evidence-based nurse-patient ratios for both hospital and community settings to ensure nurse safety and improved patient outcomes.
2.16	Mental health – RN psychotherapy	Amend "Roadmap to Wellness" to incorporate programming for 500 RN psychotherapists by 2029 – starting with 250 in the upcoming fiscal year – allocating public funds within program to support access across Ontario.
2.17	Mental health - Dementia care	Fund RNAO to develop and administer a Dementia Care Centre of Excellence to promote the delivery of evidence-based and compassionate dementia care.

Recommendation #		RNAO recommendation summary
2.18	Pediatric care	Designate sustained funding to right-size pediatric health care in Ontario.
2.19	Indigenous health – RNAO's Indigenous Health Program	Continue to fund RNAO's work with Indigenous communities in Ontario to advance equity and inclusion by increasing the number of BPSOs.
2.20	Health system – Equity, diversity and inclusion	Mandate anti-racism, anti-oppression, cultural safety, and EDI training, orientation and mechanisms for staff at all levels in all workplace and academic settings.
2.21	Health system – Cultural and linguistic diversity	Establish comprehensive, publicly funded, 24-hour professional interpretation services for refugees and other language minorities in health-care settings.
3. Social determinants of health		
3.1	Toxic drug crisis	Invest in an integrated substance use model of care across all care settings.
3.2	Alcohol sales and consumption	Implement a comprehensive and evidence-based provincial alcohol strategy
3.3	Housing	Invest one per cent of the provincial budget annually in non-market housing.
3.4	Income security – sick days	Amend the Employment Standards Act to provide 10 permanent paid sick days for all employees and an additional 14 days paid sick days during a public health emergency.
3.5	Income security – minimum wage	Increase the minimum wage immediately to **$19.60** per hour, indexed annually to inflation.
3.6	Income security – supports for people on low incomes	Immediately double provincial Ontario Disability Support Program (ODSP) and Ontario Works (OW) rates and index annually to inflation.
4. Environmental determinants of health		
4.1	Climate crisis – Greenhouse gas emissions	Adopt science-based measures to implement a 43 per cent reduction in Ontario's greenhouse gas emissions, relative to the 2019 level, by 2030.
5. Fiscal capacity		
5.1	Tax reform	Increase the government's fiscal capacity to devote more money to publicly funded health care and determinants of health.

Recommendations

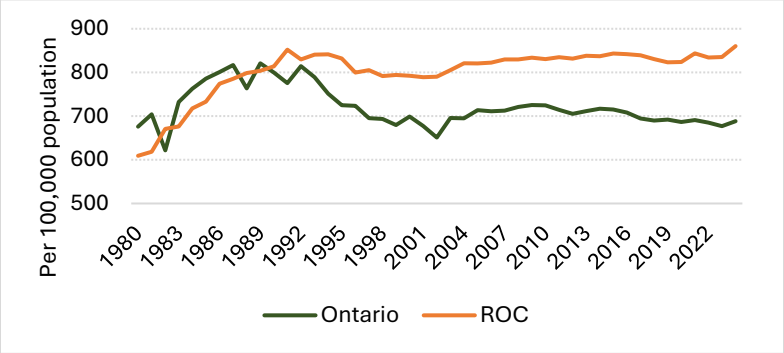
RNAO urges the government to reconvene and consider the following recommendations as those minimally necessary to ensure the wellbeing of Ontarians.

1. Nursing

Nursing is a profession that inspires, attracts and sustains people who choose to care for the wellbeing of others through knowledge, skill and compassion. As the largest group of regulated health professionals in Ontario and across Canada, nurses work in every sector of the health system. They are essential for its effective functioning and the health of the public.

Yet, the potential impact of nursing as a profession has been compromised by decades of underinvestment, including understaffing. As Ontario's population continues to grow, age and complexify, RN per capita levels in the province remain below pre-pandemic levels.

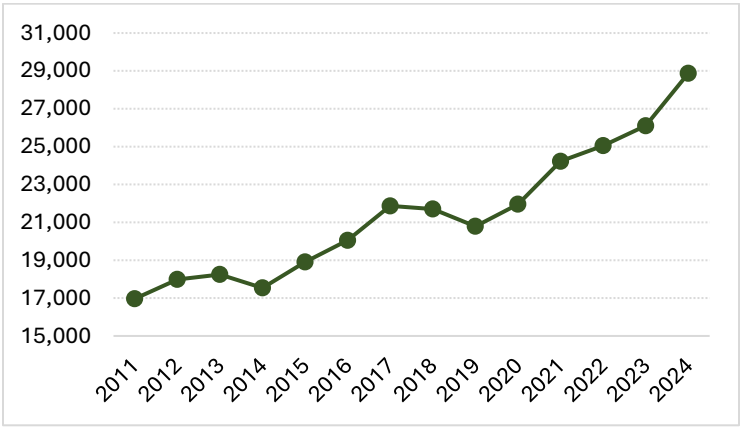
Figure 1: RNs & NPs per 100,000 population: Ontario vs. rest of Canada, 1980-2024



Data sources: Canadian Institute for Health Information. Nursing in Canada, 2024 — Data Tables. Ottawa, ON: CIHI; 2025; Statistics Canada, Table 17-10-0005-01 Population estimates on July 1, by age and gender and RNAO calculation.

Ontario's efforts to bolster this workforce are falling far short of other Canadian jurisdictions.

Figure 2: Ontario RN deficits compared to rest of Canada, 2011-2024

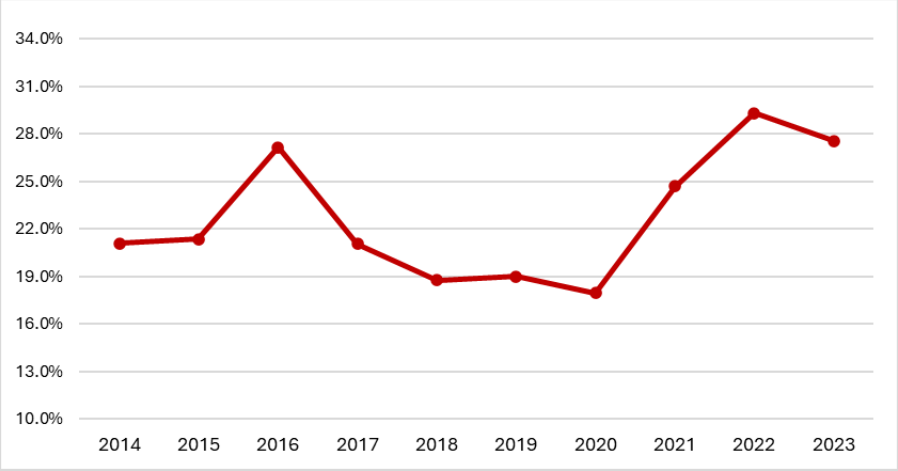


Data sources: Canadian Institute for Health Information. Nursing in Canada, 2024 — Data Tables. Ottawa, ON: CIHI; 2025.Statistics Canada. Table 17-10-0005-01 Population estimates on July 1, by age and gender and RNAO calculation.

The gap in RNs per capita between Ontario and the rest of Canada continues to widen, despite the significant and effective efforts of the College of Nurses of Ontario (CNO) to expedite registration processes for internationally educated nurses. Indeed, the proportion of IENs has been growing since 2020 and now accounts for 17.2 per cent of the Ontario nursing supply in 2025 (32,886 nurses) while the number of new internationally educated RNs overtook the number of new Ontario RNs making up over half (53.5 per cent) of new RN registrants in 2024 (1).

Despite their importance to the workforce, IENs lack the support needed for integration; in 2025, more than one in five internationally educated RNs were seeking employment – a 6.4 per cent increase from the previous year (1). IENs also remain less likely to renew during their first year compared to Ontario graduates (1). Early career nurses are also in need of greater supports in the workplace. Since 2020, the percentage of losses in the RN supply has been increasingly attributed to nurses under the age of 35, rising from 20.2 per cent in 2020 to 25.7 per cent in 2025 (1).

Figure 3: Ratio of RNs under 35 leaving the profession to those entering in Ontario, 2014-2023



Data source: Canadian Institute for Health Information. Nursing in Canada, 2024 — Data Tables

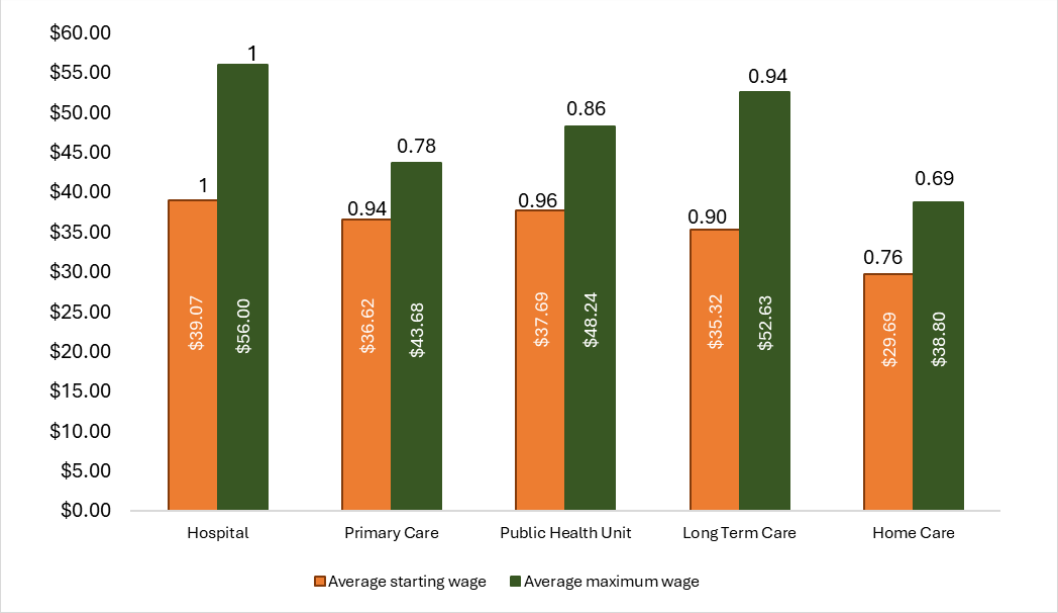
Moreover, early career nurses are more likely than mid/late career nurses to experience abuse, consider leaving nursing, have clinical anxiety, depression, and burnout (2). Amid a nursing shortage, we ideally need new nursing graduates to be employed and employed in full time positions. And yet, the reality is that the number of new nurses working full time has decreased by approximately five per cent between 2024 and 2025, and RNs at their first year renewal are less likely to work full time as compared to all nurses (1).

The RN shortage has triggered a vicious circle of eroding working conditions, declining patient access to care, decreasing quality of care, and higher costs to the health system. In 2024, Ontario experienced its highest rates of emergency department closures and high levels of unintentional harm in hospitals, while an estimated 3 million Ontarians were unattached to a primary care provider (3). Following sustained RNAO advocacy, the government has taken steps to address the RN staffing crisis, including: expanding nursing education seats and bridging supports; introducing workforce support programs; improving pathways for internationally educated nurses (IEN); and modestly broadening scope of practice.

The health system - most commonly hospitals and long-term care (LTC) homes – have increasingly relied on for-profit nursing agencies to address the shortage of RNs, reducing continuity and quality of care (4). Nursing agencies have cost Ontario public hospitals $9.2 billion between 2013-2022, diverting public funds that could be used for recruitment and retention strategies such as mentorship, return-to-practice incentives, and retention bonuses for permanent staff. These agencies operate with limited transparency, accountability, and regulatory oversight regarding their fees and profit margins, contribute to pay inequities among nurses, and place additional strain on organizational budgets.

Yet, the systemic drivers of the nursing workforce crisis persist. Compensation – particularly the disparities both between and within sectors – remains one of the crucial contributing factors to RN retention and recruitment. Although the gap between the hospital wages and LTC has narrowed, the gap between hospital wages and other community care sectors remains unchanged from 2023. Further, substantial and inequitable wage disparities continue within sectors themselves. For example, RN wages in the palliative and hospice sector care are generally lower than in hospital settings; even within this sector, pay can vary considerably.

RN hourly wage rates and ratios across sectors in 2024



Data sources: Ontario Ministry of Labour, Immigration, Training and Skills Development's Collective Agreements Interactive Search; Ontario Nurses' Association; and RNAO calculation.

While RN wages in the hospital sector are significantly higher than other sectors of the system, in real terms, hospital RN wages remain below 2010 levels (3–5) and uncompetitive with many jurisdictions, including the U.S. (5). RNAO urges the government to address the nursing crisis and rebuild nursing by investing in a comprehensive retention plan (6).

1.1 Compensation

Recommendation: Increase nurses' compensation and address existing pay disparities within the health system as follows:

- Increase compensation for nurses working in all roles, domains and sectors.
- Harmonize compensation upwards to address pay disparities affecting, primary care, home care, and long-term care.
- Guarantee competitive compensation comparable to jurisdictions such as the U.S.

Cost estimate: Depends on implementation.

1.2 Internationally educated nurses

Recommendation: Improve ability of IENs already residing in Canada to contribute to the workforce, while ensuring ethical workforce practices. This can be done by:

- Maintaining streamlined pathways such as the Supervised Practice Experience Partnership (SPEP) program to integrate all qualified IENs into the workforce; monitor trends in IEN inflow to ensure all IENs eligible for SPEP have access to the program.
- Addressing systemic racism, discrimination, and workplace barriers that limit IENs access to fair employment, full-time positions, and leadership opportunities.
- Monitoring outcomes to ensure IENs achieve equitable access to permanent full-time, positions across all sectors.
- Enacting proactive measures to ensure there are no international recruitment campaigns that draw nurses away from countries already experiencing severe health human resource shortages.

Cost estimate: No additional costs.

1.3 Nursing Graduate Guarantee

Recommendation: Strengthen mentorship and retention programs to attract nurses to the Ontario workforce. This includes:

- Expanding the Nursing Graduate Guarantee (NGG) to ensure access to all new nursing registrants including IENs.
- Enticing experienced nurses, including those in the non-practicing class and recently retired nurses, into practice to support the expansion of the NGG program.

Cost estimate: $582M for the total cost of RPN/RN NGG positions and $436M for the total cost of enticing experienced practicing/experienced non practicing/recently retired nurses to act as NGG preceptors.

1.4 Healthy workplaces for nurses and other health-care staff

Fund RNAO to expand the Best Practice Spotlight Organization® (BPSO®) Program and develop and update healthy workplace guidelines and resources for health settings.

Background: RNAO has developed 12 healthy work environment (HWE) best practice guidelines (BPG) to help health-care organizations create and sustain positive work environments, leading to better staff, patient, organizational and financial outcomes. The guidelines cover leadership, collaborative practice, workload and staffing, professionalism, embracing diversity, and workplace health, safety and well-being. RNAO aims to integrate the GRADE approach and the Implementation in Context (ICON) framework – the only meta-framework designed to guide health-care professionals in implementing research evidence into clinical practice – into all HWE BPGs.

Cost estimate: Fund $1.5M through 2031, starting with $300,000 during 2026.

1.5 Extern programs

Recommendation: Expand the hospital-focused nursing clinical extern program and LTC nursing extern pilot to be inclusive of all community care sectors. Prioritize future program evaluation of these projects, ensuring that pilots and expansions are scaled adequately to achieve this.

Cost estimate: Costs depend on scale of program and implementation.

1.6 Nursing education - RNs

Assuming BScN seat allocations of 600 for 2026–2027 and 700 for 2027–2028, implement a 5 per cent increase in each of the following two years to match the RN per capita ratio in rest of Canada by 2029.

Cost estimate: $6M in the first year, $23M in the second year, $44M in the third year and $59M in the fourth year, based on a per-seat cost of $9,400.

1.7 Nursing education - NPs

Recommendation: Increase the number of seats in NP programs, starting with 200 in 2026 with the goal of having 7,500 registered NPs in Ontario by 2029 to respond to the enormous and growing population of Ontarians without a regular primary care provider.

Cost estimate: $81M

1.8 Nurse education – Equity, diversion and inclusion

Recommendation: Include racism and discrimination as a mandatory topic in nursing, interprofessional and continuing education curricula. Provide mandatory courses or workshops that include topics of cultural humility, anti-oppressive behaviors, anti-racism and trauma-informed care in orientation and continuing education programs.

Cost estimate: No additional cost

1.9 NP residency programs

Recommendation: Introduce funding to develop paid post-graduate NP residency programs to support a retention and recruitment strategy for both new graduates and practicing NPs to improve access to specialized care for Ontarians.

Cost estimate: Costing depends on the model and services required for implementation.

1.10 Nursing faculty

Recommendation: Recruit and retain faculty for nursing programs and promote funding for PhD and DN students to support the nurse educator workforce.

Cost estimate: Cost is dependent on rate of program expansion.

1.11 Nursing continuing education

Recommendation: Increase funding for continuing education, professional development, specialty certifications, and leadership training to strengthen evidence-based practice, improve health outcomes and enhance job satisfaction.

Cost estimate: Dependent on the expansion of services and programs required.

1.12 Funded educational stipends

Recommendation: Implement a standardized, provincially funded educational stipend for experienced and licensed nursing professionals completing mandatory immersive clinical placements required for credential advancement, including RPN-to-RN bridging students, nurse practitioner students and internationally educated nurses. This compensation framework recognizes the value of regulated nursing labour to the health system while supporting retention, workforce sustainability and equitable access to continued nursing education.

Cost estimate: $25 million annually.

1.13 RN scope of practice - prescribing

Recommendations:

- Continue to provide funding to incentive the early integration of RN prescribing education into BScN curriculum.
- Provide tuition support for RN prescribing to prepare up to 20,000 RNs as prescribers over four years.
- Enhance RN prescribing by expanding:
  - the list of approved drugs that RNs can prescribe in parallel with other regulated health professions such as pharmacists.
  - RN scope of practice to include the ability to order laboratory and diagnostic testing.
  - the ability of RNs to prescribe in hospitals and outpatient settings.

Cost estimate: $21M

1.14 RN scope of practice

Recommendation: Expand RN scope of practice to increase timely access to care by giving RNs the authority to:

- Apply automated-external defibrillators (AEDs) and defibrillators in AED mode for in hospital cardiac arrests.
- Refer to interprofessional health care providers such as occupational therapists, physiotherapists and registered dietitians.

Cost estimate: No additional cost

1.15 NP scope of practice

Recommendations: Expand NP scope of practice to enable NPs to work to their full potential to improve access to timely and efficient primary care. These expansions must include:

- Allowing NPs to initiate legal forms under the Mental Health Act including Forms 1, 3, and 4.
- Authorizing NPs to order additional forms of energy such as diagnostic tests with contrast (CT/MRI) and nuclear imaging (bone scans and thyroid scans).
- Authorizing NPs to complete the mandatory letter to support the government of Ontario Application for a Change of Sex Designation on a Birth Registration of an Adult, and the Statutory Declaration for a Change of Sex Designation on a Birth Registration of an Adult forms for gender-affirming care.
- Excusing NPs from jury duty.

Cost estimate: No additional costs

1.16 Violence against health-care providers

Recommendation: Formalize existing workplace violence prevention guidelines as provincial requirements for health care employers, establishing minimum standards for risk assessments, training, mitigation, response and accountability measures, enforced through funding and oversight mechanisms to protect nurses and nursing students across all Ontario health-care workplace and educational settings.

Cost estimate: Cost savings

1.17 Reliance on nursing agencies

Recommendation: Reducing reliance on nursing agencies will require strengthening nurse recruitment and retention strategies, including competitive compensation, mentorship, and other supports that encourage nurses to remain in permanent roles. In addition, reform Ontario's approach to nursing to strengthen a stable, permanent workforce by:

- Making full- and part-time employment in all sectors more financially attractive than agency work through fair compensation, benefits, and predictable scheduling.
- Establishing non-profit or hospital-based staffing pools to replace for-profit agencies and keep public funds within the health system.
- Requiring transparency and regulation of agency contracts, rates, and profit margins to prevent misuse of taxpayer dollars.
- Redirecting agency expenditures toward retention programs that support mentorship, return-to-practice initiatives, and long-term workforce stability.

Cost estimate: Cost savings will emerge as reliance on nursing agencies is reduced with a stronger permanent workforce.

2. Care delivery

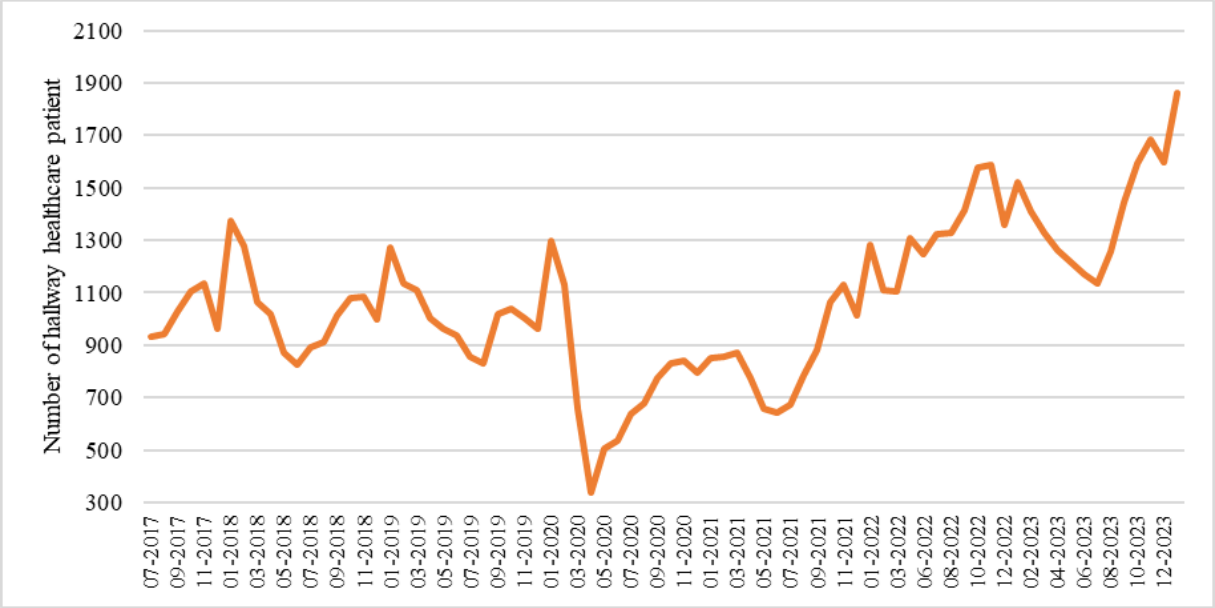
Health is a resource for everyday living, grounded in the principle that health care is a universal human right and human dignity must be upheld in practice. Yet the ability of our health system to deliver respectful and dignified care is jeopardized by several issues:

- underfunding
- expanding privatization disguised as "innovation" and investor-driven interests
- health human resource shortages (particularly, nursing) and consequent challenges to retention
- uneven and incomplete system transformation and integration

In addition, Ontario's health system is structurally misaligned – overly reliant on hospitals while chronically underfunding community care (5). The consequences of this imbalance – worsened by the COVID-19 pandemic – are evident across the system and are undermining timely, appropriate, and person-centred care. For example, Ontario's hospitals are overwhelmed, over capacity and sinking into debt. Patients are routinely treated in unconventional spaces such as emergency department corridors. Due in part to long wait lists for long-term care – now exceeding 50,000 people – and an underfunded home care system, nearly one in five hospital beds is occupied by patients awaiting alternate levels of care (ALC) – representing 1.5 million ALC days or the equivalent of 4,000 beds at full occupancy (7).

[see graph on next page]

Average number of ON hospital patients per day receiving care in unconventional spaces



Data source: The Trillium, 2024, Hospital data shows Ontario's hallway health care problem is worse than ever.

Primary care – the cornerstone of an equitable, high-functioning health system – in Ontario is experiencing its own crisis. RNAO estimates that over 3 million Ontarians currently lack a regular primary care provider (PCP), with newcomers, racialized people and people on low incomes disproportionately unattached (3). And, many who do have a provider can't access timely services.

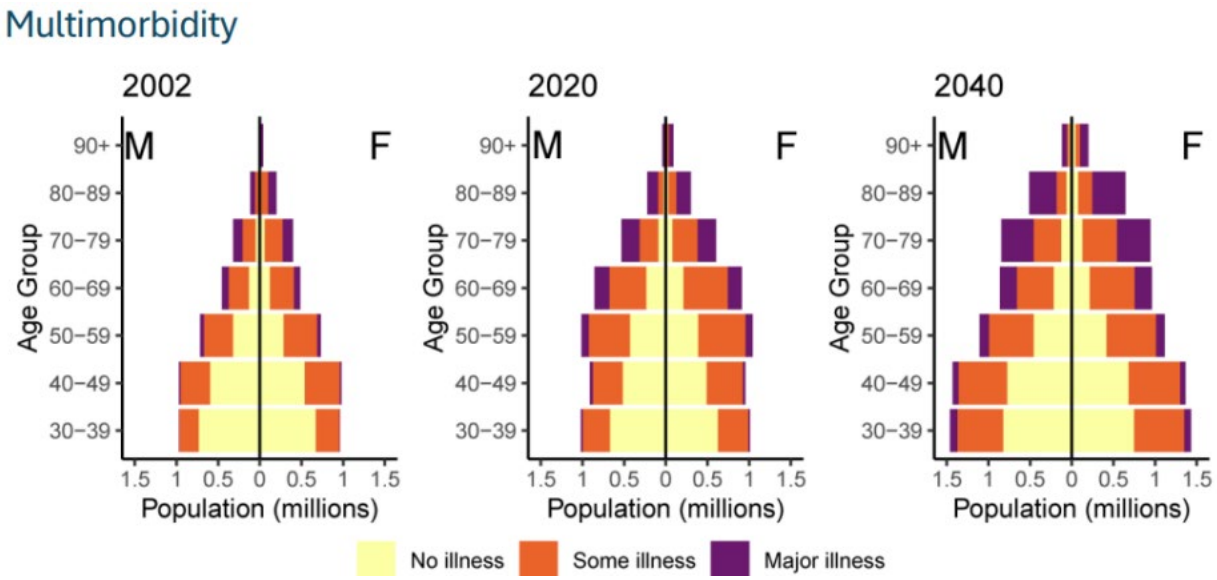
RNAO applauds the government's commitment to attach everyone who lives in Ontario to a PCP by 2029. This aligns with evidence that: 1) primary care is the foundation of equitable, high-functioning health systems, and 2) attachment to a PCP improves patient outcomes and relieves burden on other sectors of the health system, particularly hospitals.

However, the government's plan vastly understates the scale and scope of the crisis. For example, despite widely accepted evidence that 2.5 million Ontarians were unattached in 2023, the government assumes that, currently, there are only 2 million Ontarians without a regular PCP. Moreover, the government response to the primary care crisis assumes that the number of unattached Ontarians will not increase through their five year planning horizon – despite population growth, an aging population, health and disease trends, and the demographics of the comprehensive family physician workforce. The government provides no basis for their current or projected estimates of unattached Ontarians. RNAO projections show that 1.8 million Ontarians will be unattached by 2029 even after the government's current primary care and associated workforce planning initiatives are implemented and successful (3).

In addition to the government's current and planned initiatives, resolving the primary care crisis will require a fundamental reimagination of who provides primary care and how that care is provided.

Most obviously, demographic trends, climate change and patterns of illness point to imminent increasing burdens on the system. Further, these trends point to the need hurry the process of

Projected patterns of multimorbidity



Data source: Rosella LC, Buajitti E, Daniel I, Alexander M, Brown A. *Projected patterns of illness in Ontario*. Toronto, ON: Dalla Lana School of Public Health; 2024.

effectively integrating system sectors to address emerging clinical priorities such as chronic disease and mental health and addiction. In part, this means stronger partnerships between public health and all sectors of the system, particularly primary care, for early detection and management of chronic conditions. It also means grounding care coordination in primary care so that publicly funded, not-for-profit mental health and addiction resources are easily reachable from the community.

RNAO urges the government to appropriately fund, staff and realign Ontario's health care system by implementing the following recommendations:

2.1 Pharmacare

Recommendation: Finalize a pharmacare agreement with the federal government and collaborate on its expansion beyond diabetes and contraception.

Cost estimate: Cost savings

2.2 Public health – base funding

Recommendations: Ensure that Public Health Ontario has sustainable resources required to deliver on the agency's mandate effectively, including emergency preparedness, by shifting from reallocating one-time annual funding to base funding and indexing to inflation.

Cost estimate: No additional costs.

2.3 Public health – First Nation community wellness

Recommendation: Increase and sustain funding and resources to all First Nation communities to ensure their public health needs – as determined by the communities themselves – are met. Begin with doubling the number of Community Wellness Nurses – from 50 to 100 - in remote First Nation communities to provide public health services.

Cost estimate: Initial cost estimate of an additional $23.5 million immediately to support existing Community Wellness Nurse complement. We are not able to estimate further costs for this item. It is imperative on the government to transfer the necessary resources, funding and authority to all Indigenous communities who opt to exercise their inherent right to determine and control their own public health programming and services.

2.4 Primary care access

Recommendation: Attach the estimated 3 million Ontarians without a regular primary care provider to an NP or family doctor by 2029 and improve access to RN-led care. RNAO recommends this be accomplished by:

- Recommendation 1.1 above re compensation
- Recommendations 1.13 – 1.15 re nursing scope of practice above
- Funding a total of 54 NP-led clinics (NPLC) by 2029
- Recognize NPs as most responsible providers (MRPs) in all models of primary care.
- Fulfilling existing commitment to fill 75 NP positions in correctional services
- Developing and implementing a public funding model for independent NPs in primary care without user-fees, such as in Alberta and British Columbia.
- Expand panels (and relieve burden on MRPs) by incorporating specialty RN roles into team-based care to address high and growing incidence of chronic disease, high and growing incidence of mental illness, and the need for care coordination and navigation to social services.

Cost estimate: Cost savings emerge from upstream care and chronic disease prevention and management.

2.5 Home care – funding model

Recommendation: Permanently increase funding and transform home care delivery in Ontario by implementing a relational funding model that supports comprehensive home and community services.

Convert existing multi-year government funding commitments into permanent base funding to sustain long-term planning and stabilize service delivery of the current home care system.

- Reform home care funding model to prioritize client needs, changing the existing per-visit funding structure to instead implement a relational model of care – i.e. flexible care baskets

that support coordinated nursing and support services, health promotion and continuity of caregiver.
- Provide a dedicated transformation envelope in additional funding to support this operational restructuring through implementation planning, updated clinical and administrative tools as well as any required training and transitional support for home-care recipients and organizations.

Cost estimate: $500M for transformation envelope, in addition to current funding.

2.6 Long-term care – Direct care and skill mix

Recommendations: Prioritize quality care from regulated health professionals by formalizing a Nursing Home Basic Care Guarantee to deliver safe, dignified, and client-centred care.

Fund and maintain a standard of at least four hours of direct care daily per resident with a skill mix of 20 per cent RNs, 25 per cent registered practical nurses (RPNs), and 55 per cent personal support workers (PSWs).

Cost estimate: $1.1B. This includes funding for 8,800 additional RN full-time equivalents (FTEs).

2.7 Long-term care – Attending NPs

Recommendation: Ensure one attending NP as most responsible care provider in long-term care per 120 residents by 2029 – with an addition of at least 150 NPs during the upcoming fiscal year.

Cost estimate: $165M

2.8 Long-term care – NPs as medical directors

Recommendation: Fund NPs as clinical directors to ensure accessible, quality care for residents and optimized outcomes.

Cost estimate: Cost savings.

2.9 Long-term care – Funding formula

Recommendation: Ensure that LTC homes that decrease acuity (Case Mix Index, or CMI) due to evidence-based care retain all savings to reinvest in staffing and/or programs for residents.

Cost estimate: Cost savings.

2.10 Long-term care – Infection prevention and control

Recommendation: Ensure one infection prevention and control (IPAC) RN lead per 120 residents.

Cost estimate: Costs are dependent on skill mix of current IPAC leads and government progress under existing legislation.

2.11 Long-term care – Embedding evidence-based guidelines into electronic medical records (EMRs)

Fund phase II of RNAO's Clinical Pathways program for three years to support long-term care homes with embedding RNAO's Best Practice Guidelines into their electronic medical record. RNAO's Clinical Pathways program is grounded in clinical expertise, credibility, collaboration, and co-design. Evidence shows that RNAO Clinical Pathways improve the quality of resident care, enhance staff satisfaction, optimize team efficiency, and support regulatory compliance within RNAO BPSO long-term care homes across Ontario. The 2026- 2029 funding will:

1. Improve outcomes for more residents in Ontario's LTCHs
2. Scale the implementation of RNAO Clinical Pathways to an additional 300 LTCHs
3. Maintain existing RNAO Clinical Pathways
4. Develop new RNAO Clinical Pathways
5. Provide ongoing change management support
6. Monitor outcomes and drive continuous quality improvement
7. Ensure policy alignment

Please see Appendix A for the attached details regarding RNAO's proposed budget for Phase II funding, submitted to the Hon. Natalia Kusendova-Bashta, Minister of Long-Term Care.

Cost estimate (rounded): $2.16M in year 1; $2.32M in year 2, and $2.27M in year 3.

2.12 Retirement homes – Attending NPs

Recommendation: Fund attending NPs in 20 retirement homes in 2026 with outcome measurements.

Cost estimate: $3.3M

2.13 Hospitals - Backlog

Recommendation: Ensure that publicly funded hospitals have the resources to clear the backlog of surgeries, treatments and procedures in a safe and timely way. Stop all funding to investor-driven, private for-profit clinics for surgeries, treatments and procedures, and instead return them to the public system. This can be accomplished by:

- Returning investor-driven clinics to the public fold, redirecting savings to the hospital system
- Making operating rooms, step-down units and diagnostic facilities and equipment available for use twenty-four hours per day, seven days per week.
- Making available all necessary staff to make these facilities and services functional and safe.

Cost estimate: Cost savings.

2.14 Hospitals - Surgical care

Recommendation: Increase the funding for an additional 500 RN first assistant and 200 NP Aanesthetists by 2029, starting with 200 RN First Assistant and 80 NP anesthetists in the upcoming fiscal year.

Cost estimate: $144.5M plus indeterminate program/training costs.

2.15 Hospitals – Minimum nurse-patient ratios

Recommendation: Implement mandatory, evidence-based nurse-patient ratios for both hospital and community settings to ensure nurse safety and improved patient outcomes.

Cost estimate: dependant on determination of ratios and implementation.

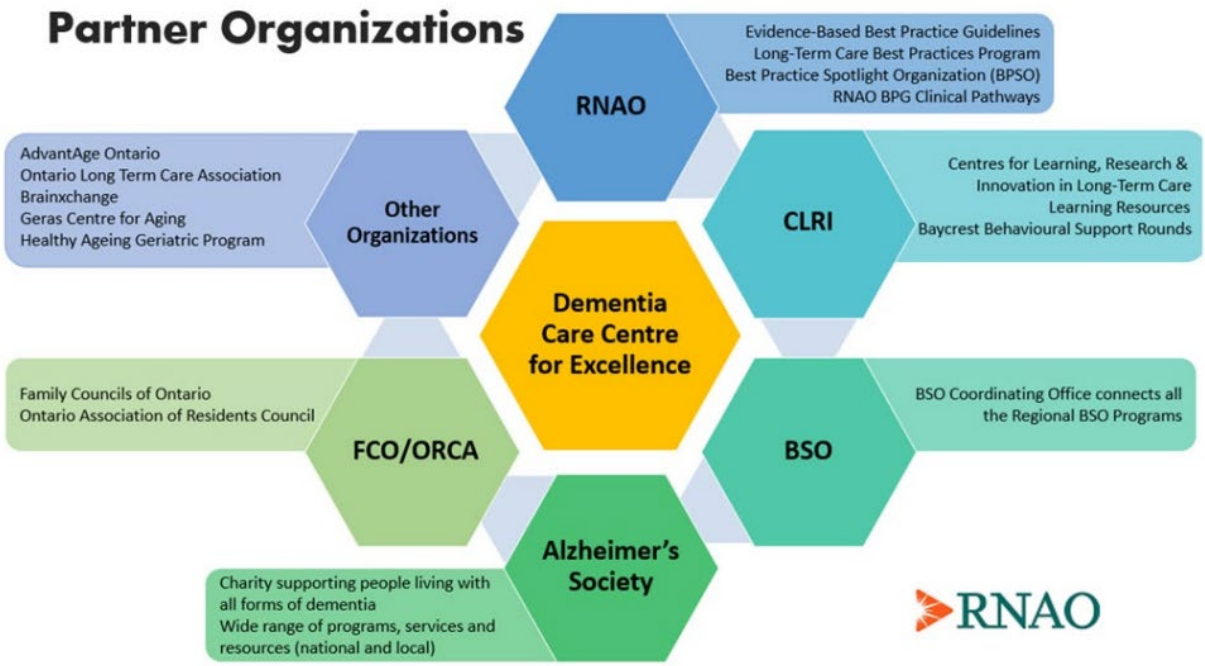
2.16 Mental health – RN psychotherapy

Recommendation: Amend "Roadmap to Wellness" to incorporate programming for 500 RN psychotherapists by 2029 – starting with 250 in the upcoming fiscal year – allocating public funds within program to support access across Ontario.

Cost estimate: No additional cost.

2.17 Mental health – dementia care

Recommendation: Fund RNAO to develop and administer a Dementia Care Centre of Excellence to promote the delivery of evidence-based and compassionate dementia care.



25 per cent of individuals 85 or older have dementia, and Ontario will have a 202% dementia increase between 2020 and 2050 (8). The goal of the Dementia Care Centre for Excellence is to advance excellence in caring for persons with cognitive impairment living in LTC homes by leveraging and sharing resources from multiple organizations and developing new tools as needed. Activities will include:

- Creating a committee of key dementia care partners to launch the Dementia Care Centre of Excellence.
- Coordinating efforts from multiple organizations to support LTC homes in caring for residents with dementia.
- Developing a website – a "one-stop shop" for resources, tools and events from multiple partner organizations.
- Advancing research in dementia care and educational support/resources for individuals, families, health-care providers and organizations.

Cost estimate: $838,000

2.18 Pediatric care

Recommendation: Designate sustained funding to right-size pediatric health care in Ontario as follows:

- Increase funding for pediatric care across all sectors, especially in primary care and home care.
- Scale up pediatric-specific infrastructure such as systems, programs, services, equipment, resources and staffing, to increase capacity.
- Increase integration between pediatric settings across the continuum of care and fostering community partnerships.
- Build a specialized pediatric workforce through increasing pediatric placement. opportunities, sustaining pediatric externship opportunities, and funding pediatric-focused learning opportunities

Cost estimate: Cost savings

2.19 Indigenous health – RNAO's Indigenous health program

Recommendation: Continue to fund RNAO's Indigenous Health Program to carry out work led by and supporting Indigenous communities in Ontario. The program is a collaborative initiative in partnership with Indigenous communities that includes delivering Indigenous-focused webinars, creating tailored BPSO programs and developing best practice guidelines that honor Indigenous ways of knowing.

Cost estimate: Continue to fund RNAO's Indigenous Health Program, with $2.5M over 3 years, starting in 2028.

2.20 Health system – Equity, diversity and inclusion

Recommendation: Implement anti-racism, anti-oppression, cultural safety, and equity, diversity and inclusion (EDI) training, orientation and mechanisms for staff at all levels in all workplace and academic settings.

- Provide tools and resources to support nurses from marginalized communities as they navigate difficult challenges when dealing with residents, patients or families who display racism or discrimination.
- Increase access to mental health supports in the workplace and academic settings to address traumas related to racism.
- Address workplace violence, staff mental health, and occupational health and safety with robust policies and supports.
- Include EDI committees in all workplaces and academic settings to address racism and discrimination.
- Create safe spaces for nurses from marginalized communities to open up about the discrimination and oppression they face in professional settings. Increase access to mental health supports in the workplace and academic settings to address traumas related to racism.

Cost estimate: No additional costs.

2.21 Health system – Cultural and linguistic diversity

Recommendation: Establish comprehensive, publicly funded, 24-hour professional interpretation services for refugees and other language minorities in health-care settings to ensure that all people can access culturally and linguistically appropriate care.

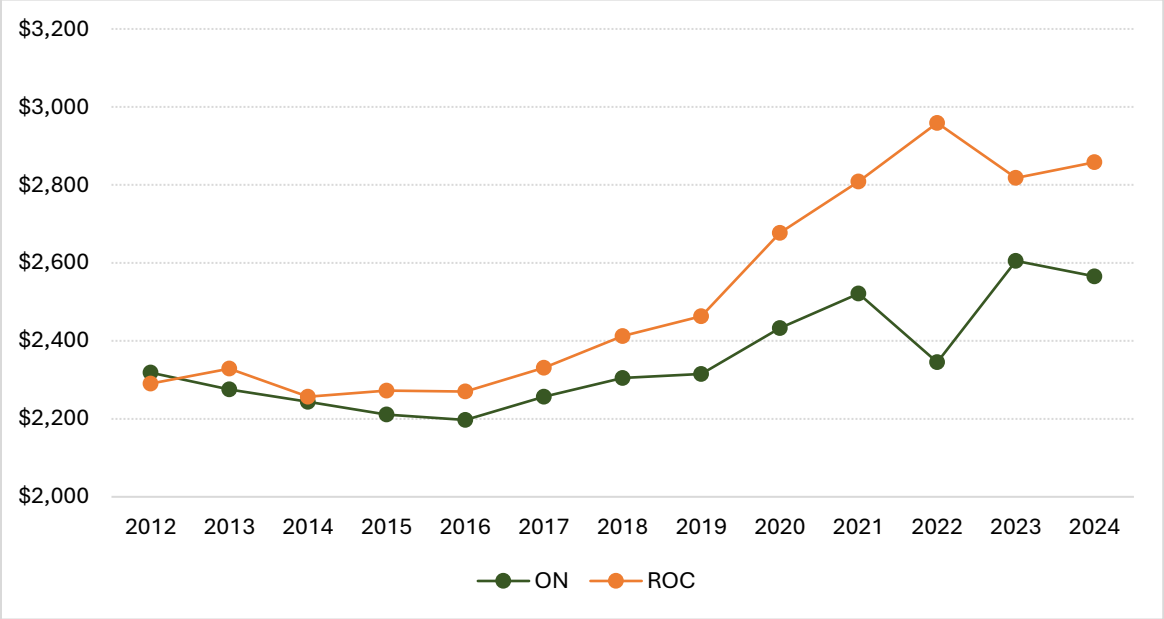
Cost estimate: Dependent on implementation.

3. Social determinants of health

Social determinants of health (SDOH) – for example, housing, income and access to health care – play a crucial role in shaping health outcomes and advancing health equities. The 2024 Projected Patterns of Illness in Ontario report indicates that patient complexity and disease burdens will rise significantly in the coming decades as the population ages and grows, suggesting that insufficient attention has been and is being paid to determinants of health (9).

For over a decade, Ontario has consistently had lower per capita spending on social and youth services, poverty programs, and housing support than the rest of Canada. In 2024, Ontario's social protection spending decreased by 1.5 per cent, whereas the rest of Canada saw an increase of 1.4 per cent.

Consolidated provincial-territorial and local governments' social protection spending per capita (constant 2025$)



Data sources: Statistics Canada. Table 10-10-0005-01 Canadian Classification of Functions of Government (CCOFOG) by consolidated government component (x 1,000,000), Statistics Canada. Table 17-10-0005-01 Population estimates on July 1, by age and gender, Statistics Canada. Table 18-10-0005-01 Consumer Price Index, annual average, not seasonally adjusted and RNAO Calculation.

In the absence of sufficient measures to address SDOH, the province's already over-burdened health care system will face unsustainable strain. Upstream approaches, including disease prevention, health promotion and targeted intervention to address SDOH and mitigate chronic illness, are essential to safeguard population health and preserve health-care capacity.

Housing, for example, has a significant impact on our physical health, mental health and social wellbeing. Ontario's housing crisis has reached alarming levels in recent years, with skyrocketing rental and housing prices, insufficient affordable housing supply and soaring homelessness. Recent data reveals that over 85,000 Ontarians experienced homelessness in 2025, an increase of more than 50 per cent since 2016, 25 per cent since 2022 and a surge of 8 per cent over 2024 (10). Over half of these individuals were chronically homeless, facing prolonged or repetitive periods without stable housing (10).

People experiencing homelessness have an increased risk of premature death, morbidity, mental illness and substance abuse. Given huge barriers to health care access due to a lack of a permanent address, people homelessness in all its forms are forced to rely heavily on emergency services for health care and even for shelter, which causes unnecessary strain on emergency services.

[see diagram on next page]

Health impacts for people facing homelessness in Ontario

7%	29%	17 years	93%
of PEH hospitalization is due to cellulitis	of PEH hospitalization due to substance use & mental illness	Average reduced life span	of PEH admitted to hospital via emergency department
Increased infection and mobidity	Increased mental illness	Increased mortality	Lack of access to primary care

Data source: RNAO. Housing, Health and Human Rights. 2025.

The housing crisis is further compounded by broader social and economic inequities. Persistent poverty, driven by income stagnation, and insufficient income support programs, disproportionately impact marginalized populations. Higher inflation in recent years has further exacerbated these challenges, making basic necessities such as food and housing increasingly unaffordable. For many, the intersection of poverty and housing insecurity has intensified health inequities and placed additional strain on the health care system.

OW and ODSP maximum shelter allowance (one person) and average market rent for a bachelor unit, Toronto, 2014-2024

Data source: RNAO. Housing, Health and Human Rights. 2025.

Against this backdrop, the toxic drug crisis continues to claim the lives of Ontarians and the scale of it is staggering. This crisis has taken the lives of nearly 20,000 Ontarians since 2018 (11). While RNAO welcomes the government's investment in Homelessness and Addiction Recovery Treatment (HART) hubs, the investment fails to recognize the scale of Ontario's toxic drug crisis, excludes harm reduction services (such as supervised consumption services [SCS] sites and needle exchange programs) and, consequently, does not align with evidence-based substance care response. Harm reduction programs are an essential component of substance use care – they do not operate in opposition to treatment and recovery models, but complement them. Harm reduction services such as SCS sites save lives and open the door to treatment and recovery. They reduce deaths, injuries, hospitalizations, emergency room visits and the incidence of HIV and hepatitis. SCS sites keep people alive and provide a gateway to supportive services, including addiction treatment.

Between March 2020 and February 2025, there were almost 24,000 non-fatal overdoses in SCSs across the province and not a single death, among which 9,187 occurred in the nine publicly-funded SCS sites that were closed as of Mar 31, 2025. The closure of SCSs and consequent withdrawal of critical health-care services will lead to preventable deaths in Ontario communities. Drug overdose has increased 288 per cent at drop-in centres as a result of the SCS closures in March 2025 (12).

Meanwhile, another substance, alcohol, is inflicting increasing harm to Ontarians, especially after the government's 2024 alcohol sale expansion policy. Alcohol as a known carcinogen is linked to various cancers including liver cancer, breast cancer and colorectal cancer. Alcohol consumption is also associated with more than 200 health conditions such as liver cirrhosis, heart disease, stroke and diabetes. Beyond these medical consequences, alcohol consumption also contributes to a wide range of social harms, including impaired driving and related accidents, violent behavior and intimate partner violence. In effect, the alcohol expansion policy, instead of strengthening the government finances, increases expenditures and burdens across multiple sectors. Independent analysis from Ontario's Financial Accountability Office projects that the alcohol sales expansion began in 2024 will result in a net cost of $1.4 billion by 2030 (13).

RNAO recommends robust investments to address the social determinants of health, lift Ontarians out of poverty and reduce costly burdens on the province's health system. The government has a responsibility to ensure the health and safety of all Ontarians. Harm reduction is an essential component of substance use care – one aligned with other mental health treatment and recovery models.

3.1 Toxic drug crisis

Recommendation: Invest in an integrated substance use model of care across all care settings by allocating existing and, if required, additional funds from the Road to Wellness.

Such a model of care includes:

- Reversing the decision to close SCS sites and ensure all established SCS sites remain operational and adequately funded.
- Increasing funding for SCS sites, including inhalation and other harm reduction services, for every community in the province in need.
- Ensuring access to voluntary, publicly funded and not-for-profit, evidence-based treatment.
- Incorporating harm reduction programs and services in Homelessness and Addiction Recovery Treatment (HART) Hubs to meet people where they are at and connect them with prevention and treatment services including primary care, mental health services, substance use services and address the determinants of health.
- Investing a portion of the profits from the sale of legalized substances, particularly alcohol and cannabis, in initiatives aimed at the prevention, early identification, and management of substance use disorders.

Cost estimate: $1.6M per supervised consumption site and $4.2M for regional trauma-informed nurse coordinators.

3.2 Alcohol sales and consumption

Recommendation: Implement a comprehensive alcohol strategy to curb alcohol-related harms, including:

- Stopping further expansion of alcohol retail access immediately.
- Launching new public health guidelines on alcohol consumption.
- Implementing a comprehensive alcohol strategy developed with recommendations by the Canadian Alcohol Policy Evaluation (CAPE) Project

Cost estimate: Cost savings.

3.3 Housing

Recommendation: Address Ontario's housing and homelessness crisis by investing one per cent of the provincial budget annually in non-market housing programming, including:

- construction of 10,000 deeply affordable units annually
- construction of 3,000 units of supportive housing annually
- support for rent subsidies and supplements
- an Indigenous-led urban rural and Indigenous housing strategy
- provision of adequate emergency shelter services, including all investments needed to end chronic homelessness by 2030, such investments to include an additional:
    - $11 billion over 10 years needed to end chronic homelessness
    - $2 billion over eight years to increase supportive, transitional and community housing capacity to ensure encampment residents being housed appropriately

Regulate the rental housing market to ensure affordability, by:

- Extending rent control to all rental units.
- Eliminating vacancy decontrol and instituting a rent increase ceiling.

Cost estimate: One per cent of total 2026-27 budget.

3.4 Income security – sick days

Recommendation: Amend the Employment Standards Act to provide 10 permanent paid sick days for all employees, and an additional 14 days paid sick days during a public health emergency.

Cost estimate: No additional costs.

3.5 Income security - minimum wage

Recommendation: Increase the minimum wage immediately to $19.60 per hour, indexed annually to inflation.

Cost estimate: No additional costs.

3.6 Income security – Ontario Disability Support Program and Ontario Works

Immediately double rates for the Ontario Disability Support Program (ODSP) and the Ontario Works program (OW) and index annually to inflation.

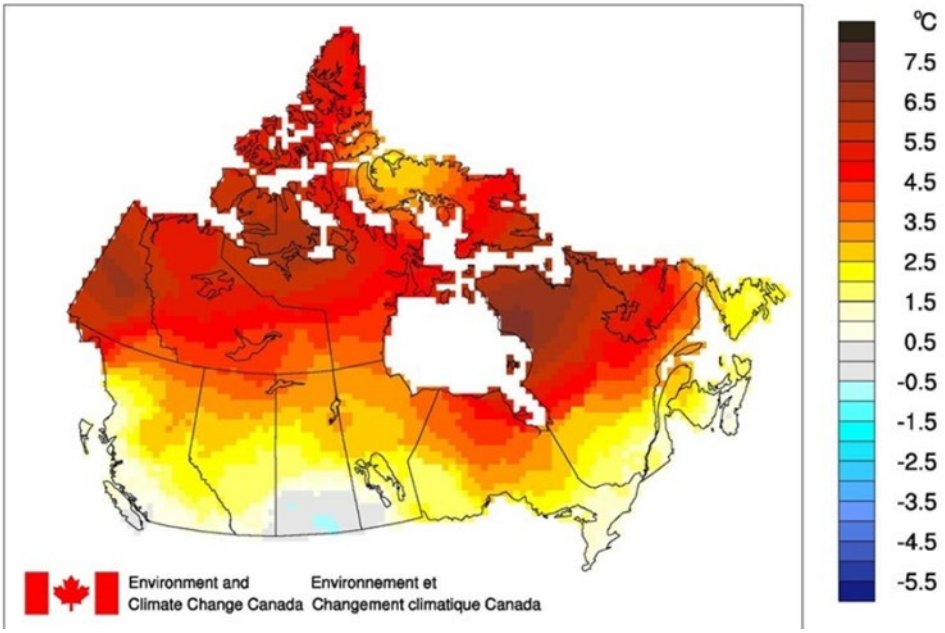
Cost estimate: $9 billion over and above current expenditures.

4. Environmental determinants of health

Ontario and the planet are facing a climate emergency. Climate change is an immediate and growing threat to human health. Globally, 2025 was the third hottest year on record, following close behind 2024 and 2023 as the hottest and second hottest years in recorded history (14). On average, the last three years exceed the 1.5 C target of the 2015 Paris Accord (15).

In Canada, average temperatures are rising at twice the global average – three times in the north (15). In 2024, the national average temperature in Canada was 3.1° C above the 1961-1990 historical average (16). And the average temperature of winter 2024-25 was 3.7° C above the 1961-1990 baseline, with the warming particular pronounced in northern regions where most areas experienced temperatures more than 3.5° C above the same baseline (16).

Temperature departures from the 1961-1990 average – winter 2023-24 in Canada



Data source: https://www.canada.ca/en/environment-climate-change/services/climate-change/science-research-data/climate-trends-variability/trends-variations/winter-2025-bulletin.html

Climate change is being driven by human activity – in particular, the burning of fossil fuels, deforestation and industrial agriculture. Sustainability of life on this planet requires massive changes in energy systems and land use across the world. In the absence of dramatic change to how we live on this planet, every region around the globe will experience catastrophic climate events: heatwaves and droughts, flooding, tropical cyclones, extra-tropical storms, and/or increases in aridity and fire weather, at great cost to human life and health.

In December 2023, the United Nations Climate Change Conference (COP28) closed with the first ever "global stocktake" and called for "deep, rapid and sustained" reductions in global GHG emissions: 43 per cent by 2030 and 60 per cent by 2035 (relative to the 2019 level), with net zero carbon dioxide emissions by 2050 (17). This is crucial to limit global warming to 1.5° C above preindustrial levels (consistent with the Paris Agreement target) to avert climate catastrophe.

Contrary to the terms of the Cap and Trade Cancellation Act, 2018, the provincial government does not have a plan to establish targets for reducing greenhouse gas emissions in Ontario. As noted in the Ontario Auditor General's October 2025 special report, *Report on Progress to Reduce Greenhouse Gas Emissions*, "despite the legal requirement to prepare a climate change plan and publicly report on progress, no finalized plan exists, and MECP has not released a new progress report since 2021." (18) Noncompliance with the Cap and Trade Cancellation Act, 2018, has weakened Ontario's climate performance. The Auditor General found that -MECP projected in January 2025 that Ontario would miss its 2030 target by 3.5 Mt, and that the combined reductions from provincial and federal initiatives are insufficient to meet that target (18).

RNAO urges the government to comply with the Cap and Trade Cancellation Act, 2018, and address climate changes as follows.

4.1 Climate crisis – greenhouse gas emissions

Recommendation: Adopt a science-driven climate action plan for the province to meet the global stocktake target of a 43 per cent reduction in Ontario's greenhouse gas (GHG) emissions by 2030, relative to the 2019 level. Such a plan must:

- Uphold Indigenous rights and ensure all climate actions comply with the United Nations Declaration on the Rights of Indigenous Peoples.
- Accelerate Ontario's transition to a low-carbon, renewable energy system by directing the Independent Electricity System Operator to:
    - Cancel procurement of new gas-fired electricity capacity and phase out gas generation by 2035.
    - Expand renewable energy procurement to triple system capacity by 2035.
    - Stop investment in nuclear rebuilds and refurbishments, redirecting funds to energy conservation and renewables.
    - End all fossil fuel subsidies and redirect funding to energy efficiency, demand management, and renewable energy.
- Cut transportation-related emissions, which account for nearly one-third of Ontario's total emissions, by:
    - Accelerating zero-emission vehicle adoption.
    - Working across governments to build walkable communities and expand transit and active transportation networks.
    - Expanding electric vehicle charging infrastructure provincewide.
- Lead in climate-aligned building and housing policy by:
    - Converting public buildings and infrastructure to high-efficiency, electrified, low-emissions systems.
    - Supporting energy efficiency upgrades for households with fewer resources.
    - Requiring heat pumps and EV-charging infrastructure in all new residential and commercial buildings.
- Support a just transition by regulating and taxing fossil-fuel-intensive industries, subsidizing green jobs, and helping workers retrain and relocate.
- Strengthen the health system's climate readiness by expanding the workforce specializing in climate-related health impacts based on local risks and needs.

Cost estimate: Cost savings

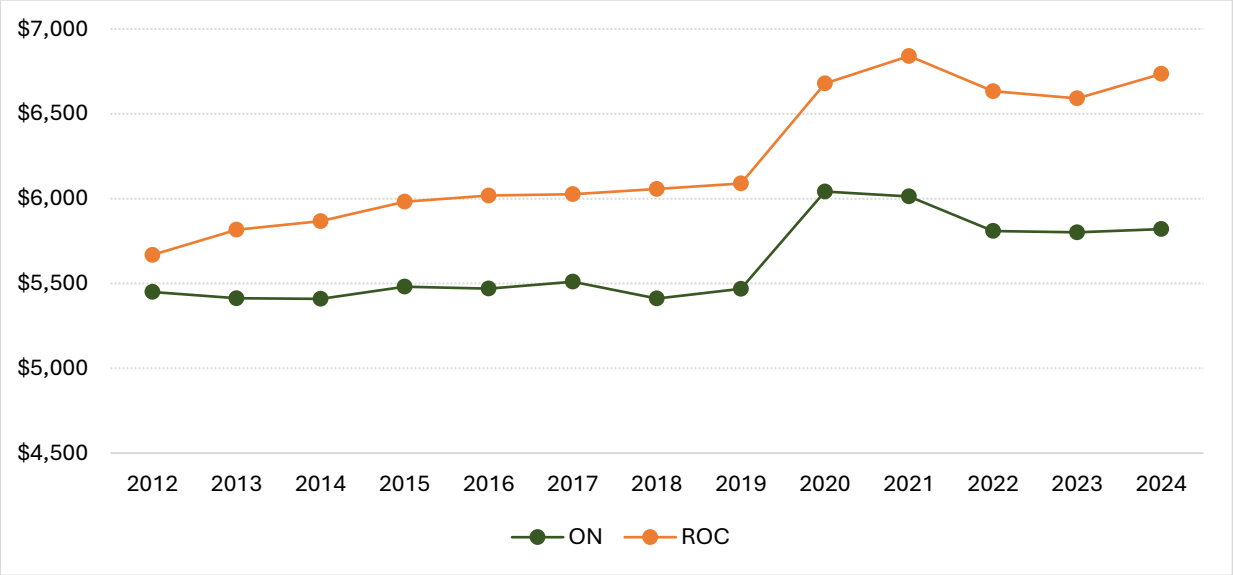
5. Fiscal capacity

With the growing and aging population, coupled with the diverse care needs of Ontarians and our sudden economic vulnerability, there is a need for higher per capita spending on core public programs. The longstanding era of Ontario consistently spending less on per capita public program

spending compared to the rest of Canada must end. In 2024, Ontario ranked at the lowest in public program spending per capita (19,20,21,22). It is projected that per capita total public program will be declining to $12,848 per person (in 2025 dollars) in 2027-28, a one per cent decrease from 2024-25 (19,20,21,22). The percentage drop translates into an $8.3 billion cut in the total public program spending.

Ontario's health spending has always been ranked lowest or near the lowest amongst Canadian sub-national jurisdictions. In 2024, Ontario's health spending per capita was 13.6 per cent below the rest of Canada. Between 2023 and 2024, Ontario saw only a 0.3 per cent increase in its per capita health spending and it is projected that per capita health spending in Ontario will decline to $5,521 (in 2025 dollars) in 2027-28.

Consolidated provincial-territorial and local governments' health spending per capita (constant 2025$)



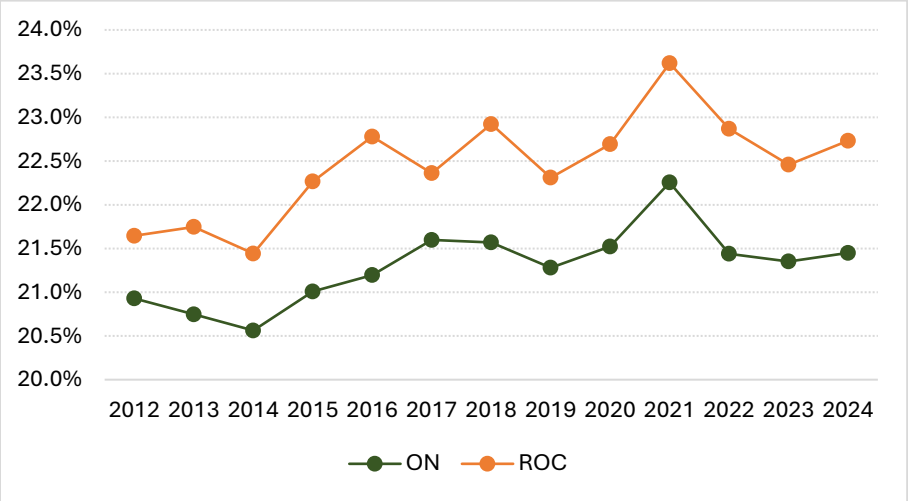
Data sources: Statistics Canada. Table 10-10-0005-01 Canadian Classification of Functions of Government (CCOFOG) by consolidated government component (x 1,000,000); Statistics Canada; Table 17-10-0005-01 Population estimates on July 1, by age and gender; Statistics Canada, Table 18-10-0005-01 Consumer Price Index, annual average, not seasonally adjusted; and RNAO calculation.

Further granular age-specific data show that per capita health spending for senior Ontarians reduced to $14,834 in 2023 from $15,761 in 2012 (22). Trends like this are concerning, as the share of Ontarians aged 65 and older in the population grew to 18.3 per cent in 2023, and the share is projected to continue growing (24). As the data suggest, the government is not doing enough to meet the health-care demands of Ontarians.

Ontario has consistently been lower than the rest of Canada's average in raising revenue from its own sources. The perennial program underspending in the context of a projected 2025-26 provincial deficit of nearly $15 billion, clearly indicates that Ontario needs to increase revenue to ensure the necessary health and social supports for Ontarians as we enter an era of profound uncertainty. In 2024, Ontario raised 21.4 per cent share of its GDP to fund public services, and the percentage has been constant for the last three years. If Ontario's own-source revenue as a share

of GDP were level with the rest of Canada's, the province would have raised $15 billion more in 2024.

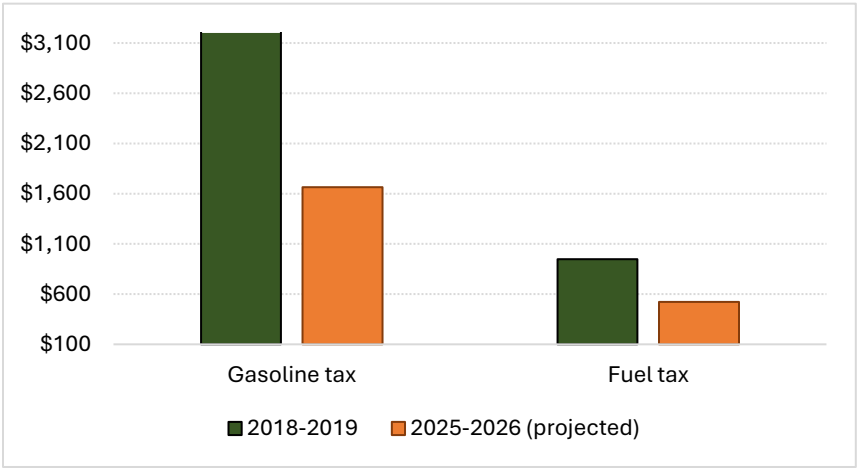
Own-source revenue as a percentage of GDP



Data sources: Statistics Canada, Table 10-10-0147-01 Canadian government finance statistics (CGFS), statement of operations and balance sheet for consolidated governments (x 1,000,000); Statistics Canada. Table 36-10-0221-01 Gross domestic product, income-based, provincial and territorial, annual (x 1,000,000); and RNAO calculation.

Further, Ontario's real own-source revenues (in 2025 dollars) are expected to drop from $11,649 per capita to 11,377 per capita from 2024-25 to 2026-27 (22). These losses in own-source revenue are due to the government's ongoing inclination towards tax cuts. In 2024, total tax revenue per capita was $12,436 (in 2025 dollars), an increase of only 0.05 per cent. The current government has implemented multiple tax cuts on gasoline and fuel, resulting in around 48 per cent and 43 per cent less revenue, respectively, in 2024–2025 compared to the revenue received in the current government's first year (2018–2019).

Taxation revenue (constant 2025$)



Data sources: Ontario Budget: past editions; Statistics Canada,.Table 18-10-0005-01 Consumer Price Index, annual average, not seasonally adjusted; and RNAO calculations.

The 2025-26 budget makes the gasoline and fuel tax cuts permanent (20), causing lower revenues in the coming years. If the gasoline and fuel taxes are reinstated to their respective previous levels, the province would have earned $1,054 and $307 million more in 2025-2026, respectively.

The current government has also been implementing tax cuts to its other two core revenue streams: income from government business enterprises and other non-tax revenue. Due to the expansion of the alcoholic beverages marketplace, it is projected that there will be 33.6 per cent less revenue from the Liquor Control Board of Ontario (LCBO), compared to the 2018-19 level. Similarly, there will be 8.3 per cent less revenue from the other non-tax sources compared to the 2018-19 level.

It is projected that the corporate income tax revenue will decrease to $28.2 million in 2027-28, at the general rate of 11.5 per cent. Increasing the corporate tax rate to the previous rate (14%) (23) would have made $6.1 million more revenue in 2027-28.

To ensure there is no room for underspending on publicly funded health care, social and youth services, poverty programs, and housing support, and so on, the province needs to increase its fiscal capacity by considering the following measures:

5.1 Tax reform

Recommendation: Increase the government's fiscal capacity to devote more money to publicly funded health care and determinants of health by implementing the following measures:

- levying more progressive taxes on all the major sources of revenue, particularly those that encourage greater social land environmental responsibility – for example, high greenhouse gas emitters
- increase corporate tax rate to 2009 level
- closing tax loopholes and tightening enforcement of the tax system
- reinstate the previous tax rates for gasoline and fuel
- increase the revenue streams from the government business enterprises and other non-tax sources.

Cost estimate: Dependent on scale of tax reform.

Conclusion

Thank you for your consideration of this submission. If questions arise with respect to any of the recommendations or assumptions, please contact RNAO Chief Executive Officer, Dr. Doris Grinspun (dgrinspun@RNAO.ca) or Director of Nursing and Health Policy, Matthew Kellway (mkellway@RNAO.ca).

References

1. College of Nurses of Ontario. Nursing Statistics Report 2025 [Internet]. 2025. Available from: https://www.cno.org/Assets/CNO/Documents/Statistics/latest-reports/nursing-statistics-report-2025.pdf

2. Canadian Federation of Nurses Unions. CFNU National Nurses Survey [Internet]. 2025 Mar. Available from: https://nursesunions.ca/wp-content/uploads/2025/03/CFNU-Member-Survey-Report_March-25_final-65.pdf

3. RNAO. Ontario's Primary Care Crisis. 2025. Available from: https://rnao.ca/media/10160/download?inline

4. Almost J. (2024). Opening the black box: Unpacking the use of nursing agencies in Canada. Available from: https://cdn.prod.website-files.com/65d513db1cd69e3321cdfd21/66d8a523480a34856f38bf42_Agency%20Report%20-%20Final%20English%20-%20Compressed.pdf

5. RNAO. Addressing Ontario's RN Crisis. 2026. Available from: https://rnao.ca/media/10283/download

6. RNAO. Enhancing Community Care for Ontarians (ECCO 4.0). 2025. Available from: ECCO 4.0: Enhancing Community Care for Ontarians - 2025 | RNAO.ca

7. Canadian Institute for Health Information. *Profile of Residents in Residential and Hospital-Based Continuing Care, 2024–2025*. 2025. Available from: Health System Context Series — Ontario | CIHI

8. Alzheimer Society. (n.d.) Dementia numbers in Canada. Available from: https://alzheimer.ca/en/about-dementia/what-dementia/dementia-numbers-canada

9. Rosella LC, Buajitti E, Daniel I, Alexander M, Phil ABD. Projected patterns of illness in Ontario. 2024

10. Association of Municipalities of Ontario. Municipalities Under Pressure One Year Later: An Update on the Human and Financial Cost of Ontario's Homelessness Crisis. 2026. Available from: MunisUnderPressure1YearUpdateReport2026-01-13.pdf

11. Ontario Drug Policy Research Network. Suspect Drug-Related and Drug Toxicity Deaths in Ontario - ODPRN [Internet]. 2025 [cited 2025 Aug 25]. Available from: https://odprn.ca/occ-opioid-and-suspect-drug-related-death-data/

12. Toronto Drop-In Networks. A community of over 50 drop-ins and allied members throughout Toronto [Internet]. 2025 [cited 2025 Aug 25]. Available from: https://www.tdin.ca/MediaRelease?utm_source=timminstoday.com&utm_campaign=timminstoday.com%3A%20outbound&utm_medium=referral

13. Financial Accountability Office of Ontario. The Financial Impact of Expanding the Beverage Alcohol Marketplace in Ontario [Internet]. Financial Accountability Office of Ontario. 2025 [cited 2025 Aug 26]. Available from: https://fao-on.org/en/report/alcohol-sales-expansion/

14. World Meteorological Organization. 2026. Available from: WMO confirms 2025 was one of warmest years on record

15. Government of Canada. Temperature change in Canada [Internet]. 2025 [cited 2025 Aug 22]. Available from: https://www.canada.ca/en/environment-climate-change/services/environmental-indicators/temperature-change.html

16. Canada E and CC. Climate Trends and Variations Bulletin – Winter 2024/2025 [Internet]. 2025 [cited 2025 Aug 25]. Available from: https://www.canada.ca/en/environment-climate-change/services/climate-change/science-research-data/climate-trends-variability/trends-variations/winter-2025-bulletin.html

17. United Nations Framework Convention on Climate Change (UNFCCC). Outcome of the first global stocktake [Internet]. 2023 [cited 2025 Aug 25]. Available from: https://unfccc.int/topics/global-stocktake/about-the-global-stocktake/outcome-of-the-first-global-stocktake

18. Office of the Auditor General of Ontario. 2025. Report on Progress to Reduce Greenhouse Gas Emissions.

19. Government of Canada SC. Consumer Price Index, annual average, not seasonally adjusted [Internet]. 2007 [cited 2025 Mar 3]. Available from: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1810000501

20. Government of Canada SC. Consumer Price Index, monthly, not seasonally adjusted [Internet]. 2007 [cited 2025 Sept 17]. Available from: https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1810000401

21. Government of Canada SC. Canadian Classification of Functions of Government (CCOFOG) by consolidated government component [Internet]. 2016 [cited 2025 Dec 9]. Available from: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1010000501

22. Ontario Ministry of Finance. 2025 Ontario Budget: A Plan to Protect Ontario [Internet]. 2025. Available from: https://budget.ontario.ca/2025/pdf/2025-ontario-budget-en.pdf

23. Canadian Institute for Health Information (CIHI). National health expenditure trends [Internet]. 2025 [cited 2025 Dec 9]. Available from: https://www.cihi.ca/en/national-health-expenditure-trends

24. Government of Ontario. Corporate Income Tax [Internet]. 2022 [cited 2025 Dec 9]. Available from: http://www.ontario.ca/document/corporations-tax/corporate-income-tax