RNAO 2025 Provincial

Pre-budget Submission

Feb. 3, 2025

500-4211 Yonge St., Toronto, ON M2P 2A9 ~ Tel. 416-599-1925 / 1-800-268-7199 ~ Fax 416-599-1926
RNAO.ca

The Registered Nurses' Association of Ontario (RNAO) represents over 54,400 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 minister of finance.

Introduction

RNAO believes that health is a resource for everyday living and that health care is a universal human right. Our approach to health – often termed "population health" – requires engagement with public policy issues across five broad policy "buckets": nursing, care delivery, social and environmental determinants of health and fiscal capacity.

Never has a population health approach been more urgent. The pandemic took an enormous toll on the health of the health-care workforce across all sectors of the system, transforming an understaffed system into a system with a health human resource crisis. Sector by sector, we are witnessing a system beset by serious challenges verging on crisis, as is the case clearly with primary care. Ontario's primary care sector, so necessary to a functional health system, emerged from the pandemic in dire straits. The number of Ontarians without a regular primary care provider increased from 1.8 million pre-pandemic to 2.5 million as of early November 2024.[1] It is anticipated to continue to grow to 4.4 million by 2026 (Ontario College of Family Physicians, 2023) absent a serious funding and policy response.

The pandemic, too, exposed a profoundly inequitable health system, leaving already-marginalized communities with even greater barriers to health care and at greater risk (absent change) in the event of a future health crisis. This pandemic also taught us all over again about the social determinants of health – that, for example, income matters, housing matters, race matters, sexual orientation matters. This pandemic reminded us that we have not yet broken with a history of anti-Indigenous and anti-Black racism. Prejudicial views on other matters, such as sexual and gender orientation, have also extended into our present and are reflected in the access to and the quality of health care.

Looking forward, it is clear that the sustainability of Ontario's health system over the long-run requires a population health approach. In real terms, health expenditures look to be shrinking and the system contracting just at a time when trends in population, patterns of illness and climate, as examples, point to the need for broad public policy change. The long and over-riding history of Ontario of limiting the fiscal capacity of its government is increasingly a concern.

We put forward the following recommendations needed to improve population health in Ontario.

Recommendation #	RNAO recommendation summary
1. Nursing	
1.1 Compensation	Increase compensation for Ontario nurses working in all roles, domains, and sectors. Harmonize compensation upward to address pay disparities affecting community care.
1.2 Internationally educated nurses (IEN)	Simplify registration for IENs residing in Canada while maintaining the BScN as the entry to practice; ban international recruitment ("poaching").
1.3 Return to Nursing Now program	Develop and fund a Return to Nursing Now program to attract RNs back into Ontario's nursing workforce.
1.4 Nursing Graduate Guarantee (NGG) and Late Career Nurse Initiative (LCNI)	Expand the Nursing Graduate Guarantee (NGG) to ensure access to all new nursing registrants and reinstate the Late Career Nurse Initiative (LCNI) to return recently-retired nurses to the workforce as mentors for NGG and preceptors for clinical placements.
1.5 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.
1.6 Extern programs	Expand the hospital-focused nursing clinical extern program to include community care settings.
1.7 Workplace mentors for new graduates, new hires and IENs	Continue to fund the Clinical Scholar Program for nurses and expand the funding to include public health, primary care, home care and the long-term care sectors.
1.8 Nursing education (RNs)	Increase the number of seats in BScN nursing programs (four-year and compressed BScN, second-entry, and bridging programs) – starting with 1000 seats in 2025, and followed by cumulative increases of 10 per cent for three years – with the goal of achieving 10,000 new RN registrants by 2029.
1.9 Nursing education (NPs)	Increase the number of seats in NP programs, starting with 200 additional seats in 2025, 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.

Recommendation #	RNAO recommendation summary
1.10 Nursing education – Equity, diversity and inclusion (EDI)	Include racism and discrimination as a mandatory topic in nursing, interprofessional and continuing education curriculums. 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.
1.11 NP residency programs	Introduce funding to develop paid post-graduate NP residency programs to support a retention and recruitment strategy, and improve access to specialized care for Ontarians.
1.12 Nursing faculty	Recruit and retain faculty for nursing programs and promote funding for PhD and DN students to support the nurse educator workforce.
1.13 Nursing – Continuing education	Increase funding for continuing education, professional development, specialty certifications, and leadership training.
2. Care delivery	
2.1 Pharmacare	Finalize an agreement with the federal government on pharmacare and collaborate in 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 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 3 million people without a regular care provider by 2029, to an NP or family doctor, starting with 800,000 people in the upcoming fiscal year.

Recommendation #	RNAO recommendation summary
2.5 Primary care – RN prescribing	Continue to provide funding to incentivize 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. Expand RN prescribing authority.
2.6 Primary care – NP scope of practice	Expand NP scope of practice to include ability to initiate more legal forms and order more forms of testing.
2.7 Hospitals	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.
2.8 Long-term care – Direct care and skill mix	Implement a Nursing Home Basic Care Guarantee to deliver safe, dignified, and client-centred care. Prioritize quality care from regulated health professionals. Provide 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).
2.9 Home care funding	Increase home care funding to support an expanded publicly funded basket of home and community services.
2.10 Long-term care – Attending NPs	Increase the funding for Attending NPs as most responsible care providers (MRP) in LTC ensuring all homes have achieved one NP per 120 residents by 2029 – with an addition of at least 150 NPs during the upcoming fiscal year.
2.11 Long-term care – NPs as medical directors	Fund NPs as clinical directors so long-term care homes can have an MD or an NP as clinical director, ensuring quality of care for residents and optimized outcomes.
2.12 Long-term care – funding formula	Ensure that LTC homes that decrease acuity (Case Mix Index, or CMI) due to evidence-based care retain all funding to reinvest in staffing and/or programs for residents.
2.13 Long-term care – infection prevention and control	Ensure one infection prevention and control (IPAC) RN per 120 residents.
2.14 Long-term care – Embedding evidence-	Extend funding for RNAO's Clinical Pathways program for three years to support long-term care homes with embedding

Recommendation #	RNAO recommendation summary
based guidelines into electronic medical records	RNAO's Best Practice Guidelines into their electronic medical record.
2.15 Retirement homes – Attending NPs	Fund attending NPs in 20 retirement homes in 2025 with outcomes measurement.
2.16 Mental health – RN psychotherapy	Amend "Roadmap to Wellness" to incorporate 500 RN psychotherapist by 2029 – starting with 200 in the upcoming fiscal year – allocating public funds within program to support access across Ontario.
2.17 Indigenous health – RNAO's Indigenous Health Program	Continue to fund RNAO's work with Indigenous communities in Ontario.
2.18 Pediatric care	Designate sustained funding to scale up and right-size pediatric health care in Ontario.
2.19 Health system – Equity, diversity and inclusion	Implement anti-racism, anti-oppression, cultural safety, and EDI training, orientation and mechanisms for staff at all levels in all workplace and academic settings. These must include tools, resources, occupational health and mental health strategies to prevent and address harms related to racist behaviours and attitudes.
2.20 Scope of practice - RNs	Expand RN scope of practice to provide authority to apply more defibrillation and to refer to interprofessional care providers.
2.21 Surgical care – Access	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.
2.22 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.
2. Social determinants of health	
3.1 Toxic drug crisis – Substance use care	Invest in an integrated substance use model of care.
3.2 Housing	Invest one per cent of the provincial budget annually in accessible, affordable housing programming.

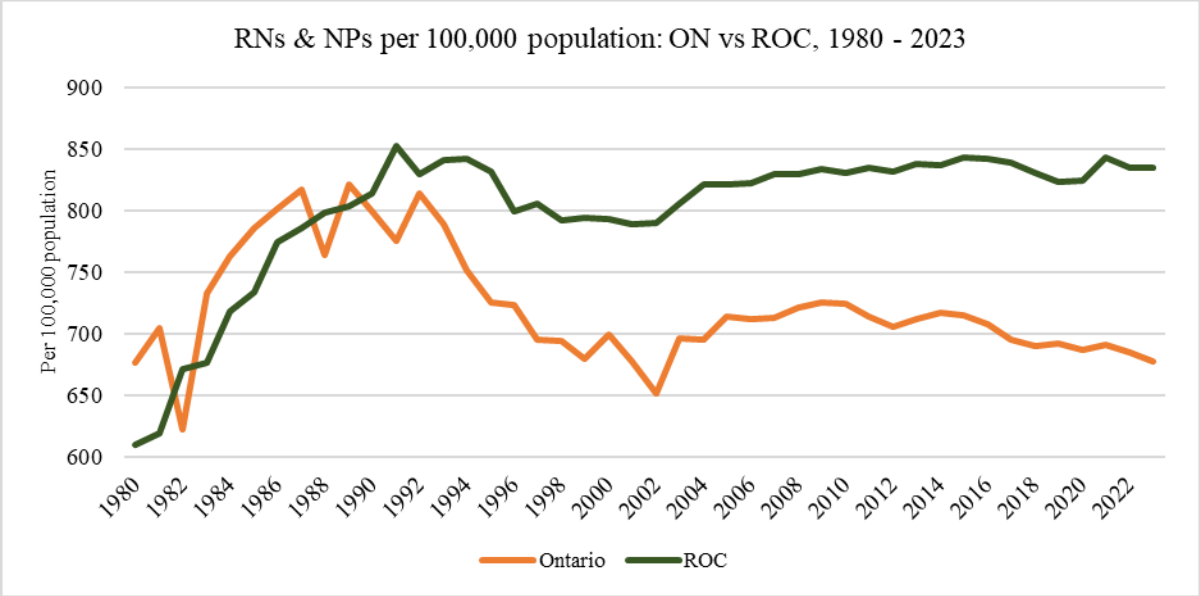
Recommendation #	RNAO recommendation summary
3.3 Income security – Employment	Amend the Employment Standards Act to provide 10 permanent paid sick days for all employees and an additional 14 days paid sick days during a public health emergency. Increase the minimum wage immediately to $19.60 per hour indexed annually to inflation.
3.4 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 fiscal capacity by imposing more fair progressive tax and identifying tax loopholes.
5.2 Environmental and social responsibility	Increase revenue sources that encourage environmental and social responsibility.

Recommendations

1. Nursing

Nurses form the largest body of registered health professionals in Ontario and Canada. They are the backbone of our health system. Yet, the promise and appeal of nursing as a profession has been compromised by decades of understaffing. Post-pandemic, the RN understaffing crisis is worse than ever before. This impacts nurses' health and wellbeing as well as patient care. According to 2023–2024 hospital data analyzed by the Canadian Institute for Health Information (CIHI), 1 in 17 patients admitted to hospital experienced unintentional harm . [2] Moreover, between July 2022 and June 2023, the Auditor General of Ontario found there were 203 ER closures across 23 Ontario hospitals – a direct result of staffing shortages.[3]

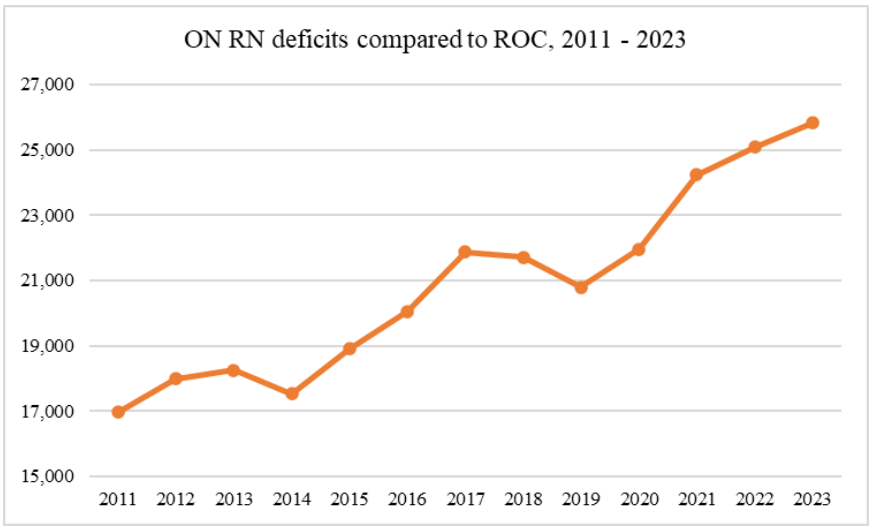
Ontario's nurses are experiencing significant depression, anxiety and stress. More and more nurses are migrating to nursing agencies for fairer compensation and more control over their lives. Overtime, sick time, and vacancy rates are on the rise. Nurses are struggling – and as long as their issues are not addressed, so will the health system struggle.



Notes: RNAO's calculation: RNAO normally combines RNs and NPs when doing this CIHI ratio for the long series.

Data sources: Canadian Institute for Health Information. Nursing in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024; Statistics Canada. Table 17-10-0005-01 Population estimates on July 1, by age and gender

While the Ontario government claims to have made significant improvements to nursing health human resources, their own (under)estimate projects a shortage of 33,200 nurses by 2032.[4] The gap between Ontario's RN workforce and the rest of Canada (ROC) continues to grow. In place of policies to retain, recruit and build nursing careers in Ontario, the government has resorted to "staffing flexibility" measures and private, for-profit care. On a per capita basis, Ontario currently has a deficit of 26,000 RNs compared to the rest of Canada.

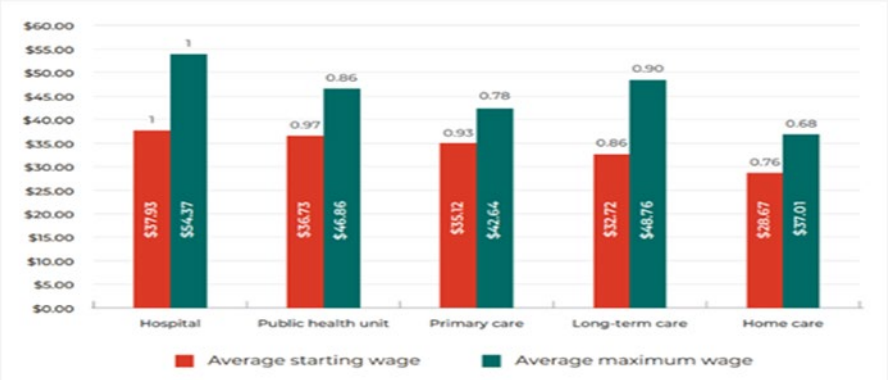


Notes: Canadian Institute for Health Information. Nursing in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024; Statistics Canada. Table 17-10-0005-01 Population estimates on July 1, by age and gender, and RNAO calculations

Additionally, nurses in Ontario are earning less today in real terms than they did in 2010. And, there are significant disparities within the system by sector.[5] RN hospital wages across the wage grid are significantly higher than RN wages in the community sector. As illustrated in the chart below, in

2023, at maximum, home care RNs and primary care RNs on average earned 68 cents and 78 cents respectively for every dollar earned by hospital RNs. These disparities undermine retention and recruitment of RNs in community settings, perpetuating a misaligned health system.

RN hourly wage rates and ratios across sectors in 2023



Data sources: Ontario Nurses' Association collective agreements webpage; Ministry of Labour, Immigration, Training and Skills Development of Ontario's Collective Bargaining Interactive Search; and RNAO calculation

Urgent action is needed to rebuild nursing in Ontario and address the nursing crisis. The Ontario government and health system employers must act **immediately** to build nursing careers in Ontario.

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, and
- guarantee competitive compensation for nurses comparable to jurisdictions, such as the United States.

1.2 Internationally educated nurses

Recommendation: Continue to support and fund expedited pathways with simplified registration for internationally educated nurses (IENs) residing in Canada while restoring the BScN as the entry to practice; ban international recruitment ("poaching").

Cost estimate: Cost savings.

1.3 Return to Nursing Now program

Recommendation: Develop and fund a Return to Nursing Now program to attract RNs back into Ontario's nursing workforce.

Cost estimate: $202M.

1.4 Nursing Graduate Guarantee and Late Career Nurse Initiative

Recommendation: Strengthen mentorship and retention programs such as the Nursing Graduate Guarantee (NGG), Late Career Nurse Initiative (LCNI), and the Return to Nursing Now program proposed by RNAO.

Cost estimate: $511M for NGG and $208M for LCNI.

1.5 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.

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 system and the Implementation in Context (ICON) framework – which is the only meta-framework of designed to guide healthcare professionals in implementing research evidence into clinical practice – into all HWE BPGs.

Cost estimate: $1M through 2029, starting with $250K during the 2025–26 budget year.

1.6 Extern Programs

Expand the hospital-focused nursing clinical extern program to include community care settings.

Cost estimate: Costs depend on scale of program.

1.7 Workplace mentors for new graduates, new hires and IENs

Recommendation: Continue to fund the Clinical Scholar Program for nurses and expand the funding to include public health, primary care, home care and the long-term care sectors. Ensure the program is designed to support equity, diversity and inclusion (EDI) goals of both academic and professional settings as follows:

- Embed mentorship programs in workplaces for equity-seeking nurses to facilitate professional growth and development, and to improve retention and recruitment.
- Provide mentoring programs for nursing students to enhance academic achievements, reduce stress, anxiety and dropout rates and to empower equity-seeking students.

Cost estimate: Cost savings.

1.8 Nursing education (RNs)

Recommendation: Increase the number of seats in BScN nursing programs (four-year and compressed BScN, second-entry, and bridging programs) – starting with 1000 seats in 2025, and

followed by cumulative increases of 10 per cent for three years – with the goal of achieving 10,000 new RN registrants by 2029.

Cost estimate: $9M in the first year, $30M in the second, $58M in the third, $94M in the fourth and $119M in the fifth year based on a per-seat cost of $9,127.

1.9 Nursing education (NPs)

Recommendation: Increase the number of seats in NP programs, starting with 200 additional seats in 2025, 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: $84M.

1.10 Nursing education (EDI)

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

Cost estimate: No additional cost.

1.11 NP residency programs

Recommendation: Introduce funding to develop paid post-graduate NP residency programs to support a retention and recruitment strategy that will improve access to specialized care for Ontarians.[6]

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

1.12 Nursing faculty

Recommendation: Recruit and retain faculty for nursing programs and promote funding for PhD and DN students to support the nurse educator workforce.[7]

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

1.13 Nursing – Continuing education

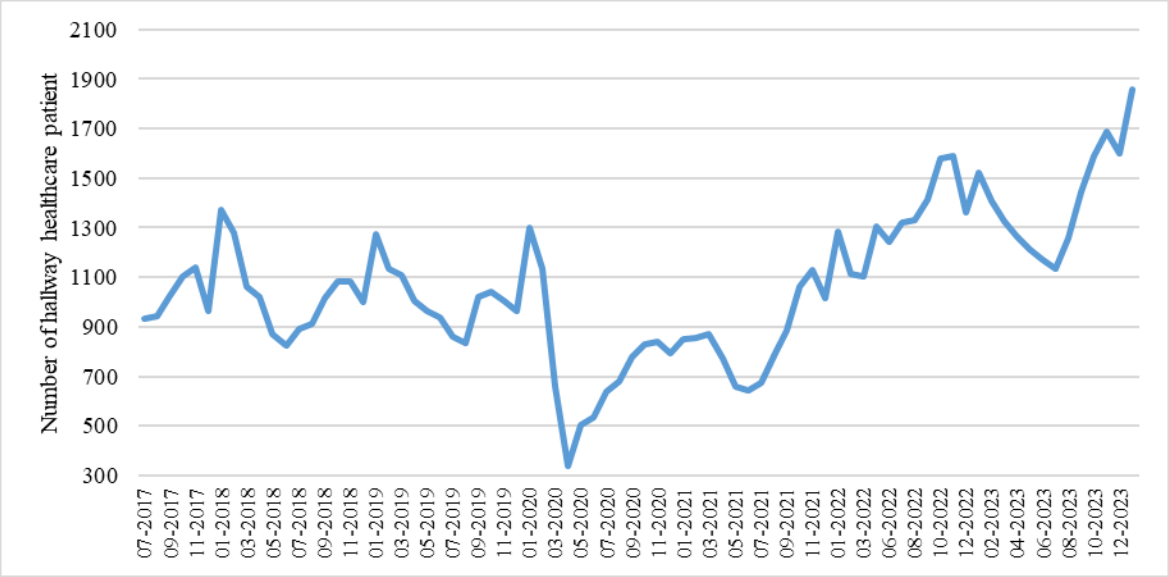
Recommendation: Increase funding for continuing education, professional development, specialty certifications, and leadership training.

Cost estimate: Costing depends on the expansion of services and programs required to support this recommendation.

2. Care delivery

The pandemic proved our health system to be precariously underfunded, understaffed, misaligned and fragile. While the pandemic was officially declared over in May 2023, its impacts have lingered and, in some cases, worsened. Hallway health care has, post-pandemic, reached record levels in Ontario in the midst of a primary care crisis. The number of alternative-level-of-care beds, similarly, has risen post-pandemic, pointing to under-resourced community care. The challenges that are currently plaguing our hospital sector reflect deficits upstream in the health system and, beyond that, an inattention to the determinants of health. (See sections 3 and 4 of this submission for more detail.)

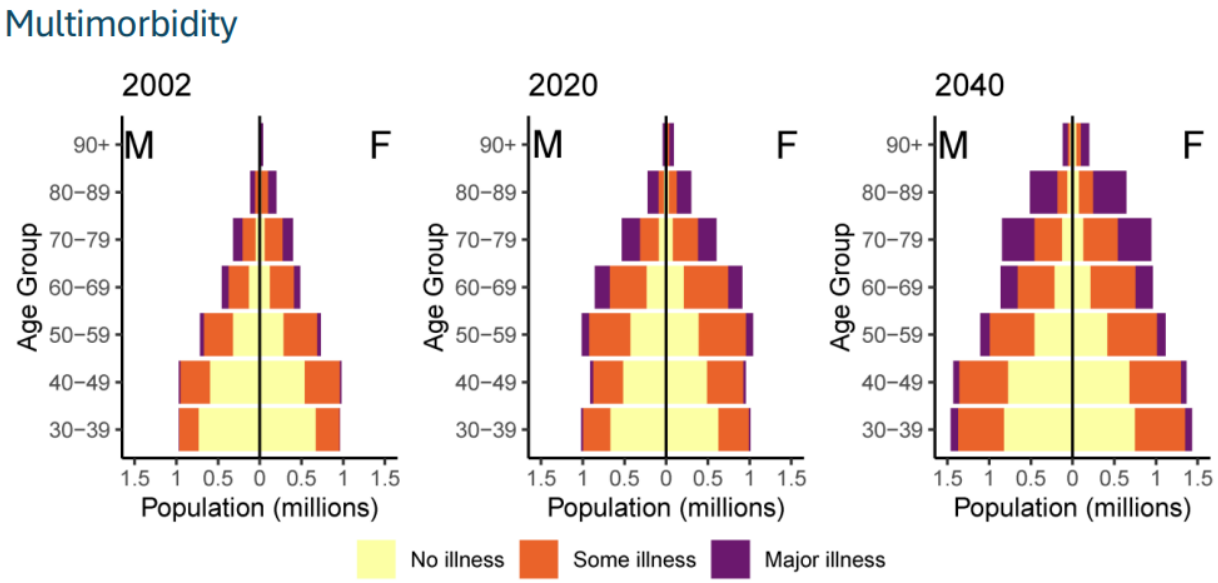
Average number of Ontario hospital patients per day receiving care in unconventional spaces



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

There is an urgent need for adequate resourcing of community care in Ontario. Apart from extant issues, demographic trends, climate change and patterns of illness point to imminent increasing burdens on the system. Most obviously, significant changes to the age structure of Ontario's population will take place over the coming decades: the number of people aged 65 or older will increase by 60 per cent to 4.2 million by 2040, and the number of people over 85 will increase by more than 150 per cent to 770,000.[8]

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. Study-Projected-Patterns-of-Illness-in-Ontario-Released-October-16-Final.pdf

Further, these trends point to the need hurry the process of 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.

2.1 Pharmacare

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

Cost estimate: Cost savings.

2.2 Public health – base funding

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

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 $10 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 3 million people without a regular care provider to an NP or family doctor by 2029, starting with 800,000 people in the upcoming fiscal year. RNAO recommends this be accomplished by:

Cost estimate: $15.8M for a total of 100 new NP positions over two years.

- Funding a total of 54 NP-led clinics (NPLC) by 2029, with 8 new ones launched during the upcoming fiscal year.

  Cost estimate: $150M (including startup costs).

- Developing and implementing a public funding model for independent NPs in primary care without user-fees, such as in Alberta and British Columbia.[9] [10] [11] [12]

  Cost estimate: $15M.

- Fulfilling existing commitment to fill 75 NP positions in correctional services by providing compensation equivalent, at a minimum, to other sectors of the health system.

  Cost estimate: $9.5M.

2.5 Primary care – RN prescribing

Recommendations:

- Continue to provide funding to incentivize 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.[13]
  - RN scope of practice to include the ability to order laboratory and diagnostic testing.[7-14]
  - the list of approved drugs that RNs can prescribe in parallel with other regulated health professions such as pharmacists.
  - the ability of RNs to prescribe in hospitals and outpatient settings.

Cost estimate: $20.6M.

2.6 Primary care – NP scope of practice

Recommendation: 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:

- Authorizing NPs to initiate all seven legal forms for mental health, including Forms 1 and 2.
- 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. [15]
- Excusing NPs from jury duty.

Cost estimate: No additional costs.

2.7 Hospitals

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, and redirect savings to public institutions.
- 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.

2.8 Home care – funding

Increase home care funding to support an expanded publicly funded basket of home and community services:

- Scale and support models of home care within OHTs that facilitate integration between home care and other sectors.
- Reform the funding model for home care services from a per-visit basis to funding baskets to allow a person-centred approach that encompasses a range of nursing interventions, including health promotion and ensuring continuity of care and continuity of caregiver.
- Stabilize the home and community care workforce and improve staffing, skill mix, and working conditions.

Cost estimate: Increase funding by $500 million over and above already committed funding increases.

2.9 Long-term care – Direct care and skill mix

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

Provide 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: $1.6B. This includes funding for 10,300 additional RN full-time equivalents (FTE), and for 6,000 additional RPN FTEs.

2.10 Long-term care – Attending NPs

Recommendation: Increase the funding for Attending NPs as most responsible care providers (MRPs) in LTC ensuring the sector provides one NP per 120 residents by 2029– with an addition of at least 150 NPs during the upcoming fiscal year.

Cost estimate: $250M.

2.11 Long-term care – NPs as clinical directors

Recommendation: Fund NPs as clinical directors so long-term care homes can have an MD or an NP as clinical director, ensuring quality of care for residents and optimized outcomes.

Cost estimate: Cost savings.

2.12 Long-term care – Funding formula

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

Cost estimate: Cost savings.

2.13 Long-term care – Infection prevention and control

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

Cost estimate: Dependent on government progress under existing legislation.

2.14 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.

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

2.15 Retirement homes – Attending NP

Recommendation: Fund Attending NPs in 20 retirement homes in 2025 with outcome measurements, to improve access to care.

Cost estimate: $3.2M.

2.16 Mental health – RN psychotherapy

Recommendation: Amend "Roadmap to Wellness" to incorporate 500 RN psychotherapist by 2029 – starting with 200 in the upcoming fiscal year – allocating public funds within program to support access across Ontario.

Cost estimate: No additional cost.

2.17 Indigenous health – RNAO's Indigenous Health Program

Continue to fund RNAO's Indigenous Health Program to carry out work led by and supporting Indigenous communities in Ontario.

Context: RNAO's Indigenous Health Program was founded by developing and sustaining meaningful partnerships with Indigenous organizations that work on practice changes that are responsive to the community's needs. Currently, 10 Indigenous-focused Best Practice Spotlight Organization® (BPSO®) organizations across Ontario are working with RNAO to create a tailored program which honors Indigenous ways of knowing, supports wholistic community wellness and optimizes community outcomes using RNAO best practice guidelines to promote a culture of evidence-based practice and management decision-making.

The program will continue to actively support these 10 BPSOs located in communities across Ontario. Other activities will include:

- working with Urban Indigenous, Métis and Inuit-led organizations that are eager to join the BPSO program
- re-designing RNAO's Best Practice Champions curriculum for the Indigenous-focused BPSO program to ensure it integrates Indigenous ways of knowing, being and doing – inclusive of Indigenous people, families and communities. (Champions training is a foundational component of the BPSO program's "capacity building" deliverable.)
- completing work on a new RNAO BPG related to children and youth suicide prevention specific to indigenous communities – a request to RNAO emanating from the communities
- conducting an impact and program evaluation co-led by RNAO and the indigenous-focused BPSOs

Cost estimate: Total of $3,080,326 by 2029: $742,950 for the 2025-26 budget year, $760,629 for the 2026–27 budget year, $778,915 for the 2027–2028 budget year and $797,832 for the 2028-2029 budget year.

2.18 Pediatric care – scaling up infrastructure

Recommendations: 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 continued learning opportunities.

Cost estimate: Dependent on whether the government sustained the annual funding increase of $330 million for pediatric health care that was announced in 2023.

2.19 Health system – equity, diversity and inclusion

Recommendations:

- Implement anti-racism, anti-oppression, cultural safety, and 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.

2.20 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. [16] [17] [18]

- Refer to interprofessional health care providers such as occupational therapists, physiotherapists and registered dietitians.

Cost estimate: No additional cost.

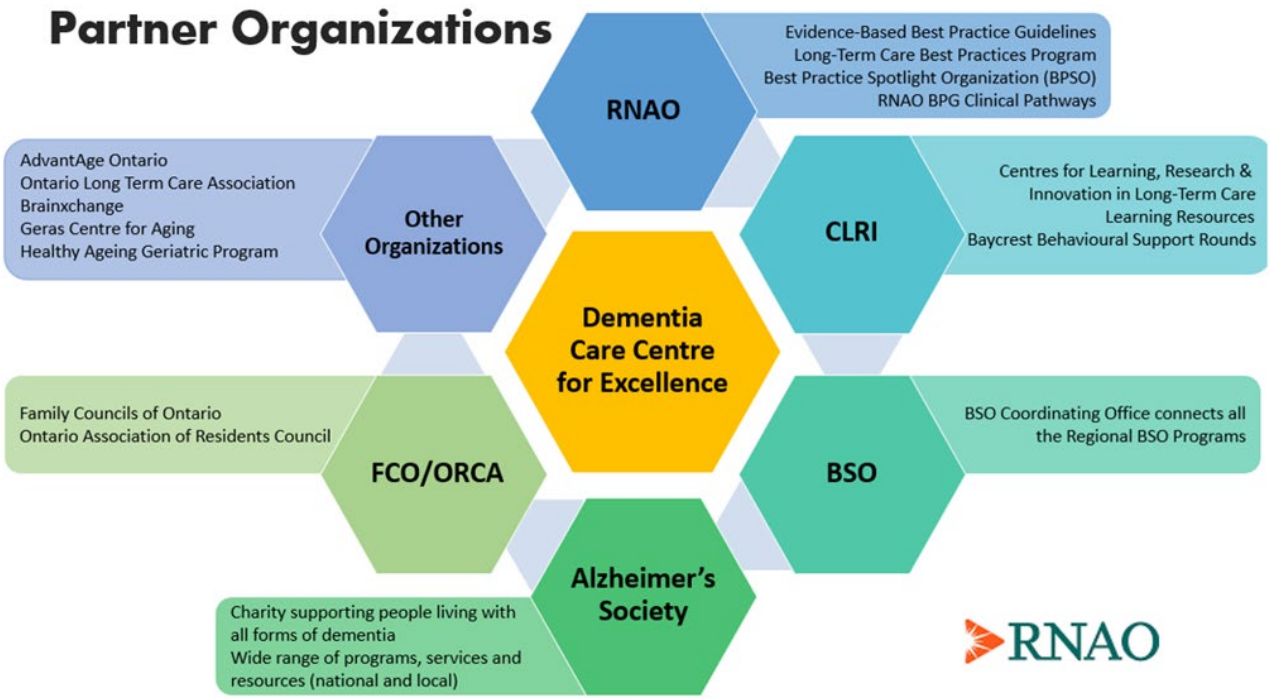
2.21 Surgical care - Access

Recommendation: 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.

Cost estimate: $140.3M plus indeterminate program/training costs.

2.2 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.



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

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. Recent projections show that patient complexity and disease burdens will rise significantly in the coming decades as the population ages and grows.[19] Without proactive measures to address SDOH, such as poverty and housing instability, 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 status has a significant impact on our physical health, mental health and social well-being. Ontario's housing crisis has reached alarming levels in 2024, with skyrocketing rental and housing prices, insufficient affordable housing supply and soaring homelessness. Recent data reveals that over 81,000 Ontarians experienced homelessness in 2024, an increase of 25 per cent since 2022 and more than 50 per cent since 2016.[20] And, over half of these individuals were chronically homeless, facing prolonged or repetitive periods without stable housing.[21]

People experiencing homelessness have an increased risk of premature death, morbidity, mental illness and substance abuse.[22] Given huge barriers to health care access due to a lack of a permanent address, people without stable or any housing are forced to rely heavily on emergency services for health care and even for shelter, which causes unnecessary strain on emergency services.

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.

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 over 22,000 Ontarians since this government took power in 2018. Over 3,500 people across Ontario died from the unregulated drug supply in 2024 alone, equivalent to almost 10 people per day.[23] 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 August 2024, there were almost 23,000 non-fatal overdoses in SCSs across the province and not a single death. 8,800 of those non-fatal overdoses happened in the 10 SCS sites slated to close in Ontario.[24] The closure of these 10 sites and consequent withdrawal of critical health-care services will lead to preventable deaths in Ontario communities.

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 – Substance use care

Recommendations: Invest in an integrated substance use model of care:

- Invest in an integrated substance use care system across all care settings by allocating existing and, if required, additional funds from the Road to Wellness.
- Reverse the decision to close SCS sites and ensure all established SCS sites remain operational and adequately funded.
- Increase funding for SCS sites, including inhalation and other harm reduction services, for every community in the province in need.
- Ensure access to voluntary, publicly funded and not-for-profit, evidence-based treatment.
- Incorporate harm reduction programs and services in the 19 new 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.
- Invest 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 Housing

Recommendation: Address Ontario's housing crisis by investing one per cent of the provincial budget annually in accessible, affordable housing programming, including:

- construction of 10,000 affordable units annually
- construction of 3,000 units of supportive housing annually
- provision of adequate emergency shelter services, including:
    - support for rent subsidies and supplements
    - an Indigenous-led urban rural and Indigenous housing strategy
    - an additional $11 billion over 10 years needed to end chronic homelessness [25]
    - an additional investment of $2 billion over eight years to increase supportive, transitional and community housing capacity to ensure encampment residents being housed appropriately [26]

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: $3.35B per year.

3.3 Income security – Employment

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. Increase the minimum wage immediately to **$19.60/hour** indexed annually to inflation.

Cost estimate: No additional costs.

3.4 Income security – Ontario Disability Support Program and Ontario Works

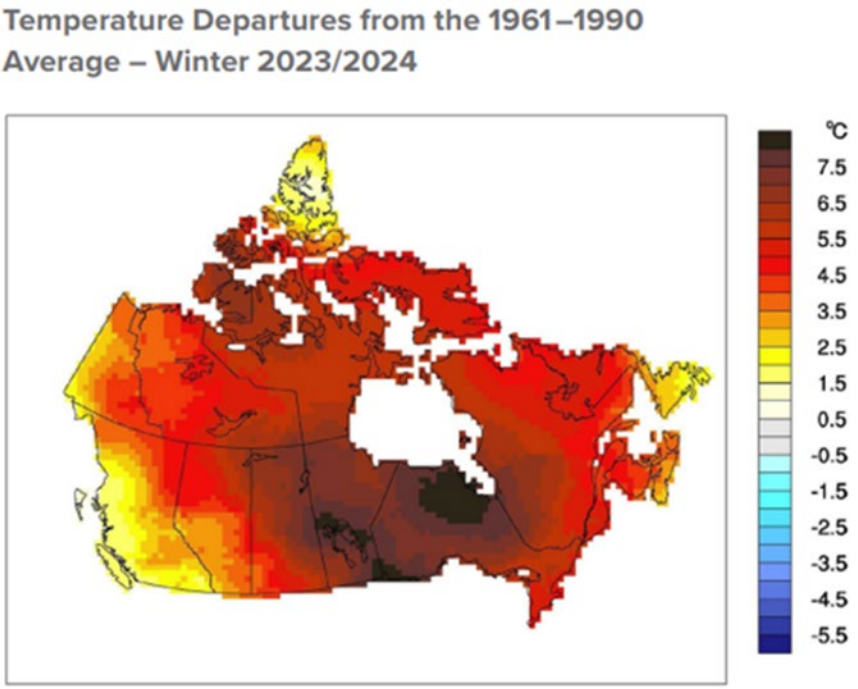
Immediately double rates for the Ontario Disability Support Program (ODSP) and the Ontario Works program (OW) and index annually to inflation.

Cost estimate: $8.8 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, 2024 was the second consecutive hottest year on record, with the average temperature about 1.55 degrees Celsius (° C) above pre-industrial levels.[27] For context: according to the United Nations Environment Program, "breaches of 1.5°C for a month or a year are early signs of getting perilously close to exceeding the long-term limit, and serve as clarion calls for increasing ambition and accelerating action in this critical decade". [28]

Globally, human activities are driving climate change – 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.



Data source: https://www.canada.ca/content/dam/eccc/documents/pdf/climate-change/trends-variations/winter2024/CTVB_Winter_2024-Bulletin_EN.pdf

In Canada, average temperatures are rising at twice the global average – three times in the north.[29] In 2023, Canada was 2.0° C hotter than it was in 1948 – the year records commenced [30]. Last winter, was the warmest Winter on record – 5.2°C above the baseline average – led largely by record highs in Ontario. Southern Ontario, defined as the Great Lakes/St. Lawrence basin, was 5.4 degrees above the baseline average while the rest of Ontario 6.3 degrees above the baseline average.[31] The first "global stocktake" – considered the central outcome of the recent Conference of the Parties on Climate Change (COP28) – identifies the need to cut global greenhouse gas emissions by 43 per cent by 2030 and 60 per cent by 2035, compared to the 2019 levels.[32] This is crucial to limit global warming to 1.5° C over preindustrial levels to avert climate catastrophe.

4.1 Climate crisis – greenhouse gas emissions

Recommendation: Ontario should declare a climate emergency and adopt a credible, science-driven climate action plan for our province to meet the global stocktake target of a 43 per cent reduction in Ontario's greenhouse gas (GHG) emissions at 94 MtCO2 equivalent by 2030, relative to the 2019 level, which requires reducing 2022 emission levels (157 MtCO2 equivalent) by 40 per cent by 2030.[33] While the contribution of Ontario's emitting economic sectors varies widely, such

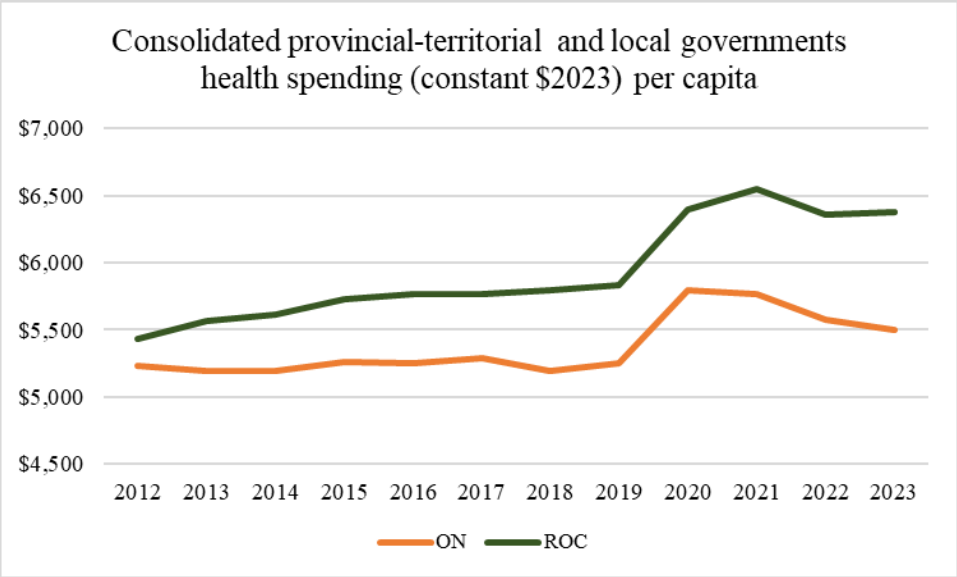
immediate cuts will require efforts across all economic sectors along with the implementation of strategies to reduce Ontario's biggest emitting sectors over the longer terms so that 2035 (60 per cent reduction) and 2050 targets (net zero emissions) can also be reached.

- Implement a science-based climate plan with revised provincial GHG emission targets, and programs, regulations and services to meet those targets, that, at a minimum, meets the requirements of the global stocktake.
- Ensure that all actions to mitigate or adapt to climate change respect the rights of Indigenous peoples and comply with the United Nations Declaration on the Rights of Indigenous Peoples.
- Create a highly efficient, lowest cost renewable-based electricity system, as part of a winding down of the fossil fuel economy and a transition to a low-carbon future. The energy transition in Ontario should include instructions to Ontario's Independent Electricity System Operator (IESO) to:
    - Cancel current procurement of gas fired generation capacity and phase out gas-fired electricity generation by 2035
    - Expand current procurement of renewable energy to triple total system capacity from renewables by 2035
    - Stop investment in nuclear re-builds and refurbishments and redirect funding toward cost-efficient energy conservation and renewables.
    - End all fossil fuel subsidies, tax and financial incentives immediately and redirect funding to energy efficiency, demand management and fully renewable energy sources.
- Reduce GHG emissions from transportation, which accounts for nearly one-third of the province's total emissions:
    - accelerate the adoption of zero-emission vehicles,
    - work with all levels of government to build communities that are safe and walkable and to expand transit and active transportation through sustainable transportation networks, and
    - expand electric vehicle infrastructure across the province.
- Take a leading role in building and housing programs by transitioning all public buildings and infrastructure to high efficiency, electrified and no/low emissions options, and by subsidizing energy efficiency in the homes of those with fewer resources. Make heat pump technology mandatory in all new residential and commercial buildings and require all new buildings to include EV-charging infrastructure.
- Commit to just transition by taxing and regulating fossil-fuel intensive industries while subsidizing green employment and supporting workers to train and relocate.
- Increase health system workforce specializing in climate-related health impacts based on local vulnerabilities and planning.

Cost estimate: Cost savings.

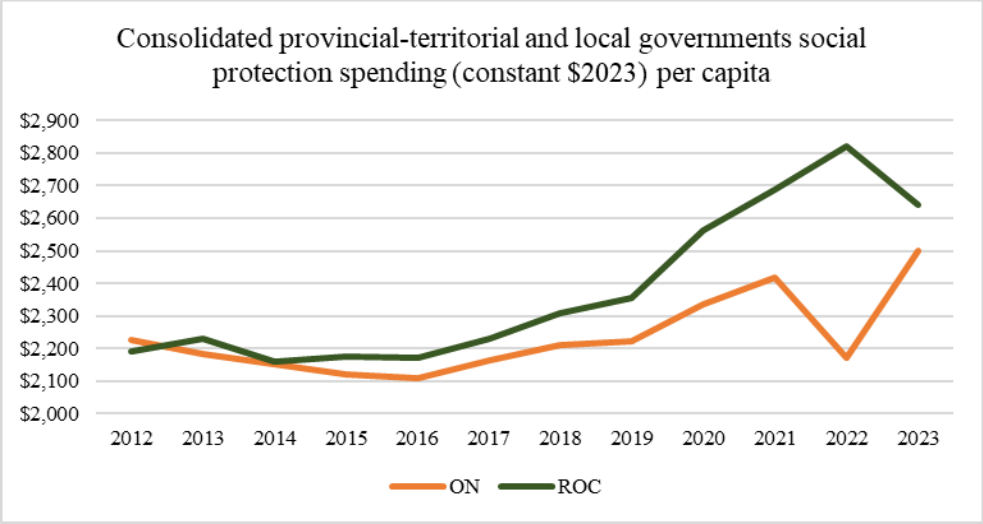
5. Fiscal capacity

Ontario has consistently spent less on per capita public program spending than the rest of Canada over the last twelve years. A closer look at this trend reveals that the province has been consistently ranked lowest or near the lowest in Canada when it comes to health care spending on a per capita basis. In 2023, Ontario's health spending per capita was $5,498, which was 13.8 per cent below the rest of Canada ($6,380). This is an alarming trend given anticipated increased burdens on the health system from, for example, trends in chronic disease and the health impacts of climate change (see section 4.1) in the coming years.[34]



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 & RNAO calculation.

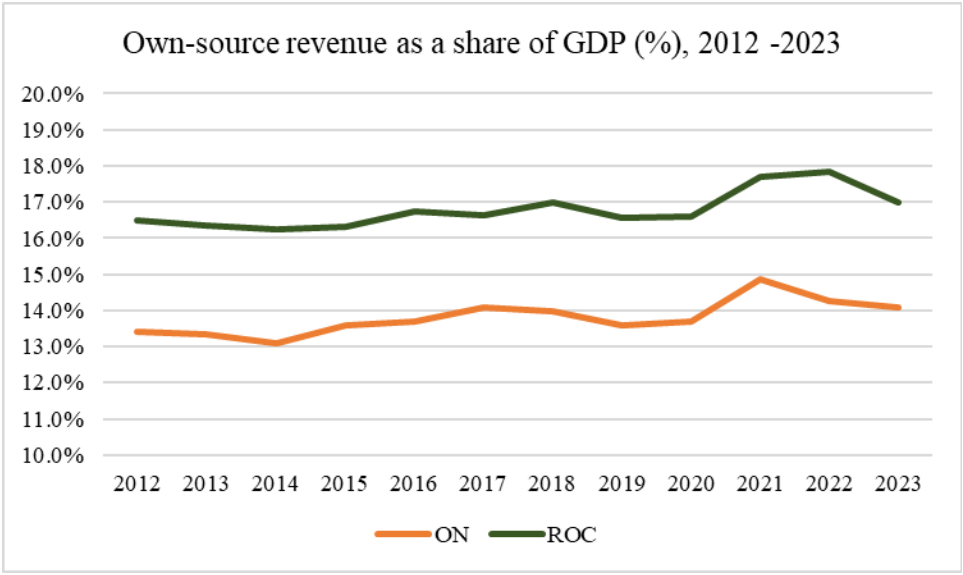
The province also needs to increase spending on a broad range of social determinants of health, including housing and income supports (see sections 3.2, 3.3 and 3.4 for more details). Since 2013, Ontario has consistently lower per capita spending on social and youth services, poverty programs, and housing support compared to the rest of Canada. In recent years, Ontario's social protection spending was $2,501 per capita and needs to increase its per capita spending by at least 5.6 percent to reach the Canadian average.



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 & RNAO calculation

The data suggests that the province will face significant challenges to meet the demand of Ontarians in the coming years if it does not increase its spending on core public programs. For this to happen, Ontario needs to raise its revenue stream.

Ontario's own source revenue as a percentage of GDP trend reveals that over the last twelve years, Ontario has been consistently lower than average at raising revenue. Ontario raised 14.1 percent share of its GDP to fund public services, the second lowest among the provinces. If Ontario increased the revenue to the rest of Canada, it would have raised $33 billion more in 2023.



Data sources: Statistics Canada. Table 10-10-0017-01 Canadian government finance statistics for the provincial and territorial 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) & RNAO calculation

Ontario received $9,305 in tax revenue per capita in 2023 – a three per cent decrease from the previous year. The province also saw a nearly 20 per cent decline in 2023 corporate tax revenue per capita, as well a nearly 23 per cent decline in gasoline and motive fuel tax revenue per capita due to temporary gasoline and fuel tax cuts since spring 2022,[35] which are further extended until June 30, 2025.[36] The Financial Accountability Office estimates that expanding the beverage alcohol marketplace in Ontario will result in a net cost to the province of $1.4 billion by 2030. Another estimate pegs the cost to provincial revenues at $510 million annually at the current consumption levels.[37]

5.1 Tax reform

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

- levying more progressive taxes on all the major sources of revenue
- closing tax loopholes and tightening enforcement of the tax system

Cost estimate: Dependent on scale of tax reform.

5.2 Increased environmental and social responsibility

Recommendation: Increase revenue sources that encourage social and environmental responsibility, for instance, imposing more tax on high carbon emitters.

Cost estimate: Dependent on the scale of program.

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] Ontario College of Family Physicians. (2024). "New Data Shows There Are Now 2.5 Million Ontarians Without a Family Doctor". Internet. Retrieved from: https://ontariofamilyphysicians.ca/news/new-data-shows-there-are-now-2-5-million-ontarians-without-a-family-doctor/

[2] Canadian Institute for Health Information. (2024) Hospital Harm Project. Internet. Retrieved from: https://www.cihi.ca/en/hospital-harm-project

[3] Office of the Auditor General of Ontario. (2023). *Value-for-Money Audit: Emergency Departments*. Retrieved from: https://www.auditor.on.ca/en/content/annualreports/arreports/en23/AR_emergencydepts_en23.pdf

[4] Jones, A. (2023). Ontario hospital nurses awarded average raises of 11% over two years, union says [Internet]. Retrieved from: https://www.cbc.ca/news/canada/toronto/hospital-nurses-pay-raise-arbitration-1.6913088

[5] Registered Nurses' Association of Ontario (RNAO). (2024). The RN Crisis in Ontario. Factsheet. Retrieved from: https://rnao.ca/media/7946/download

[6] Kesten, K. S., & El-Banna, M. M. (2020). Facilitators, barriers, benefits, and funding to implement post-graduate nurse practitioner residency/fellowship programs. *Journal of the American Association of Nurse Practitioners, 33*(8), 611-617. 10.1097/JXX.0000000000000412

[7] McDonough, K. E. (2024). Outcomes of post graduate fellowships and residencies for nurse practitioners: An integrative review. *Journal of Professional Nursing, 53*, 95-103. https://doi.org/10.1016/j.profnurs.2024.05.005

[8] Rosella, L. C., Buajitti, E., Daniel, I., Alexander, M., & Phil, A. B. D. (2024). *Projected patterns of illness in Ontario*. Retrieved from: https://pophealthanalytics.com/wp-content/uploads/2024/10/Study-Projected-Patterns-of-Illness-in-Ontario-Released-October-16-Final.pdf

[9] Registered Nurses' Association of Ontario. (2021.) Nurse practitioner task force: Vision for tomorrow. https://rnao.ca/policy/library/vision-for-tomorrow-2021

[10] Government of Alberta. (2025, April 25). Nurse practitioner primary care program: program guide. https://open.alberta.ca/publications/nurse-practitioner-primary-care-program-guide#summary; Ministry of Health. (2021, October 18).

[11] *PCN NP guideline*. https://www.pcnbc.ca/media/pcn/PCN_NP_Guideline_v1.2.pdf

[12] Primary Care Network British Columbia. (2023, June 29). *UPCC/PCN practitioner costing*. https://www.pcnbc.ca/media/pcn/Practitioner-Costing.pdf

[13] Registered Nurses' Association of Ontario (RNAO). (2019, January 18). *RNAO submission on RN prescribing – Proposed regulation changes: Submission to the College of Nurses of Ontario*. https://rnao.ca/sites/rnao-ca/files/RNAO_Submission_RN_prescribing_Jan_28_2019.pdf

[14] RNAO (2020, May). Enhancing community care for Ontarian's (ECCO) 3.0. https://rnao.ca/policy/enhancing-community-care-for-ontarians-ecco-30-2020

[15] Government of Ontario. (2024, Mary 27). Changing your sex designation on your birth registration and birth certificate. https://www.ontario.ca/page/changing-your-sex-designation-your-birth-registration-and-birth-certificate

[16] Andrews, J., Vaillancourt, C., Jensen, J., Kasaboski A., Charette, C. M., Brehaut, J. C., Osmond, M. H., Wells, G. A., Stiell, I., & Grimshaw, J. (2018). Factors influencing the intentions of nurses and respiratory

therapists to use automated external defibrillators during in-hospital cardiac arrest: a qualitative interview study. *CJEM, 20*(1), 68-70. 10.17/cem.2016.403

[17] Nallamothu, B. K., Greif, R., Anderson, T., Atiq, H., Couto, T. B., Considine, J., De Caen, A. R., Djärv, T., Doll, A., Douma, M. J., Edelson, D. P., Xu, F., Finn, J. C., Firestone, G., Girotra, S., Lauridsen, K. G., Leong, C. K., Lim, S. H., Morley, P. T., . . . Chan, P. S. (2023). Ten Steps Toward Improving In-Hospital Cardiac Arrest Quality of Care and Outcomes. Circulation. *Cardiovascular Quality and Outcomes, 16*(11). https://doi.org/10.1161/circoutcomes.123.010491

[18] Vaillancourt, C., Charette, M., Lanos, C., Godbout, J., Buhariwalla, H., Dale-Tam, J., Nemnom, M. J., Brehaut, J., Wells, G., Stiell, I. (2024). Multi-phase implementation of automated external defibrillator use by nurses during in-hospital cardiac and its impact on survival. *Resuscitation, 197*. 10.1016/j.resucitation.2024.110148

[19] See Rosella et al., note 5

[20] Donaldson, J., Wang, D., Escamilla, C., & Turner, A. (2025). *Municipalities Under Pressure: The Growing Human and Financial Cost of Ontario's Homelessness Crisis*. Retrieved from: https://www.amo.on.ca/sites/default/files/assets/DOCUMENTS/Reports/2025/2025-01-08-AMOHomelessnessReportSummaryFinal.pdf

[21] See Donaldson et al., note 20.

[22] Forchuk, C., Husni, S., Scott, L., Serrato, J., & Booth, R. (2023). Community Stakeholders' Perceptions of the Impact of the Coronavirus Pandemic on Homelessness in Canada. *International Journal on Homelessness*, 1–17. Retrieved from: https://doi.org/10.5206/ijoh.2023.3.15051

[23] Ontario Drug Policy Research Network. (2024). *Suspect Drug-Related and Drug Toxicity Deaths in Ontario* [Dataset]. Retrieved from: https://odprn.ca/occ-opioid-and-suspect-drug-related-death-data/

[24] Government of Canada. (2024). *Supervised consumption sites dashboard* [Dataset]. Retrieved from: https://health-infobase.canada.ca/supervised-consumption-sites/

[25] See Donaldson et al., note 20.

[26] See Donaldson et al., note 20.

[27] World Meteorological Association. (2025). Retrieved from: https://wmo.int/media/news/wmo-confirms-2024-warmest-year-record-about-155degc-above-pre-industrial-level

[28] United Nations. (n.d.). 1.5ºC: what it means and why it matters. Internet; citing United Nations Environment Programme (2023). Emissions Gap Report 2023: Broken Record – Temperatures hit new highs, yet world fails to cut emissions (again). Nairobi. Retrieved from: https://www.un.org/en/climatechange/science/climate-issues/degrees-matter

[29] Environment and Climate Change Canada. (2024). *Canadian Environmental Sustainability Indicators: Greenhouse gas emissions*. Retrieved from: https://www.canada.ca/content/dam/eccc/documents/pdf/cesindicators/ghg-emissions/2024/greenhouse-gas-emissions-en.pdf

[30] Government of Canada. (2024). Temperature change in Canada [Internet]. Retrieved from: https://www.canada.ca/en/environment-climate-change/services/environmental-indicators/ temperature-change.html

[31] See Government of Canada, note 30.

[32] United Nations Framework Convention on Climate Change. (2023). *First global stocktake*.

Retrieved from: https://unfccc.int/sites/default/files/resource/cma2023_L17_adv.pdf

[33] Environment and Climate Change Canada. (2024). *Canadian Environmental Sustainability Indicators: Greenhouse gas emissions*. Retrieved from: https://www.canada.ca/content/dam/eccc/documents/pdf/cesindicators/ghg-emissions/2024/greenhouse-gas-emissions-en.pdf

[34] See Rosella et al., note 8.

[35] Ontario Ministry of Finance. 2024 Ontario Budget: Building a Better Ontario. 2024; Available from: https://budget.ontario.ca/2024/pdf/2024-ontario-budget-en.pdf

[36] Ontario Government Newsroom [Internet]. (2025 Jan 21). Ontario Extending Gas and Fuel Tax Cuts to Keep Costs Down for Drivers. Available from: https://news.ontario.ca/en/release/1005233/ontario-extending-gas-and-fuel-tax-cuts-to-keep-costs-down-for-drivers

[37] Robinson R. New alcohol plan could cost Ontario $510 million a year [Internet]. CCPA. 2024 [cited 2025 Jan 21]. Available from: https://www.policyalternatives.ca/news-research/new-alcohol-plan-could-cost-ontario-510-million-a-year/