RNAO's Response to the Changing Workplaces Review

Submission to the Ministry of Labour

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The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP) and nursing students in all settings and roles across Ontario. RNAO welcomes the opportunity to modernize labour relations and employment standards legislation in light of changes in the workplace that weaken existing legislative protections for many people. In particular, the growth of precarious, contingent and casual and part-time employment is of concern to RNAO because not only does it affect a significant number of RNs and NPs, it also adversely affects the well-being and health of more and more Ontarians.

A. The Changing Workplaces Review: Context

As its name implies, the Changing Workplaces Review is responding to the changing realities in the Canadian workplace. In particular, in recent years there have been material changes in workers' access to traditional labour rights and protections. As the *Guide to Consultations* points out, there are many different elements in these changes - some positive and some extremely damaging. Women and immigrants comprise increasing shares of the workforce, with the labour force becoming increasingly racialized. This reflects, in part, growing immigration and improved access to the job market. A growing share of employment is held by workers over 55 years of age - a function of the aging of the Baby Boom. Free trade agreements have increased trade volumes, making employment more volatile. Such agreements have also allowed a number of Canadian companies to move to lower-wage jurisdictions or to threaten to do so. The result is weak labour demand, which, creates a number of problems for workers:

- Employment is more uncertain and unstable; when jobs move away from the country, they are often replaced by lower paying jobs.
- Traditional higher paid jobs in manufacturing are being replaced by lower paying jobs in the service sector.
- Lower-paid, precarious work is disproportionately held by women and racialized populations.[1] [2] [3]
- There has been a shift from regular full-time employment with full benefits including pensions, to non-standard contingent employment often characterized by part-time hours, uncertain duration of employment, irregular schedules and limited benefits (the Guide includes as non-standard employment the following: temporary employment, self-employment without paid help, involuntary part-time employment and multiple job holding where total earnings fall below the median level).
- Technological change amplifies the effect by replacing workers in productive activity that remains in the country and the effect is not uniform - winners and losers are created. For example, good jobs are created in the high tech sector even as blue collar workers lose their jobs in manufacturing. In an era of constant change and high mobility of employers, fewer workers have access to permanent, full-time jobs and the associated benefits and incomes.

- Employers don't necessarily comply with all the requirements of the *Employment Standards Act (ESA)* and *Labour Relations Act (LRA)*, and precariously employed workers find it challenging to seek redress under that legislation.[4]

As the consultation guide points out, work organization has also changed, with smaller, leaner and more casualized workplaces, flatter hierarchies and more intense use of highly skilled workers. This means that change is not just affecting workers who fall into the new non-standard employment group. Again, there are winners and losers created by this shift.

All told, the above trends result in a skewing of the benefits of work in society, with fewer and fewer workers having access to the protections of secure contracts and full protections of labour legislation, including the *ESA* and *LRA.* In turn, the dimming of employment prospects is linked to the growth of poverty. In Ontario, the child poverty rate grew from an estimated to 12.4 per cent in 1989 to 19.9 per cent in 2012 (latest available data).[5] This is of great concern to RNs, NPs and nursing students, because we know that access to secure and stable employment, with livable incomes, improves the conditions needed to achieve good health and decreases strains on the health-care system.

Responding to the New Context

We applaud the government for holding this consultation. The new environment demands policy changes to compensate for the many changes affecting the labour market. The status quo is not an option. The stated goal of the Review is to protect workers and support business in the modern economy. Of course, there are other tools (e.g., fiscal policy, monetary policy, industrial policy, etc.) to achieve both goals, and we as a society ought to bring the full suite of tools to bear to those ends. However, the *ESA* and *LRA* are principal tools to protect workers, and they should not be distorted to promote business at the expense of labour protection.

B. Changing Workplaces -- Issues for RNs, NPs and Nursing Students

As noted above, RNAO is concerned about non-standard employment for two reasons: the effects on nurses and nursing care, and the health effects this has on certain groups

B.1) Effects on RNs/NPs and Nursing Care

Recent Trends in Nonstandard Nursing Employment: Part-time and Casual Employment
Access to stable full-time employment for RNs has been a major issue for RNAO for a very long time, as the Ontario RN full-time share of employment had sunk to 50 per cent by 1999. This distributing trend disrupted continuity of care and continuity of care-provider, which ultimately led to poorer health outcomes for Ontarians and contributed to an inefficient use of health-care system resources. The goal of having 70 per cent of all RNs working full-time was initiated in the year 2000 by RNAO[6] and is a goal we consistently reinforce in submissions and policy papers.[78] The first step towards revitalization came from Elizabeth Witmer, Ontario's Minister of Health at the time, in a series of recommendations in the Report of the Provincial Nursing Task Force,[9] which sought to reverse the downward cycle for nursing. The human resource problems in

nursing were country-wide, and triggered a series of national studies[10] .[11] The Minister of Health provided $375 million to create 12,000 new nursing positions by March 2001.[12] This was followed by a campaign promise by the Liberal party in 2003 to hire 8,000 more nurses,[13] part of which came as a $50 million commitment to add at least 800 full-time positions in hospitals.[14] The government's platform further confirmed their commitment to and investment in nurses by formally announcing a goal of 70 per cent of RNs working full-time.[15] Supporting this "70 per cent solution" (as it came to be called) was the creation of thousands of full-time positions, such as the 800 mentioned above and another 2,400 full-time nursing positions announced by the Health Minister in 2004.[16] That commitment was reinforced yet again in the 2007 Liberal election undertaking to hire 9,000 more nurses and meet the goal of 70 per cent of nurses working full-time.[17]

Two other nurse retention programs also triggered by RNAO, contribute further to effect of the above interventions:

1. The Nursing Graduate Guarantee (NGG) provides six months funding for temporary full-time positions for recent nursing graduates, and is responsible for dramatically increasing full-time employment for new grads. Employers are given incentives to bridge new nursing graduates from these temporary positions into permanent full-time positions.
2. The Late Career Nurse Initiative (LCNI) is a retention strategy that allows veteran/older nurses to spend 20 per cent of their time doing less physical nursing activities such as mentoring younger colleagues.

These combined nursing commitments had a significant effect on the measured share of full-time employment for RNs (general class plus NPs), which rose from 49.9 per cent to 68.6 per cent between 1998 and 2012, before dropping back to 66.8 per cent in 2013 and recovering slightly to 66.9 per cent in 2014 (see Figure 1).[18]

Retention and recruitment challenges are particularly palpable within the nursing workforce in rural, remote and northern communities. In May 2015, RNAO released a report: *Coming Together, Moving Forward: Building the Next Chapter of Ontario's Rural, Remote and Northern Nursing Workforce.*[19] This report is the product of an expert provincial task force and provides 23 pivotal recommendations that if implemented, will lead to a sustainable nursing workforce and equitable access to health services. One of the key findings of the task force, validating earlier work, is that the availability of full-time employment is a significant enabler of retention and recruitment. Often, there is an abundance of part-time positions available because employers perceive these positions to be 'flexible' to respond to fluctuating service volumes in rural/northern areas. However, research has found that the prevalence of part-time positions in these areas leads to multiple employment and results in employers competing against each other and staffing gaps persist.[20] This can be avoided through increased full-time employment.

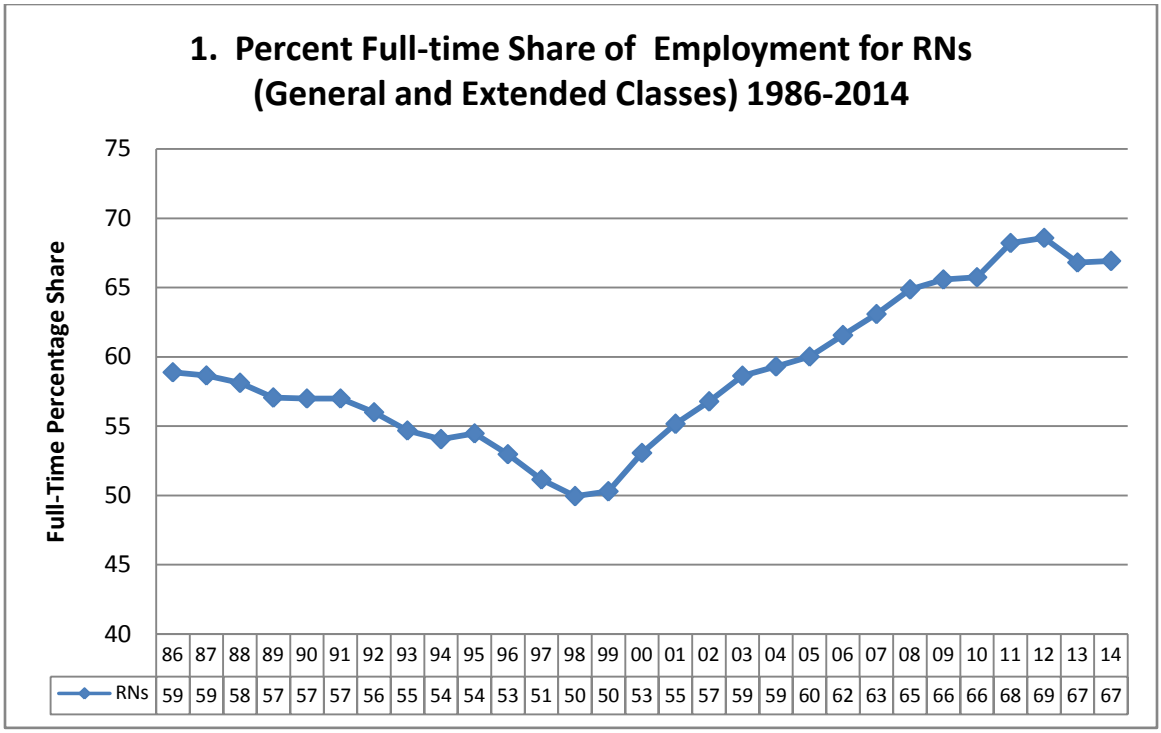
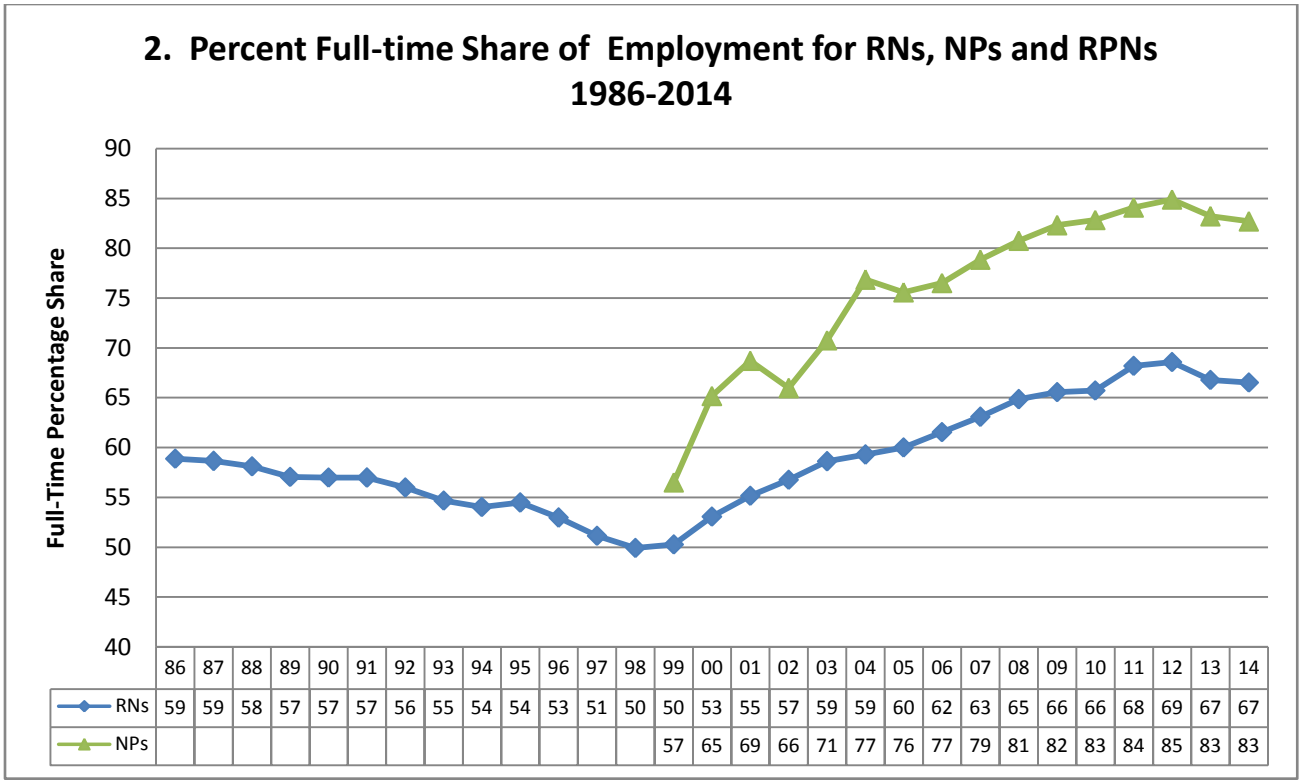
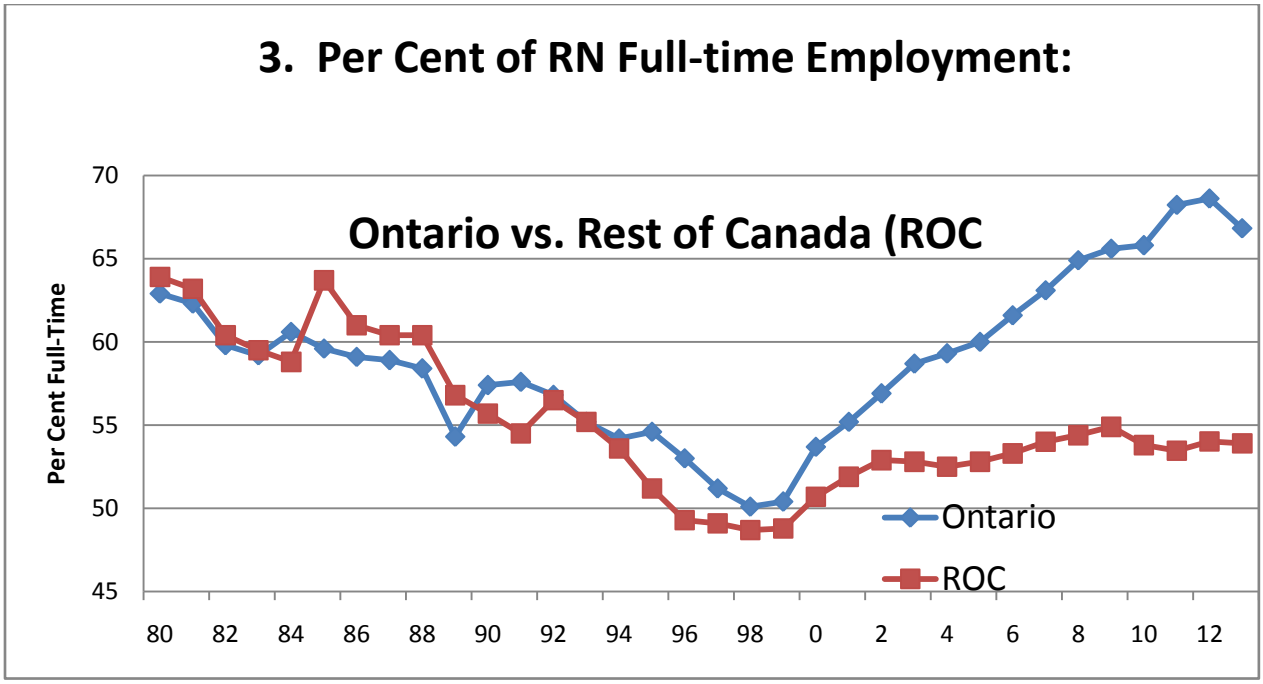


Figure 2 breaks down the proportion of nurses working full-time into: the RN extended class (EC) (also known as Nurse Practitioners or "NPs") and the RN general class (GC). The province has already attained well over 70 per cent full-time for NPs (over 80 per cent since 2008), and was close to achieving 70 per cent with RNs in the general class at 68.3 per cent; that dropped to 66.4 per cent in 2013 and rose slightly to 66.5 per cent in 2014. Overall, changes in full-time employment have been more volatile for NPs as compared to RNs, in part due to the large number in the RN pool.



A striking illustration of how well the initiative to raise Ontario RNs' full-time share of employment comes from a comparison with the rest of Canada (Figure 3). Based on statistics from the Canadian Institute for Health Information,[21] Ontario and the rest of Canada experienced similar patterns with respect to shares of full-time employment over time. In 1980, both started well above 60 per cent in full-time employment, but thereafter both followed a general downward trend, with the lowest figures bottoming out at or below 50 per cent by 1999. After that, both jurisdictions trended upwards, with Ontario rising much more quickly than the rest of Canada. As of 2013, 66.8 per cent of Ontario RNs were working full-time as compared to only 53.9 per cent of RNs in the rest of Canada. Full-time shares in the rest of Canada began to deteriorate again after 2009 highlighting the significant divergence Ontario has made from the rest of the country in full-time employment. In fact, Ontario RNs in 2012 enjoyed higher full-time shares of employment than at any other time in the past 30 years. This shows that when government makes the commitment, it can dramatically change the average employment status in a target group.



Although progress has been made, many nurses working part-time or casual hours prefer other employment statuses. While most nurses are working their preferred status, a significant minority is not, and the bulk of those are part-time or casual nurses who would prefer full-time employment.

- 72 per cent of RN (GC)s would prefer full time, while just 66.6 per cent have it (Figure 4)
- 82.5 per cent of NPs would prefer full time, and 82.7 per cent work full time

If all nurses had their preferred work status, Ontario would easily surpass its 70 per cent full-time objective for nurses.

4. RN (GC)s: Preferred vs. Actual Work Status

	Actual Work Status						Preferred		Actual	
Preferred	**Full-time**		**Part-time**		**Casual**					
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Full-time	61,565	95.1	7,460	29.4	944	13.4	69,969	72.0	64,745	66.6
Part-time	2,711	4.2	17,331	68.2	1,008	14.3	21,050	21.7	25,405	26.1
Casual	469	0.7	614	2.4	5,115	72.4	6,198	6.4	7,067	7.3
Total	64,745	100	25,405	100	7,067	100	97,217	100.0	97,217	100.0

B.2) Incidence of Multiple Nursing Employment

A significant number of nurses work for more than one employer: 15.8 per cent of RN (GC)s, and 25.7 per cent of NPs (Figure 5). Between 2013 and 2014, the incidence of multiple job holding rose for nurses in all categories. This has negative implications for continuity of care. And it is problematic at times of epidemics, such as the 2003 SARS crisis in Ontario.

5. Percentage of Nurses with Multiple Employers

Number of Employers	RN (GC)s			NPs		
	2012	2013	2014	2012	2013	2014
One nursing employer	84.4	84.5	84.2	75.9	75.3	74.3
Two nursing employers	13.8	13.6	13.8	19	20.3	20.9
More than two nursing employers	1.8	1.9	2.0	5.1	4.4	4.8
Total	100	100	100	100	100	100

B.3) Replacement of Registered Nurses

Recently, a disturbing trend has resurfaced within Ontario. Largely motivated by funding decisions, RNs are being replaced by less qualified providers in a number of health-care organizations. This is happening at a time when Ontario already has the second-lowest RN to population ratio in Canada. The trend is concerning and short-sighted given that RNs have direct influence on patients/clients by decreasing mortality and morbidity, improving quality of life, shortening lengths of stay in the hospital and in home care, and reducing adverse events and complications. Fewer RNs mean worse outcomes and higher expenses. In a time when the health system is shifting to provide care for only the sickest of the sick in hospitals and patients in the community have higher health needs, it is simply wrong to replace RNs with less qualified health-care providers. Investing in RNs is investing in the foundation of our publicly-funded, not-for-profit health system. Continuing to replace RNs with less qualified providers will erode the progress made to stabilize the nursing workforce after the disastrous effects of casualization and precarious employment of the 1990s. Rather, the full and expanded utilization of RNs in all health settings will enable retention and recruitment.[22]

B.4) Effects of Non-Standard Employment on Nurses

There is substantial literature on the effects of non-standard employment on nurses. Some of the more recent literature is further highlighted in the appendix. The literature identifies benefits and disadvantages going both ways, with a preponderant advantage to full-time employment, as one would expect when one sees that 72 per cent of Ontario RNs would prefer full-time employment.

As with the rest of the workforce, full-time employment provides significant advantages for nurses: superior benefits, higher income, more certainty about hours and better working

conditions. The system benefits from greater continuity of care and better quality of care. Indeed, a major psychological benefit to nurses comes from being better able to deliver the quality of care they were educated to provide.

Despite nursing being a physically and psychologically demanding profession, particularly when workloads are excessive, as is too often the case - nurses prefer full time over part-time or casual employment. That means that the benefits of full-time employment outweigh the costs for most nurses. It is important that nurses have the employment status of their choice, for their own good, and for the good of patients and the health system.

Full-time nursing employment can also save the system money by avoiding costly overtime and agency costs. Nursing turnover and associated costs are reduced by more full-time employment (which can be a retention strategy). Full-time nurses are more engaged within their organizations. Departures from employers are more likely with part-time nurses, and most likely with casual nurses.

The security of permanent employment confers significant benefits, in terms of enhanced social cohesion, lower stress and more stable schedules. This, in turn, yields more supportive action by permanent than temporary nurses. Permanent, full-time work is particularly important for recent nursing graduates, yet in the absence of government programs, it has been historically hard for them to secure scarce full-time employment. Thanks to Ontario's Nursing Graduate Guarantee program, many new nursing graduates do obtain full-time employment, but it is important to take all feasible measures to ensure that new graduates and other nurses who want full-time employment are able to get it.

B.5) Effects on Patients

There is a complexity of factors involved in attributing patient outcomes to particular factors. At present, there is some evidence to support a link between full-time employment and better patient outcomes. However, nursing employment status affects patient outcomes through effects on the quality of nursing care. There is a great deal of evidence linking full-time nursing employment with improved quality of nursing care: by continuity of care and of caregiver (continuity of care in turn is associated with reduced hospitalization, better quality of care, better cost effectiveness and greater patient satisfaction); by better knowledge of the patient; by higher compliance with best practices; by better task completion; by willingness to attend work during disasters; by reduced management effort to achieve optimal nurse performance; by better reaching nursing potential; by being more included in decision-making; by being more connected to the workplace; by better access to professional development; by having the organizational knowledge to work effectively (awareness of policies, procedures, resource and client population); by less fragmenting of the workforce compared to casual employees (this fragmentation is counterproductive to optimal communication and organizational cohesion, which are essential for achieving higher quality of patient outcomes); by better communication; by costing less and being able to spend more time with clients (compared to temporary employees); and by better infection control (relative to temporary nurses or agency nurses).

Further evidence on the positive correlation between quality of care and full-time employment comes from supervisors' ratings and teamwork scores.

C) Effects on Ontarians

C.1) Determinants of Health

Nurses know that income and jobs are major determinants of health. A disproportionate share of illness burden comes from people whose jobs don't provide an adequate living. While not all non-standard positions have poor incomes, the concern is about the precariously employed, who have disproportionately lower incomes and weaker terms of employment. As the Law Commission of Ontario (LCO) writes, "Precarious work is characterized by job instability, lack of benefits, low wages and degree of control over the process. It may also involve greater potential for injury."[23] These are all well-known health hazards, and the government must act to minimize their effect. This is a large problem. As the LCO notes,

- "In Ontario, approximately 22% of jobs could be characterized as precarious work, defined as having low wages and at least two of three other features: no pension, no union and/or small firm size.
- "Part-time employees are more likely to be precariously employed than full-time employees: about 33% of part-time workers are in positions with low wages, no union and no pension, as compared to almost 9% of full-time employees.
- "Precarious work can include temporary foreign labour, service industry jobs, food services and accommodation jobs, temporary agency work and own account self-employment."[24]

The LCO has an extensive list of recommendations on the Employment Standards Act and other relevant legislation,[25] aimed at leveling the playing field for precariously employed workers, and those recommendations are worthy of consideration.

C. 2) Minimum Wage

The minimum wage in Ontario was frozen at $6.85 per hour from 1995 to 2004, which corresponded to a 17 per cent cut in purchasing power. From February 2004 to March 2010, a series of increases brought the minimum wage up to $10.25 per hour. After staying flat for four years, the minimum wage increased to $11.00 per hour as of June 1, 2014 and will increase to $11.25 on October 1st, 2015. While the increases and indexing of the minimum wage were welcome, the current wage amount still leaves a full-time worker below the poverty line. Having at least a $14 per hour minimum wage with increased attentiveness to ensuring fair legislation and enforcement of labour standards, would create a pathway out of poverty. This would also provide Ontarians with a more livable income and improved health and well-being.

D) Recommendations

RNAO is pleased to offer the following recommendations to the Ontario Government in response to the Changing Workplaces Review:

1. Meet its commitment to have 70 per cent full-time employment for RNs and NPs in Ontario.
2. Continue to fund and support the Nursing Graduate Guarantee and Late Career Nurse Initiative programs and support emerging nursing human resource interventions that are evidence-informed and enable retention and recruitment.
3. Issue a mandate to health organizations to stop the replacement of RNs with less qualified providers.
4. Ensure that workers with non-standard employment enjoy the same protections and benefits as those with standard employment, including the protections under the ESA and the LRA.
5. Cover all classes of worker and employers under the ESA without any exemptions. That would include younger workers, farm workers, workers with shorter tenure and managerial staff.
6. Develop and implement a plan (preferably via changes to the ESA) to deliver the same wages, benefits and working conditions to workers in nonstandard employment as those in standard employment, under the same terms and conditions (e.g., doing the same work with the same seniority).
7. Ensure that flexible employment arrangements acknowledge the preferences and needs of workers, and not merely the convenience and business interests of employers.
8. Implement a proactive deterrence model of enforcement that does not tolerate illegal activities and compels employers to comply with the ESA
9. Build capacity for proactive enforcement of ESA, including increased staffing of enforcement teams and partnering with organizations working with precarious workers.
10. Raise the minimum wage to at least $14 per hour.

Appendix

Literature Review on the Effects of Part-Time and Casual Employment on Nurses and Patients

Patient Outcomes

Currently, the evidence supporting a relationship between full-time shares of nursing employment and patient outcomes is mixed. In 2002 and again in 2006, Tourangeau et al. [26] [27] tested a variety of explanatory variables, but did not find that a higher proportion of full-time nursing staff was statistically related to 30-day mortality in patients with acute myocardial infarction, stroke, pneumonia, or septicaemia. More recently however, Estabrooks [28] found that 30-day mortality "with a primary diagnosis of acute myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, stroke, or pneumonia." was higher in hospitals with higher proportions of temporary and casual nurses. A small study of the impact of school nursing on asthma management found student absenteeism reduced with full-time (vs. part-time) school nurses (Rodriguez et al. (2013).[29] Given that the degree of full-time nursing employment affects patient outcomes indirectly through quality of nursing care (see below); it is not surprising that separating the full-time effect from other influences is very difficult when controlled experiments are not possible.

More conclusive evidence, however, supports a strong positive correlation between full-time nursing employment and quality of care. Chu & Hsu[30] investigated the impact of hospital nurse employment status on work-related attitudes, organizational citizenship behavior, and job performance and found nursing job performance of full-time nurses was rated more highly by supervisors than that of contract nurses. Similarly, a study of four central Indiana nursing schools rate full-time nursing faculty as more effective clinical instructors (DeSantis).[31] Duffield et al.[32] confirmed this finding noting full-time employment is associated with higher compliance with best practices, which required fewer interventions to promote higher quality of care. Nichol et al. (2008)[33] provides further support of compliance with its finding that full-time nurses were three times more likely than part-timers to say they complied with facial protection to reduce transmission of communicable diseases. In a similar vein, Arbon et al. (2013) found that full-time Australasian emergency nurses were more likely to attend their workplaces during disasters if they were working full-time.[34] Moreover, Rafferty, Ball & Aiken[35] found a small but significantly higher proportion of full-time than part-time nursing staff had high teamwork scores (27 per cent vs. 21 per cent). This research suggests that more management effort is required to oblige part-time nurses to achieve optimal performance.

Studies of non-full-time employment yield similar conclusions. Jamieson et al. (2008)[36] found part-time nurses in Australia believed they were not reaching their nursing potential and this affected their ability to deliver patient care (they also found that, regardless of employment status, nurses were not able to achieve their perceived personal optimal nursing potential). Causal factors included exclusion from decision-making, not being known or valued by other health professionals, disconnectedness from the workplace and less access to professional development.

Research points to particular risks to care from casual nursing employment. In a literature review on the relationship between casualization of nursing and communication of nurses in health care, Batch, Barnard & Windsor[37] found that fragmentation of the nursing workforce, brought about by more flexible working arrangements, is counterproductive to optimal communication and organizational cohesion, which are essential for achieving higher quality of patient outcomes. May et al. raised general concerns about quality of care provided by temporary and inexperienced staff.[38] In a 2006 study, Baumann, Blyth and Underwood[39] identified casual and agency employment of nurses as problematic and unreliable when confronted with a need for surge capacity, as during epidemics (consistent with Arbon et al).[40] The Ontario Expert Panel on SARS and Infectious Disease Control (2004)[41] found that current rates of casual, part-time and agency work reduced the capacity to deliver stable and cohesive workplaces, and limited organizations' ability to deliver care when nurses could no longer move between hospitals. Recommendations included reducing the degree of casualization of health care employment, raising the share of hospital health care worker full-time employment to 70 per cent, raising the number of full-time positions and minimizing the use of agency staff. Suggested strategies included creation of resource teams, cross-training, and increased base staffing. Furthermore Hurst and Smith[42] found that staff mixes with permanent and temporary nurses spend less time with clients and were more expensive to run, impacting the sustainability of the health care organization.

There is a substantial body of evidence that raises concerns about temporary nursing staff. Hurst and Smith note that they may lack sufficient organizational knowledge to work effectively (e.g., lack of information about policies, procedures, resource and client population),[43] Part of the problem comes from compressed orientations and exclusion from training. The National Audit Office (NAO) found that mandatory training was not given to 70 per cent of UK temporary nurses in hospital internal resource pools.[44] The same study reported that lack of familiarity with the environment caused 13 per cent of clinical incidents, while a further lack of training and experience caused 8 per cent. The NAO also found that infection control was hampered by use of temporary staff.[45] Use of temporary staff contributes to turnover of staff (Creegan et al.[46] and Duffield et al.[47]), which in turn can hurt continuity of care. That in turn can affect quality of care and outcomes (as Lerner et al. (2014) concluded in a study of nursing homes).[48]

In the early 2000's, Grinspun[495051] noted how fragmentation of the workforce adversely effects nurses, which in turn has a negative impact on client outcomes. Nurses may be driven away by care fragmentation, and their departure further hamstrings the relationship between employers and the remaining nurses. When this occurs, patient care suffers from a reduced continuity of care and caregiver, a reduced capacity of the nurse to know the patient and a reduced ability of the nurse to participate in decision-making. Continuity of care in health care itself is associated with reduced hospitalization and greater patient satisfaction (Beattie et al.[52], better quality of care (Solberg et al.)[53], and cost effectiveness (Sander et al.)[54]. In a later report, Grinspun[55] summarized the case for full-time employment, suggesting it was essential to healthy workplaces and productive teamwork to acknowledge full-time nurses know the patient better, and that continuity of caregiver improves outcomes and system utilization. In addition Grinspun notes that it is particularly crucial for new graduates to obtain full-time employment, although that is often a major challenge.

As noted above, enhancements to care associated with full-time nursing employment are often linked to the provision of continuity of care. Duffield et al.[56] found that continuity of care was enhanced by full-time employment, due in part to a higher awareness of the skills, expertise, strengths and weaknesses of fellow staff members, which resulted in an overall efficiency requiring less supervision by nursing managers. A survey of Italian nurses reported that part-timers complained about insufficient information on clients and lack of involvement in ward projects and planning (Ferrazzo et al (2012)).[57] Similarly, Edwards et al.[58] reported that significant numbers of surveyed managers reported part-time care interfered with continuity of care and task completion (28 per cent), with exchanging information (40 per cent) and with team communication (25 per cent). They also found a longer-term threat to quality of care with part-time nursing due to skills erosion and weakened career advancement.

Further indirect effects on clients by employment status operate through impacts on the nurse, as discussed below.

Nursing Outcomes

A number of studies identified that the disconnect between preferred and actual employment status had a number of significant impacts. Burke (2004)[59] found that nursing staff who had their preferred employment status were emotionally and physically healthier. Havlovic et al. (2002)[60] similarly found that nurses who had their preferred shift and work week were healthier, more satisfied and more positive about their quality of care, while Kapborg[61] found that Swedish nurses forced into part-time (due to government budgetary policy) reported reduced self-confidence and health problems.

A few surveys found a degree of mismatch between preferred and actual employment status. In 2002, McGillis Hall et al.[62] surveyed nurses in adult medical, surgical and obstetrical units in Ontario teaching hospitals and found that 63 per cent were full-time, the large majority of all nurses (89 per cent) had their preferred work status, and that 6 per cent wanted more hours. In 2005, RNAO [63] found that in particular, many part-time and casual RNs preferred full-time, and concluded that if Ontario RNs had their preferred work status, 64.5 per cent would be full-time as opposed to the then 59.3 per cent. Many other part-time and casual RNs would conditionally go full-time, assuming that workplace challenges that drove them away from full-time were addressed. If all of those RNs obtained full-time employment, the province would have had 78.4 per cent full-time RNs. In 2002, The Canadian Labour and Business Centre [64] found 26 per cent of Canadian RNs were part-time, in contrast to the 41per cent reported by CIHI (due to different methodologies). It concluded that if involuntary part-time RNs were able to work full-time, 4.7 million more hours, which is the equivalent of 2,592 more FTEs, could have been added in 2001. Most recently, CNO (2014) reported that 72.0 per cent of RNs in the general class preferred full-time employment, while only 66.6 per cent actually had it. The figure was even more striking for RPNs: 55.9 per cent had full-time employment in 2014, while 76.8 per cent wanted it.[65]

Recent grads tend to have a strong preference for full-time, yet often have the greatest difficulty in obtaining it of all nurses. Montour et al.[66] found that younger nurses in particular seek

professional opportunities including full-time work in large urban centres, thus contributing to "urban drift". Sloan et al. (2006)[67] had similar findings when it studied small non-urban hospitals.

Because nurses face different circumstances and have different employment status preferences, the literature identifies problems with each employment status. Full-time employment does have a number of advantages, such as greater job security and more opportunities for career advancement.[68] As discussed above, temporary staff members do not get the same level of training and orientation.[6970]And, variable shift work brings its own health risks, including increased risk of needlestick injuries (Rohde, Dupler, Postma and Sanders).[71] However given the demanding nature and workload of many health-care settings, nurses often experience fatigue[72]. To the extent that some nurses experience fatigue, client care may be compromised; Scott et al. (2014) found that nurses with decision regret were more likely to report fatigue, daytime sleepiness, less inter-shift recovery and worse sleep quality.[73]

There is abundant literature on adverse effects experienced by full-time nurses. For example, full-timers experience greater volumes of stress, including more intense psychological effects of bullying (Rodwell and Demir).[74] A systematic review by Toh et al (2012) of the effects of a nursing shortage in oncology/haematology settings found that full-time nurses were more likely to identify staffing shortages as contributory to job dissatisfaction, stress and burnout.[75]Edwards et al. [76] reported part-timers work fewer hours and are less stressed (Hegney et al (2014) also found that Australian nurses who were younger, full-time and lacking post-graduate qualification experienced higher anxiety.),[77] which may result in better retention of part-time nurses. A South African study (Colff and Rothmann, 2014) similarly found that full-time employment was a factor in burnout, along with language, age, rank, job satisfaction, reciprocity, and specialized training.[78] Gui et al (2014) found that full-time nurse teachers in China and the UK faced greater work challenges than their part-time counterparts.[79] A small older study of Canadian women nurses found no statistical differences in the well-being of full-time, part-time and casual nurses, although job-share nurses did better (Kane and Kartha (1992).[80] Part-time and casual work is chosen by some nurses for the flexibility it offers, which provides individuals with more control over work-life balance or time for further education (Kemp;[81]Philip;[82]Wetzel, Soloshy and Gallagher[83]).Studies in the US, UK and Australia found the appeal for some nurses was the flexibility, higher pay rates, and control of the schedule (Gordon;[84] Lumley, Stanton, and Bartram;[85] Creegan, Duffield, and Forrester[86]). McGillis Hall et al.[87] found that rising workload and patient acuity could be contributing to nurses' preference to work part-time or causal. Several participants added that part-time and causal employment increased their autonomy. Burke & Greenglass (2000)[88] discovered hospital restructuring in Ontario had different impacts on full-time and part-time nursing staff. According to their research, full-time nurses reported heavier workloads, were more likely to be absent, and were less likely to quit. Furthermore, they reported more exhaustion and cynicism, poorer physical health, more medication use, and poorer lifestyles. Zboril-Benson[89] studied frontline long-term and acute care nurses in Saskatchewan and also found that full-time nurses were more likely to experience absenteeism.

Other research has documented the physical toll of full-time employment. In 2008, Alamgir, Yu and Ngan[90] found that in British Columbia, full-time RNs in hospitals had significantly higher risk of injury than part-time and casual nurses. In general, full-time health care workers have higher injury rates than in other industries. In 2002, Shamian et al.[91] studied hospital RNs and found that full-time RNs had more illness, burnout and job dissatisfaction than part-time RNs. In fact, Jameson et al.[92] identified that nurses' reasons for working part-time were: their health; work intensification; non-work responsibilities; scheduling inflexibility; finances; and "the need to maintain workplace and professional links."

The above suggests workload may be a causal factor to burnout and job dissatisfaction, and that while more full-time positions may improve the stability of the workforce, workloads in some settings should be addressed to guarantee enough RNs will take those positions.

Nursing Workforce Sustainability

Nevertheless, a solid majority of nurses are full-time, meaning that substantial advantages remain for nurses in full-time employment, despite significant workload concerns. Those advantages include superior benefits, higher income, more certainty about hours and better working conditions.[93] There are also additional cost advantages of full-time nursing employment to the system. O'Brien-Pallas et al. (2001)[94] point out the irony that reducing the full-time/part-time ratio was employed as a cost-minimizing strategy. However, insufficient full-time employment incurred higher system costs due to effects on quality of care that were in turn caused by reduced continuity of care and less familiarity with the organization. Moreover, as Drebit, Ngan, Hay and Alamgir point out, creation of full-time positions from the costly and growing overtime nursing bill is one way to reduce costs.[95]

Benefits of increasing the proportion of full-time employment arise in other related ways. In 2008, O'Brien-Pallas, Tomblin Murphy, and Shamian,[96] found that higher full-time shares of nursing employment were associated with lower turnover. This was also found by Heinen et al (2013) (OR = 0.76 for turnover),[97] Burke and Greenglass (2000),[98] Zeytinoglu, Denton, Davies & Plenderleith (2009),[99] Toren, Zelker, Lipschuetz, Riba, Reicher & Nirel (2009),[100] Rajacich et al, (2013, for Canadian male nurses),[101] and Austen et al. (2013).[102] Alameddine et al (2014) concluded subsector stickiness (persistence in a given subsector) increased with the offering of full-time jobs.[103]Toren et al (2012) found that part-time RNs in Israel were more likely to leave.[104] May et al. found that a heavy reliance on temporary staff worsened nursing shortages.[105] This is consistent with findings that nurses who preferred full-time were leaving Ontario or seeking multiple employers to obtain full-time hours (Baumann A, O'Brien-Pallas L, Armstrong-Stassen M, Blythe J, Bourbonnais R, Cameron S, et al.;[106] and Registered Nurses' Association of Ontario. (2001)).[107] Results must be interpreted carefully as correlation between turnover and work status may be driven by other factors; for example New Zealand nurses over 50 who reported lower health-related quality of life were more likely to move to casual employment and to retire earlier (Clendon 2013).[108]

A few studies had somewhat contrary findings. Brewer et al (2012) found that full-time employment and injury were associated with more turnover, in a survey of newly licensed American hospital RNs.[109] The report advised policies to reduce strains and sprains. In a small study of medical-surgical nurses, Jolma (1990) found that full-time status, hospital size and unit size were all positively associated with higher workload and intent to leave. Kachi et al (2010) found that full-time professional caregivers for the elderly in Japan were more likely to intend to leave.[110]

In a study of a sample of Ontario LTC facilities, McGilton, Tourangeau, Kavcic and Wodchis (2013), conclude that access to full-time work and benefits is a part of a nurse retention strategy that also includes opportunities for self-scheduling, models of care that strengthen resident relationships, and management of workload to minimize burnout.[111] Jurisdictional retention was addressed by McGillis Hall et al. (2013a), who identified the following factors in interprovincial mobility: access to full-time work, flexible scheduling, and career advancement.[112] McGillis Hall et al (2013b)[113] and (2009)[114] warn that availability of full-time employment is also a retention strategy to keep nurses from moving to the US. Cameron et al. (2010) found that on both sides of the Canada-US border, the primary reason for choosing their current workplace was full-time work.[115]

But nurses do not have the same needs at all points in their careers, and employers must attend to changing needs and preferences. A New Zealand study by Clendon and Walker (2013a) recommended more flexible scheduling (and greater access to part-time hours) as a retention strategy for older nurses.[116] Clendon and Walker (2013b) found New Zealand nurses were more likely to switch to casual and flexible hours as they age.[117]

Turnover costs are a major consideration. O'Brien-Pallas, Griffin, Shamian et al.(2006)[118] found the average unit cost of turnover was $21,514 and the mean turnover rates for medical and surgical units were 9.49 per cent and 11.4 per cent. The highest direct cost was that associated with temporary replacements and the highest indirect cost was reduced productivity of the new hire. Hayes et al. noted adverse effects on staff morale and staff productivity, with potential effects on quality of care.[119] Much higher unit costs were estimated by Jones (2008) for replacement of nurses in the US: $82,000 to $88,000.[120] Jones points out the ease of underestimating the largely hidden turnover costs (burnout, low morale and effects on patient care).Doran et al.[121] found that full-time employment status was associated with more job security in home care nurses, and recommended creating more opportunities for full-time positions.

One mechanism for permanent employment to promote gains is via enhanced social cohesion, due to lower stress and more stable schedules (Shader et al.).[122] Yeh et al. found lower stress and higher commitment among permanent than temporary nurses.[123] In turn, that commitment yields more supportive action by permanent than temporary staff (Van Dyne and Ang).[124] Temporary nurses may contribute to loss of team cohesion (Kalisch and Begeny).[125]

As noted above, new nursing graduates are most severely affected by lack of full-time positions. Given their propensity for mobility, there is strong likelihood that new graduates may leave Ontario in search of full-time employment elsewhere, which negatively impacts the workforce's long-term sustainability. McGillis Hall et al. (2009) [126] concluded key factors for keeping Canadian RNs from moving to the US included opportunities for full-time employment and ongoing education. McGillis Hall et al. found that those Canadian RNs in the US were more likely to have full-time than their US and Canadian counterparts, which strengthened their conclusion. In 2002, the Canadian Nursing Advisory Committee [127] identified lack of full-time employment and excessive part-time work as factors contributing to the nursing shortage, along with other causes, such as insufficient numbers of nursing education seats combined with an aging nursing workforce, HR management issues, and lack of funding for nursing positions. This result was supported by a study of Ontario nurse faculty by Tourangeau et al. (2014), which identified full-time employment and having preferred job status (full-time or part-time) as both positively correlated with intention to remain employed in the current position.[128]

Prior to the introduction of the Ontario government's Nursing Graduate Guarantee program in 2006, new graduates were leaving the province in droves. In 2004, Cleverly et al.[129] found that 79.3 per cent (2004) and 70.7 per cent (2005) of new Ontario RN graduates wanted full-time, but only 31.7 per cent (2004) and 42.5 per cent (2005) obtained it after six months. For new RPN graduates, 60.2 per cent preferred full-time but only 14.2 per cent reported having such work after six months. As a result, a significant number of new grads considered moving out of Ontario, particularly in the southwest part of the province. Graduates were concerned about the lack of full-time jobs, the surplus of casual employment, and unstable employment. The report recommended that government provide financial support for more full-time employment and to increase employment of new nursing grads. It also recommended that nursing employers should convert casual positions into full-time positions.

Based on data from a survey of nurses from three southern Ontario hospitals, Zeytinoglu et al. (2006)[130] also identified non-full-time status as a risk factor for departure. (see also Zeytinoglu et al. (2007)).[131] While nurses in this study displayed interest in leaving their facility, few seriously considered leaving the profession. Casual nurses had the highest propensity to leave their hospitals (26 per cent vs. 16 per cent part-time and 13 per cent full-time) and profession (21 per cent vs. 14 per cent part-time and 12 per cent full-time). Income of full-time nurses was more important to family economic wellbeing, and thus was negatively correlated with their tendency to leave. Casual nurses were most likely (26 per cent) to prefer other employment statuses. Stress was the biggest factor affecting desire to leave the hospital. Zeytinoglu et al. recommended attention to key departure factors of stress, job preference, importance of earnings, and unpaid overtime, suggesting separate policies should be geared to each employment category (full-time, part-time and casual).To complete the circle, turnover may beget turnover, as the elevated workloads and stress lead some of the remaining staff to quit themselves (Hayes et al.[132]).

Confirming the work of Zeytinoglu et al, Daniels, Laporte, Lemieux-Charles, Baumann, Onate and Deber (2012) found casual nurses had the greatest tendency to leave, while full-time nurses

were least likely to depart, with part-time nurses falling in-between. They found a number of other variables correlated to departure risk: 1) sector: hospital nurses were least likely to leave, followed by LTC nurses and nurses in other sectors; 2) age: older (over 55) and younger (under 31) nurses were more likely to leave; 3) gender: male nurses were more likely to leave; education: RNs with higher education were more likely to leave; and 4) nurses with higher levels of education were more likely to leave.[133]
Mallette (2005) found more of a relational psychological contract for full-time nurses, which is associated with higher reported job satisfaction and lower intent to withdraw.[134]

MacPhee and Svendsen Borra (2012)[135] noted that there are many concepts of flexibility in nursing work arrangements (e.g., over hours, scheduling, location, and multi-skilling), and that it is important to distinguish between those that reflect nurses' choices and needs to accommodate work-life balance (e.g., flexible scheduling, the late-career/80/20 model in Ontario, and phased retirement) and those that reflect institutionalized insecurity and lack of nursing choice. The latter is more associated with the pejorative sense of casualization of nursing employment. MacPhee and Svendsen Borra argue that inappropriate flexibility is ultimately bad management practice that benefits neither nurse nor client nor employer. It is worrisome that Houseman et al.[136] and Mercer et al. found that temporary employment was primarily initiated by employers[137]

MacPhee and Svendsen Borra concluded that choice around flexible work options was associated with enhanced job satisfaction, greater commitment to the organization, and intent to stay. They added that it was a powerful recruitment and retention tool.[138] Choice on work status and work flexibility remains a powerful recruitment and retention tool.[139] Nurses with preferred shifts and scheduling perform better and have greater job satisfaction (Havlovic et al. as noted above by MacPhee and Svendsen Borra 2002,[140] Shader et al. 2001,[141] Pryce et al. 2006).[142]

Other studies supporting the recruitment and retention virtues of choice-based flexible arrangements include Hart (2006; RNs),[143] Durand and Randhawa (nurses),[144] Arun et al. (women workers),[145] Aiken et al. (nurses),[146] Heath et al. (nurses),[147] Schmalenberg and Kramer,[148] Baumann,[149] Stone et al.,[150] and Buchan and Calman.[151]A number of articles cite flexibility as a way of mitigating the stress of high workloads (Vetter et al.,[152] Pryce et al.,[153]Kane,[154]and Lea and Bloodworth[155]).Tanaka et al found that choice was an important element linking nurses' self-assessed health and flexible work practices.[156] Ingersol et al found that when nurses had the ability to adjust their schedules to fit family obligations, they exhibited greater satisfaction and organizational commitment.[157] In a case study, Abney-Roberts and Boll (2014) found that self-scheduling led to greater satisfaction and no reported resignations due to dissatisfaction related to scheduling.[158] An important consideration in retaining late career nurses is their family care obligations; Jacobs et al (2014) concluded that encouraging later retirement may require more flexible work options.[159] Dissatisfaction with work schedules is a departure risk, according to a study of Finnish nurses (Flinkman et al. (2008).[160] Inflexible work schedules are one of the causes of stress, job dissatisfaction, intent to leave, and voluntary

turnover.[161162] They are not the principal cause, but they compound or fail to mitigate problems like excessive workloads (Strachota et al,[163] Pillay,[164] Josten et al.[165]).

A different strand of research speaks to empowerment. Yang et al. (2013) found that work environments that empowered nursing practice among Chinese staff nurses strengthened the commitment of those nurses.[166] Choice may be seen as a component of empowerment. More generally, involvement of nurses in decision-making is important to job outcomes and nurse-assessed quality of care (Bogaert et al. (2013).[167] Additional resources tailored to job demands can help to reduce work-related strain (Lavoie-Tremblay et al. (2014).[168] More generally, "the empowerment dimensions of support, resources and opportunities were strong predictors of intention to stay, with support being the strongest predictor" (Milanese, 2013).[169]

Finally, the literature shows that retention is enhanced by accommodating nurses' preference for work status (Zeytinoglu et al (2006),[170] Baumann et al (2003),[171] and Zeytinoglu (1993)[172]). Hiscott (1994) found ease of changing employment status was associated with duration of employment for Ontario RNs.[173] Not all nurses have their preferred employment status; some want more hours and some want fewer. Nurses have different preferences depending upon age and work-life requirements.[174] This mirrors findings in research on workers' preferences (Reynold,[175] Fagan (2001),[176] Boheim and Taylor (2004)[177] and Isaksson and Bellagh (2002)). [178] A study of Norwegian nurses (Halvari, H., Vansteenkiste, M., Brorby, S., and Karlsen, H.P. (2013))[179] identified in more detail factors influencing the desire to move to full-time: managerial support of part-time (reduces preference), negative feedback from colleagues on part-time status (increases preference), household income (negatively correlated), income aspirations (positively correlated), age (negatively correlated), involvement in the work rotation planning (positively correlated), and share of an FTE worked (negatively correlated).

As noted above, RNAO (2005) concluded that Ontario would have increased its full-time share for RNs by over 5 percentage points by accommodating the preferences of all its nurses; this is because there were more non-full-time nurses seeking full-time than the reverse. Furthermore, it concluded that if the circumstances that caused RNs to go part-time or casual were fixed, up to 78.4 per cent of the RN workforce could be full-time. Also as noted previously, CNO (2014) reported that 72.0 per cent of RNs in the general class preferred full-time employment, while only 66.6 per cent actually had it. The figures for RPNs were 76.8 per cent and 55.9 per cent respectively.[180]

And of course, creating full-time positions can meet other objectives, such as increasing the number of FTEs (Maier and Afentakis (2013)).[181] This in turn would promote nursing workforce sustainability by reducing workloads and by allowing nurses to address more of their clients' needs.

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