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Ensuring The Care Will Be There

Report on Nursing Recruitment and Retention in Ontario

Submitted to the Ontario Ministry of Health and Long-Term Care

March 2000

FULL REPORT

This report was prepared by the Registered Nurses Association of Ontario in collaboration with the Registered Practical Nurses Association of Ontario in response to Recommendation 4 from ***Good Nursing, Good Health: An Investment for the 21st Century – Report of the Nursing Task Force,*** January 1999.

CONSULTATIONS

Registered Nurse/Registered Practical Nurse Recruitment and Retention Working Group	June 14
Student Recruitment and Retention Working Group	June 14
RNAO and RPNAO Board of Directors	October 8
Loyalist College Nursing Students (First Year) Focus Group	October 19
Rural Ontario RN/RPN Focus Group	October 25
Ottawa Area RN/RPN Focus Group	October 26
Northern Ontario RN/RPN Focus Group	October 28
Registered Nurse/Registered Practical Nurse Recruitment and Retention Working Group	November 3
Student Recruitment and Retention Working Group	November 3
Ministry of Health and Long-Term Care Sectoral Meetings	November 9
Interdisciplinary Focus Group	November 16
Human Resources Focus Group	November 16
Educators Focus Group	November 18
Joint Provincial Nursing Committee	November 30 January 31, 2000

Except if noted, all consultations occurred during 1999.

Copies of this *Report*

This is the full version of the report. A summary version is also available. Copies of both versions can be downloaded from RNAO's Web site (www.rnao.org) and RPNAO's Web site (www.cdn-domain.com/rpnao).

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Acknowledgements

We have benefited, and will continue to benefit, from the input of the nursing community, other provider groups and Ministry of Health and Long-Term Care representatives. We are grateful for the hard work of RNAO staff in preparing this report and the invaluable input of RPNAO. Doris Grinspun led the project and the preparation of the report. Jacqueline Choiniere prepared the policy context and work environment sections. Kim Jarvi prepared the labour market trends section. Doris Grinspun and Lianne Jeffs discussed the integration of research and policy to recruitment and retention. Lianne also prepared an extensive literature review. Alongside them, Sue Bookey-Bassett and Peggi Mace drafted the recommendations and the detailed plan of action. Sue Williams prepared the section on education environment. Peggi Mace also served as the secretariat for co-ordinating the various working and focus group sessions with secretarial support from Denise King. Julie Abelsohn and Lesley Frey provided editorial assistance and Leda Kessel administrative assistance. In addition, we thank Ricardo Grinspun for his thoughtful comments and editorial review.

Acronyms

BScN	Bachelor of Science in Nursing
CAATS	Colleges of Applied Arts and Technology
CCAC	Community Care Access Centre
CHA	Canada Health Act
CIHI	Canadian Institute for Health Information
CHST	Canada Health and Social Transfer
CNA	Canadian Nurses Association
CHEPA	Centre for Health Economics and Policy Analysis
CNF	Canadian Nurses Foundation
CNO	College of Nurses of Ontario
CNS	Clinical Nurse Specialist
COUPN	Council of Ontario University Programs in Nursing
FTE	full-time equivalent
HR	human resources
HSRC	Health Services Restructuring Commission
ICES	Institute of Clinical Evaluative Sciences
JPNC	Joint Provincial Nursing Committee
JPPC	Joint Provincial Planning Committee
LPN	licensed practical nurse
LTC	long-term care
MET	Ministry of Education and Training
MOHLTC	Ministry of Health and Long-Term Care
NP	nurse practitioner
NRU	Nursing Effectiveness, Utilization and Outcomes Research Unit
NTF	Nursing Task Force (December 1999)
OANHSS	Ontario Association of Non-Profit Homes and Services for Seniors
OHA	Ontario Hospital Association
ONA	Ontario Nurses' Association
ONHA	Ontario Nursing Home Association
PCNO	Provincial Chief Nursing Officer
PLA	prior learning assessment
PNFO	Practical Nurses Federation of Ontario
PSA	Public Service Announcement
R & R	recruitment and retention
RHPA	Regulated Health Professions Act
RN	registered nurse
RN (EC)	registered nurse (extended class)
RNC	Rural and Northern Communities
RPN	registered practical nurse
RNAO	Registered Nurses Association of Ontario
RPNAO	Registered Practical Nurses Association of Ontario
RNFOO	Registered Nurses Foundation of Ontario

Introduction

About this Report

Ensuring The Care Will Be There: A Report on Recruitment and Retention in Ontario addresses key issues for Ontario nurses and the public. This *Recruitment and Retention Report* is a response to an imminent and severe nursing shortage across Canada. Over the past two decades, the nursing profession has been buffeted by sharp changes in employment opportunities. Sudden drops in employment, driven by cuts in funding, drove people away from nursing and turned into dangerous shortages in supply. To avoid problems throughout the health-care system, the emerging nursing shortage must be immediately attended to. We must act now!

This report owes its existence to provincial government recognition that an adequate supply of motivated and qualified nurses is fundamental to the health and well-being of Ontarians. In September 1998, the Honourable Elizabeth Witmer, Ontario's Minister of Health and Long-Term Care, responded to the nursing profession's call for action on the pending shortage and other nursing resource issues by establishing the Nursing Task Force. The Task Force "was directed to examine the level of access to quality nursing services and to identify changes in nursing related to health-care reform. The Task Force was also asked to assess how these changes may affect both health-care professionals and health-care consumers."

The January 1999 *Report of the Nursing Task Force – Good Nursing, Good Health: An Investment for the 21st Century* (Queen's Printer for Ontario), contained eight recommendations regarding nursing in Ontario. The government of Ontario accepted and committed to implement all the recommendations in March 1999. Recommendation 4 focussed on encouraging women and men to choose nursing as a career and on the retention and recruitment of registered nurses and registered practical nurses.

> Nursing Task Force Recommendation 4:
>
> Continuity and quality of care is highly dependent on the retention of experienced and knowledgeable nurses and requires not only a sufficient number of permanent positions for RNs and RPNs but also a working environment that offers flexibility and professional satisfaction. It is therefore recommended that employers of nurses mount pilot projects to test alternative models of nursing care (e.g. flexible hours, environments that enable nurses to develop clinical skills, etc.) and that these models be evaluated to assess the impact on client outcomes and the working environment for nurses…
>
> To heighten awareness of a career in nursing and to encourage young women and men to choose a career in nursing, it is recommended that the professional nursing

associations, with the support of the Ministry of Health and Long-Term Care, mount a comprehensive marketing and communications plan.

The *Report on Recruitment and Retention* is a reflection of the strong consensus within the nursing profession on the urgent action required to address the causes of inadequate nursing resources. The nursing community has had an extraordinary level of involvement in this project (see Appendices 3 and 4). Nurses across all sectors and regions of the province are united in their resolve to take immediate action.

The Mandate

The Registered Nurses Association of Ontario (RNAO) was asked by the Ministry of Health and Long-Term Care to take the lead and collaborate with the Registered Practical Nurses Association of Ontario (RPNAO) to translate Recommendation 4 from the Nursing Task Force report into reality.

This report presents an analysis of the current situation and offers a plan of action with specific recommendations and strategies for the recruitment and retention of nurses – both RNs and RPNs – in Ontario.

The Challenge of Recruitment and Retention

There are sound, fundamental reasons why nursing should be a very attractive professional choice. The nursing profession has the ingredients to be an exciting and fulfilling lifetime career option offering challenging and diverse practice opportunities. It allows for flexibility of employment and the opportunity for a balanced family and work life. It provides for endless career experiences in practice, administration, education, research, policy, and combinations of all these. Nurses work with people, addressing holistic human needs throughout the health-care continuum: health promotion, illness prevention, cure, care, rehabilitation and palliation. The profession attracts people dedicated to care.

Nurses are critical for a healthy society and societal trends are increasing the need for nurses. These trends include: a growing and aging population; an heterogeneous, differentiated and more unequal society; contrasts between urban, rural and northern contexts; cultural diversity and vulnerable social groups facing marginalization; a technologized health-care delivery system thirsty for human touch; and finite resources. These trends call for providers that are competent to deal with multiple challenges. Nurses are prepared and eager to respond to the call.

Although nurses provide vital services, and nursing is an exciting career option, we are in a serious situation provincially, nationally and internationally. As the need for nurses increases, the pool of available nurses continues to decline. Funding cuts have resulted in unbearable working conditions and unhealthy work environments. Poor staffing patterns resulting in heavy workloads, and the lack of professional development opportunities,

have lead to an emotionally and physically exhausted nursing workforce. The widespread forced move to part-time and casual work, unique to the US and Canadian health-care systems, has led to fragmented patient care and the disillusionment of nurses with their profession. All of these serve as disincentives for the retention of nurses. Furthermore, boom and bust cycles of nursing employment, in the context of widening career opportunities for women, do not contribute to the recruitment of women and men into the profession.

The challenge of recruitment and retention of nurses in Ontario is multi-dimensional, and we treat it inclusively. We provide specific recommendations regarding immediate recruitment and retention strategies, and we also address key policy and organizational imperatives. Our argument is that unless we address the latter, we will not prevent the cyclical waves of nursing shortages and surpluses in the future.

Nursing is central to the provision of quality health care. The public, employers, other health-care providers, and nurses themselves expect quality nursing care. However, a large gap exists between these expectations and the barriers that limit a nurse's ability to fulfil her or his professional and social responsibility.

This *Report* is an urgent call to action for nurses, nursing organizations, employers and the provincial and federal governments. There is a way to encourage nurses to remain in practice and position nursing as a most desirable profession, a profession that will attract bright, capable women and men now and in the future. The ability to recruit and retain nurses is essential for the health of Ontarians. This is our shared responsibility. We must act now.

Definition of Terms

In this report:

The word "nurses" refers to RNs and RPNs.

The word "patient" refers to all those individuals and communities for which nurses provide their services.

Key Findings

The analysis and findings of this project are presented later in detail. Here we present a summary of key findings.

To the question – what needs to be done to recruit and retain nurses in Ontario? The answer is twofold.

First, we must *establish the policy framework and address the structural constraints that impact on recruitment and retention.* These policies will ensure that nursing enjoys a permanent status as a highly valued and indispensable service to the public.

Second, we must *apply the lessons from research on recruitment and retention.* The best recruitment strategies for nurses are those that influence the image of nursing and the career choices of young people. The best retention strategies are those that are specific to the health-care organization and are based on extensive staff involvement as a critical source of recruitment and retention information within the organization.

The Policy Context

Policy directions taken by governments and health-care organizations over the past several years have been detrimental to the recruitment and retention of nurses. Funding cuts, system restructuring and reorganization, and human resource policies have negatively affected nurses. The public has supported the nursing profession and shown growing concern for the well-being of our health-care system. We acknowledge current efforts on the part of the provincial and federal governments to reverse some of these policy directions, but much more needs to be done. We are all stakeholders in our health-care system, and we must work collaboratively and assertively to support and encourage healthy public policies.

The Work Environment

In virtually all settings, patient care needs have increased as the number of nurses has declined. Change has been considerable both within individual sectors and in ways that span all sectors. The work environment difficulties experienced by nurses in all sectors include: replacement by unregulated care providers, casualization, poor staffing patterns in the context of increased patient acuity, and funding that has not kept pace with need. These are a serious threat to quality patient care and to the well-being of nurses. Nurses faced with the reality of practising with inadequate numbers of professional personnel are soon disillusioned and experience burnout. Nurses' health and, at times, the quality of patient care are compromised in these environments. When such stresses are endured over

extensive periods of time, the sustainability of the profession is under threat. The result is that nurses leave and recruits fail to enter the profession. Until decision-makers formally acknowledge the central value of nursing to health-care delivery and until resources are invested in long-term, comprehensive planning, we are destined to hinder recruitment and retention efforts and, thus, repeat the dramatic supply challenges of the past.

The Labour Market

Nursing employment has been falling in spite of growing population and increasing need. The strong downward trend in nursing employment and the shift to part-time and casual employment contribute to the role stress and dissatisfaction experienced by nurses in recent years.

Ontario has recognized that its current level of nursing staffing is too low. It has accepted the recommendations of the Nursing Task Force to invest $375 million in new and permanent nursing positions. The objective is to bring Ontario up to the 1997 national average, in terms of nurse/population ratios, which requires an immediate need for an increase of over 10,000 new nurses. In fact, the province committed to creating "nearly 10,000" new jobs during 1999, and 12,000 new nursing positions by the end of 2000/2001. This will require a serious and concerted effort, particularly in view of the reported continuing decline of nursing employment in 1999. There are nurses available. The problem is creating the positions.

The availability and prospect of good and stable employment are key factors in determining the supply of nursing services. When Ontario employment prospects are better: nurses are attracted to the province; students are attracted into nursing programs; and nurses stay within the system.

The Educational Environment

Delivering increasingly complex care requires more sophisticated knowledge and skills, and the educational environment of nurses should respond to these challenges. We need to address long-standing issues related to entry level and ongoing nursing education that are essential to attract and retain nurses within the system.

The College of Nurses of Ontario's move to new competencies for RNs and RPNs and the decision of on baccalaureate preparation as the single educational entry for RNs, are critical achievements. It is now imperative that these educational initiatives receive adequate financial support to ensure their implementation.

* * *

These findings guide the policy and action recommendations in the next section. Such permanent structural changes, brought about by clearly articulated policies, supportive

legislation, and adequate funding, will provide a stable view of nursing as fundamental to the health-care system. Nursing will become a valued profession and a very desirable career choice. The recommendations and the detailed plan of action that follows incorporate the messages we received from nurses, other stakeholders, and what we learned from the literature. The plan of action builds on what works, what doesn't, and what is missing in the traditional approach. This framework for recruitment and retention will ensure that Ontarians are well served by the nursing profession now and in the future.

Recommendations

Between 60,000 and 90,000 new recruits must enter the nursing labour force in Ontario by the year 2011. To avoid a devastating nursing shortage we must engage in aggressive policy initiatives and also implement a systematic recruitment and retention plan.

The recommendations and action plan that follow respond to today's needs and ensure a sustainable nursing workforce in the future. We require action in direct activities of recruitment and retention, to attract students and to retain nurses in the workplace. We also must confront the policy and organizational precursors to recruitment and retention.

Recommendation # 1 – Integrate nursing into public policy development, implementation and evaluation. Strong nursing input is essential in health policy development at all levels of government. Nursing's active participation in policy-making will help optimize health human resource utilization, improve patient outcomes and positively affect healthy public policy.

Recommendation # 2 – Ensure sustainable and equitable funding while advancing health-care reform that preserves the letter and spirit of the *Canada Health Act.* Adequate, sustainable and equitable funding across health-care sectors and throughout the province is paramount to protecting universal access and quality nursing care. A direct link exists between stable employment opportunities for, and a stable continuing supply of, nurses. To preserve and strengthen quality patient care, health-care restructuring must ensure universal access to nursing and other services, across the continuum of care.

Recommendation # 3 – Integrate nursing into decision-making at all levels of health-care organizations. Nursing leadership is required at all times, in all health-care organizations, and across all nursing roles: staff nurses, educators, researchers, and administrators. Full participation of nurses in decision-making, at all levels of a health-care organization, is essential to improving the quality and effectiveness of patient care and to fostering nurse satisfaction.

Recommendation #4 – Position nursing as an entry point to the health-care system. We need to realize the full scope of nursing practice by ensuring regulations and structures that enable Ontarians to access nurses as an entry point to the health-care system.

Recommendation # 5 – Ensure sustainable and healthy work environments. Poor working conditions and unhealthy work environments are central barriers to the retention of nurses, and a major deterrent to attracting women and men into the profession. Trends toward casualization, poor staffing patterns resulting in heavy workloads, the lack of professional development opportunities, as well as inadequate compensation and benefits, are key factors leading to nursing shortages.

The strongest recruitment strategy is staff retention. Staff that are satisfied with their practice and work environment will share their excitement and become the most effective and active recruiters.

Recommendation # 6 – Promote life-long learning and improved access to educational programs. Nursing education must keep pace with the needs of nursing practice. Nursing practice must continuously integrate changes in society, health-care needs, new knowledge, and an evolving practice setting. The structured nature of nurses' work leaves little flexibility to participate in educational opportunities. We must support nurses to continuously upgrade their knowledge and skills.

Recommendation # 7 – Implement full utilization of and specialized support for nurses working in rural and northern communities (RNC). Most nurses live and want to work in their own communities. Nurses and nurse practitioners in rural, northern or under serviced areas need support to gain fair employment, and the specialized knowledge to best serve their communities.

Recommendation # 8 – Foster a positive image of nursing. Long-term improvements in nursing recruitment and retention require a public image of nursing as an attractive career. The high regard and strong ability to influence that the public attributes to nursing must be shared. Strategic advertising, media relations and other types of marketing have a cumulative effect that impact on perceptions and decisions. These activities provide public ways to acknowledge and honour the value of nurses to the health-care system and to society.

Recommendation # 9 – Facilitate the match between employers and potential employees. Create frequent and accessible opportunities to ease the connection between nurses and potential employers in welcoming ways.

Recommendation # 10 – Attract high school and mature students to nursing programs. To stabilize the nursing workforce we must attract a steady flow of high-performing students into nursing programs. The profession needs to broaden its catchment to non-traditional students and males. Students are very interested in career planning, and nursing must develop a strategic approach to provide students and career counsellors with focused information about nursing as a career choice.

These ten recommendations are detailed in the Plan of Action that follows. Each recommendation contains several strategies, briefly described. Many strategies will support more than one recommendation, but they are listed only once under the most relevant one, to avoid redundancy. The plan also identifies the budget, lead responsibility, timeline, and who will be responsible for monitoring and evaluation.

Existing commitments: The Plan of Action assumes full and timely implementation of the Government of Ontario's commitments in the *Nursing Task*

Force Report (January 1999) and the crucial commitment in the *Blueprint* election platform, later reiterated in the *Throne Speech*, to create 12,000 new permanent nursing positions by the end of 2001. These commitments are central to advancing the recruitment and retention of nurses in Ontario. Appendix 2 – Government Commitments – spells out the status of these commitments to date.

Plan of Action

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 1 – Integrate nursing into public policy development, implementation and evaluation. Strong nursing input is essential in health policy development at all levels of government. Nursing's active participation in policy-making will help optimize health human resource utilization, improve patient outcomes and positively affect healthy public policy.		
a) Appoint JPNC nursing co-chair as representative to JPPC.	Nursing must be represented in key health-care policy-setting and decision-making bodies to ensure nurses' input, to signal the value of nursing in public policy, and to create synergy in policy initiatives. We are asking for immediate representation of nursing in the Joint Provincial Planning Committee (JPPC). The Joint Provincial Nursing Committee (JPNC) has requested this representation for more than three years, and the Minister of Health and Long-Term Care has indicated her strong support, however no results have been achieved.	*Budget:* None. *Lead:* MOHLTC and OHA. *Timeline:* Spring 2000. *Monitoring/Evaluation:* JPNC.
b) JPNC to recommend and facilitate implementation of nursing and health-care reform that benefits Ontarians	Policy initiatives have suffered from inadequate input of nursing's expertise and experience. JPNC must periodically examine new models of care delivery, and provide nursing's perspective as to their benefit for Ontarians, the role of nurses, and the potential impact of their implementation. A timely example is primary health-care reform and other solutions to prevent further erosion of medicare.	*Budget:* None. *Lead:* JPNC. *Timeline:* Spring 2000 and quarterly afterwards. *Monitoring/Evaluation:* Nursing organizations.
c) Establish the position of Provincial Chief Nursing Officer (PCNO) at the MOHLTC and create a nursing secretariat.	We commend the government for establishing the Provincial Chief Nursing Officer (PCNO) position at the MOHLTC. We request that this position be supported by a nursing secretariat. This will allow for substantive input into the formulation, implementation and evaluation of new health-care initiatives, and policy directions ensuring optimum utilization of nursing human resources that benefit Ontarians. The nursing secretariat must work in synergy with JPNC.	*Budget:* To be determined. *Lead:* MOHLTC. *Timeline:* Spring 2000. *Monitoring/Evaluation:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 1 - continued		
d) Maintain current nursing advisors and appoint new nursing advisors to each division within MOHLTC.	We commend the increase, in recent years, of nursing specific positions within MOHLTC. To ensure effective nursing input into health policy, we ask that the vacant nursing policy advisor position in the Office of the Minister be filled, and that every major division of the Ontario Ministry of Health and Long-Term Care (MOHLTC) appoint nursing policy advisers. This includes: Integrated Services for Children, Health Services, Restructuring Projects, Health-care Programs, Integrated Policy and Planning, and Corporate Services. We request that nursing advisors report in a matrix model to their assigned division and to the Provincial Chief Nursing Officer.	*Budget:* To be determined. *Lead:* MOHLTC. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.
e) Ensure nursing-specific data collection that allows for adequate evaluation of nursing human resources utilization, and mandate annual reports from all publicly funded bodies that collect nursing related data.	Significant barriers exist in the type, quality and accessibility of nursing specific data required to maximize quality care and ensure accountability of nursing human resources utilization. MIS data has just begun to capture nursing specific data (i.e., FT/PT/Casual nursing positions) segregated separately for RNs and for RPNs. However, the data remain largely unavailable. In addition much of the data being collected by publicly funded bodies (i.e., OHA) remains inaccessible (i.e., absenteeism, attrition). Data collection gaps are even more acute in the home health-care sector. Adequate data collection and access to information are essential to the understanding of recruitment and retention issues, management of nursing human resources, health outcomes of nursing, and the formulation of constructive public policy.	*Budget:* Absorbed by each organization. *Lead:* MOHLTC. *Timeline:* Within regular reporting time frames. *Monitoring/Evaluation:* JPNC.
f) Establish 4 annual nursing internships at MOHLTC (3 for RNs, 1 for RPNs).	The creation of nursing internships will provide a first hand experience in public policy-making and encourage nurses to engage in policy issues.	*Budget:* Salary replacements or other arrangements. *Lead:* PCNO. *Timeline:* Fall 2000 and annual afterwards. *Monitoring/Eval:* JPNC.
g) Incorporate public policy education into all basic and graduate nursing programs.	Many nursing programs do not include public policy analysis and the political process within their curricula. The public, nurses and governments suffer the consequences of this deficiency. Public policy must be integrated within educational programs, particularly those oriented to the health-care discipline with the largest number of providers.	*Budget:* Within regular curricula. *Lead:* CAATS and COUPN. *Timeline:* Fall 2001. *Monitoring/Eval:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 1 - continued		
h) Develop and offer public policy education workshops.	These workshops will enrich nurses' understanding of, and participation in, discussions, development, implementation and evaluation of public policy.	*Budget:* Absorbed by each nursing organization. *Lead:* Professional associations and nursing unions. *Timeline:* Spring 2001. *Monitoring/Eval:* JPNC.
i) Develop and distribute policy-related material for broad utilization.	Policy analysis and its application to health care and nursing issues is time consuming and requires advanced knowledge and expertise. This strategy builds on work already undertaken by nursing organizations and other relevant bodies. Examples of currently available material are RNAO's *Environmental Scan* produced twice a year, and policy papers on key nursing and health-care issues. Material should be readily available to facilitate nurses' engagement in public policy.	*Budget:* Absorbed by each nursing organization. *Lead:* Professional associations and nursing unions. *Timeline:* Ongoing. *Monitoring/Eval:* JPNC.

Existing commitments: This recommendation assumes full and timely implementation of Nursing Task Force Recommendations 3 and 6. For details, see appendix 2.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 2 – Ensure sustainable and equitable funding while advancing health-care reform that preserves the letter and spirit of the *Canada Health Act*. Adequate, sustainable and equitable funding across health-care sectors and throughout the province is paramount to protecting universal access and quality nursing care. A direct link exists between stable employment opportunities for, and a stable continuing supply of, nurses. To preserve and strengthen quality patient care, health-care restructuring must ensure universal access to nursing and other services, across the continuum of care.		
a) The federal government and the Ontario government must provide adequate and sustainable funding for health care in a framework of health-care reform that protects the letter and spirit of the *Canada Health Act*, and substantially increases Ontarians' access to publicly funded health-care services at the right time, in the right place, and by the right provider.	Cutbacks in Canadian Health and Social Transfer (CHST) since 1995 have had a dramatic impact on the ability of provincial governments to adequately fund health and nursing services. The 1999 and 2000 inflows of additional federal funding are welcome but insufficient responses to population needs. We call upon the Federal Government to ensure sustainable, adequate funding so that Canadians receive the health and nursing services they deserve. The federal government should immediately return to real per capita transfer levels that existed in the mid-1990s. Ultimately, the federal government should return closer to the 50-50 share of health-care expenses as per their initial understanding with the provinces. The Ontario government should immediately raise its real per capita health-care expenditures to mid-1990s levels as well. Increased levels of federal and provincial funding should serve as the basis for health-care restructuring that occurs in a co-ordinated and logical form across various levels of government and health-care sectors. The goal of national and provincial health-care reform should be to stop the creeping privatization of our health care system, enhance universal access, ensure quality services, and secure economic sustainability through efficient utilization of all health care providers and sectors across the continuum of care.	*Budget:* To be determined. *Lead:* Federal government and Ontario government. *Timeline:* First Ministers meetings; Health Ministers meetings; and annual federal and provincial budgets. *Monitoring/Evaluation:* National and provincial nursing organizations across Canada.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 2 - continued		
b) Fully implement the recommendations of the Health Services Restructuring Commission's (HSRC) Primary Health Care Strategy.	Primary health-care (PHC) services enhance access and reduce the need for hospital utilization. The HSRC's December 1999 report on *Primary Health Care Strategy* lays the groundwork for comprehensive PHC services. It is a foundation on which consumers, government and the full range of health-care providers can build on the strengths of our publicly funded health-care system. Access to comprehensive PHC will assist also in stemming the tide of privatization, and contribute greatly to continuity of care for Ontarians. Effective reform, with commitment and resolve can remedy our strained health-care system to successfully meet the health-care needs of each and every Ontario resident – now and well into the future.	*Budget:* According to the costing document on PHC from the HSRC. *Lead:* MOHLTC. *Timeline:* Begin six year implementation plan by Fall 2000. *Monitoring/Evaluation:* JPNC (see strategy 4a).
c) Revert the funding cuts, relaxation of regulation, managed competition, and downloading of responsibilities to municipalities, all of which have reduced the amount, continuity, and quality of nursing care provided to clients in the community.	The regulation changes and downloading of funding have lowered standards of care. In certain health-care sectors, less care is guaranteed and the use of unregulated care providers has increased significantly. The system is becoming rigid and less able to effectively handle the fluctuation in service demand. Recruitment and retention suffer as nurses are faced with the stress and conflict of providing care in circumstances of declining resources. In particular, the provincial government should: i) revert the deletion from the Nursing Home Act of the requirements that nursing homes have at least one RN on site 24 hrs-a-day, and should employ sufficient staff to provide each resident a minimum of 2.25 hours of care per day; ii) fully restore to mid 1990s levels the funding to, and staffing of, public health units that were downsized due to downloading to municipalities and other funding cuts; iii) revert regulatory changes that limit the amount of personal care and nursing care that Community Care Access Centres (CCAC) provide, and affect the criteria governing access to care in the community (which effectively place added burden on families, mainly women); iv) revert the implementation of managed competition marked by a bidding process for service delivery in the home care sector, which has led to significant pressures on all potential care providers to lower costs, cut the amount and level of services, and negatively impact on continuity of care that clients receive.	*Budget:* To be determined. *Lead:* MOHLTC, CCACs, municipalities, and community health-care providers. *Timeline:* Spring 2001. *Monitoring/Evaluation:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 2 - continued		
d) Create a task force to explore longer-term funding mechanisms for hospital, community, and long-term care sectors.	Current, annual, and in some sectors, volume-driven funding mechanisms discourage long-range program planning and the planning of nursing and other health human resources. This approach contributes to an unstable health-care work environment. In nursing, this often results in higher percentages of casualization of personnel.	*Budget:* To cover the work of the Task Force. *Lead:* MOHLTC/employer organizations/nursing unions/professional associations. *Timeline:* Fall 2000. Monitoring: JPNC (for nursing aspects).
e) Target the average nurse-to-population ratio in Canada as a key indicator for funding nursing in Ontario.	We commend the Ontario government for the recent funding initiatives aimed at raising the province's nurse-to-population ratio to the national average. We ask that the national average of nurse-to-population ratio become a critical standard for funding nursing in Ontario year after year. Funding for nursing services must also be based on the needs of the client(s) rather than on historical funding inequities among health-care agencies and sectors. Work must also be done to create, validate and fund outcome measures that are sensitive to nursing input.	*Budget:* Dependent on nurse-population ratios. *Lead:* MOHLTC. *Timeline:* Annual, during budget allocation. *Monitoring/Evaluation:* JPNC.
f) Resolve inequities in remuneration, benefits, and other work conditions that affect nurses working in different health-care sectors. Where appropriate, this should be achieved through collective bargaining.	The exodus of nurses from sectors that provide lower salaries and benefits and poor working conditions (such as lesser administrative and educational support) to sectors which provide better employment opportunities, is detrimental to patient care and to the nursing profession. Central to this issue are the current inequities between the hospital, long-term care, and home health-care sectors. Nursing services are essential in all sectors and equity in employment conditions is key to the retention and recruitment of nurses, and to workforce stability.	*Budget:* To be determined. *Lead:* PCNO with representation from employers, nursing unions, and professional associations. *Timeline:* Winter 2000. *Monitoring/Eval:* JPNC.

Existing commitments: This recommendation assumes full and timely implementation of Nursing Task Force Recommendations 1 and 5, and the crucial commitment in the Blueprint election platform, later reiterated in the throne speech, to create 12,000 new permanent nursing positions in Ontario by the end of year 2001. For details, see appendix 2.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 3 – Integrate nursing into decision-making at all levels of health-care organizations. Nursing leadership is required at all times, in all health-care organizations, and across all nursing roles: staff nurses, educators, researchers, and administrators. Full participation of nurses in decision-making, at all levels of a health-care organization, is essential to improving the quality and effectiveness of patient care and to fostering nurse satisfaction.		
a) "Putting Patients First": Develop resources and offer educational venues (i.e., workshops, videos, on-line resources) to support nurses' efforts to put patients first, and to support the implementation of models of care delivery that promote continuity of care and continuity of caregiver.	Nurses repeatedly state that what keeps them involved in nursing is the relationship they have with their clients. This strategy will assist nurses to enhance their knowledge and skills as they continue to place patients at the centre of their care. Models of care delivery also deeply affect the practice of nursing. This strategy will also support the implementation of models of care delivery that promote continuity of care and continuity of caregiver, to enable nurses' meaningful participation in decision making related to patient care. This will enhance quality patient care and nurses' fulfilment with their work, a key determinant of staff retention. Continuity of caregiver is essential to facilitate an enriched nurse-client relationship.	*Budget:* $70,000 ($35,000 each year). *Lead:* Professional associations and nursing unions. *Timeline:* Fall 2000; Spring 2001. *Monitoring/Eval:* JPNC and health-care organizations.
b) Develop and offer workshops to increase staff nurse participation.	Increased staff nurse participation in workplace decision making contributes to staff nurse job satisfaction. Interactive workshops focused on effective communication, team work, conflict and stress management, and leadership skills will enhance the ability of staff nurses to contribute in a significant way to organizational decision making.	*Budget:* Absorbed by each nursing organization. *Lead:* Professional associations and nursing unions. *Timeline:* Winter 2000. *Monitoring/Eval:* JPNC.
c) Establish mechanisms to facilitate staff nurse participation in key organizational and unit committees. Where appropriate these mechanisms should be dealt through collective bargaining.	Nurses' desire to participate in the life of an organization is tempered by the stress of workload and the pace of work. Nurses who wish to attend a meeting can't ask a colleague to provide clinical coverage for their patients, since that colleague already has a very heavy assignment. We must ensure proper support, such as adequate patient coverage, to assist nurses in their participatory efforts.	*Budget:* To be determined. *Lead:* Health-care organizations and nursing unions. *Timeline:* Fall 2000. Monitor/Eval: JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 3 - continued		
d1) RNs ask to reinstate the role of the RN as a first-line manager in all settings in which the majority of direct care providers are nurses. First-line managers must possess appropriate clinical and management preparation for each given setting and be positioned, through education and experience, to support all members of the health-care team under their direction.	Research shows that the nurse administrator is well positioned to influence staff morale and act as an advocate for appropriate nursing and other human resources utilization. Undervaluing this expertise in the recent past has contributed to staff shortages, nurse burnout, and patient and system problems. We ask that the professional designation of the first-line manager be captured in the Nursing Plans submitted to the MOHLTC by all health-care organizations in every sector. For those sectors that do not submit Nursing Plans, the information must be provided through other reports to government.	*Budget:* None. *Lead:* MOHLTC and health-care organizations. *Timeline:* Summer 2000. *Monitoring/Evaluation:* JPNC.
d2) RPNs support the use of appropriately designated and educated individuals in care unit manager positions and recognize that this individual will, in many cases, be a RN.	RPNs identify a need for all first-line managers (RNs, RPNs and others) to possess appropriate clinical and management preparation for each given setting and to be positioned, through education and experience, to support all members of the health-care team under their direction.	

Existing commitments: This recommendation assumes full and timely implementation of Nursing Task Force Recommendation 2. For details see appendix 2.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation #4 – Position nursing as an entry point to the health-care system. We need to realize the full scope of nursing practice by ensuring regulations and structures that enable Ontarians to access nurses as an entry point to the health-care system.		
a) Fund and ensure utilization of nurse practitioners with RN (EC) designation in <u>all</u> primary health-care practice groups.	We commend the Ontario government for its foresight in implementing the *Expanded Act for Nursing Legislation* on February 11, 1998, and for allocating funds for primary care nurse practitioner utilization. NPs provide a cost-effective solution to the public's limited access to health-care services, and acknowledge nursing's contribution to the health-care system thus enhancing the professions' image. We urge the government to move immediately with full implementation of the Health Services Restructuring Commission (HSRC) recommendations contained in the report, *Primary Health Care Strategy*, and we ask for substantial nursing representation on the implementation and monitoring committee.	*Budget:* As per HSRC report. *Lead:* MOHLTC. *Timeline:* As per HSRC recommendations. *Monitoring/Eval:* through JPNC representation in primary health care implementation and monitoring committee.
b) Pilot the utilization of primary health care NP within home health-care agencies.	Primary health care NP utilization within home health care can prove a positive mechanism to decrease hospital re-admissions and promote healthy behaviours, while using the infrastructure of the home care organization. The increased acuity of clients receiving home health care calls for expanded nursing roles.	*Budget:* Salaries of NP's in pilot projects. *Lead:* MOHLTC and the home health-care sector. *Timeline:* Fall 2000. *Monitoring/Eval:* JPNC.
c) Change regulation 965 of the *Public Hospitals Act* to enable RNs (EC) to practice to their full scope in primary health-care settings in hospitals.	The *Hospital Management Regulation* (965) of the *Public Hospitals Act* contains legal obstacles to RNs (EC) ordering treatment within hospitals. Prevented from utilizing their full scope of practice, the RNs (EC) must rely on medical directives to provide treatment for their clients, an unnecessary and costly bureaucratic delay. MOHLTC has demonstrated leadership by integrating the role of the primary health-care nurse practitioner through legislation and initial funding. We call on MOHLTC to continue to play a leadership role by removing regulatory barriers to the RN (EC) full scope of practice.	*Budget:* To be determined. *Lead:* MOHLTC. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.
d) Establish a task force to propose regulatory changes to enable acute care nurse practitioners to attain RN (EC) designation.	As in-hospital patient acuity levels continue to rise, patients need the expertise and skills of extended class nurses in the various acute-care settings. We ask that the College of Nurses of Ontario with the support of MOHLTC, and in consultation with the nursing community and other key stakeholders, prepare the background work to propose regulations that will enable acute-care nurse practitioners to acquire RN (EC) designation.	*Budget:* To be determined. *Lead:* College of Nurses of Ontario and MOHLTC. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 4 - continued		
e) Expand *Mandatory Health Program Service Guidelines* enabling public health nurses to fully utilize their scope of practice.	The omission in *The Mandatory Health Program Service Guidelines* of issues related to violence against women, violence against children, and mental health and emotional supports is highly problematic for the achievement of healthy populations. These and other omissions indicate problems with decision-making regarding programs that are included in the *Guidelines*. Public health is positioned to take a leadership role in health-care reform. Public health nurses, functioning within comprehensive guidelines, can enhance access to publicly funded health promotion and illness prevention services.	*Budget:* To be determined. *Lead:* MOHLTC (Public Health Branch). *Timeline:* Summer 2000. *Monitoring/Evaluation:* JPNC.
f) Rescind part 4 of Regulation 386/99, establishing service maximums for nursing care in the home.	The restructuring of acute-care hospitals is increasing the number of persons requiring nursing services in the home as well as the intensity of the services they need. Since it is well within the nurse's scope of practice to make health assessments, patient safety requires that we dispose of regulatory constraints on practice. Instead, we propose to adopt statutory provisions similar to those found in the *Nursing Homes Act*, the *Municipal Homes for the Aged and Rest Homes Act*, and the *Charitable Institutions Act*. These provisions require that there be a plan of care for each client that meets the client's needs and that the care outlined in the plan be delivered.	*Budget:* To be determined. *Lead:* MOHLTC and CCACs. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 5 – Ensure sustainable and healthy work environments. Poor working conditions and unhealthy work environments are central barriers to the retention of nurses, and a major deterrent to attracting women and men into the profession. Trends toward casualization, poor staffing patterns resulting in heavy workloads, the lack of professional development opportunities, as well as inadequate compensation and benefits, are key factors leading to nursing shortages. The strongest recruitment strategy is staff retention. Staff that are satisfied with their practice and work environment will share their excitement and become the most effective and active recruiters.		
a) Develop and widely distribute a *Healthy Work Environment Guide.*	This document will outline the characteristics of a healthy nursing work environment, and provide concrete strategies for its achievement. The document will assist health-care organizations to create thriving work environments, contributing to high quality health care for Ontarians and the retention and recruitment of professional nursing staff. It will address in detail programs such as: orientation, preceptorship, mentorship, participatory hiring, professional development, career advancement, staff recognition, illness and injury prevention, collaborative practice models, and leadership.	*Budget:* $ 25,000. *Lead:* RNAO/RPNAO, employees/employers and nursing unions. *Timeline:* Summer 2000. *Monitoring/Evaluation:* JPNC.
b) Monitor that earmarked funds flow to create new permanent nursing positions, and conduct random audits to encourage compliance.	The Nursing Task Force Report's intent was to create permanent, new nursing positions, and not simply to replace existing positions or hire temporary ones. Recruitment efforts must focus on achieving the intended goal. We ask that health-care organizations report bi-annually on their progress and that random audits be conducted immediately. Data reported should include: • number of new, permanent part-time nursing positions hired, • number of new permanent full-time nursing positions hired, • number of new temporary part-time positions hired, • number of new temporary full-time positions hired (i.e., to cover for maternity and educational leaves), • number of casual nursing hours worked, and • payroll hours, by category of nursing (RN, RPN) and employment status (FT, PT -- permanent or temporary -- and casual), as a measurable indicator for the achievement of the NTF Recommendation 1 (see appendix 2).	*Budget:* Within current reporting mechanism. *Lead:* MOHLTC. *Timeline:* Spring and Winter 2000, and each year afterwards. *Monitoring/Evaluation:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 5 - continued		
c) Develop mechanisms to ensure diminished levels of casualization.	Casualization is a key contributor to nurse dissatisfaction. We must create incentives for health-care organizations to convert casual positions into permanent ones. For example, funding formulas should reward organizations that convert casual positions to permanent ones.	*Budget:* To be determined. *Lead:* MOHLTC with representation from employers, nursing unions and professional associations. *Timeline:* Fall 2000. *Monitoring/Eval:* JPNC.
d) Develop organizational guidelines to assist in determining adequate levels of nurse-patient ratios and proper RN/RPN/NP utilization.	Staffing patterns have been consistently poor in the past five years. The result: dissatisfied patients / clients, overworked nurses, burnout, increased absenteeism, and low morale. Guidelines to assist in determining adequate staffing levels must consider patient/client acuity, complexity level, complexity of work environment and the availability of expert resources. These guidelines will serve to ensure that professional nursing staff (RN and RPN) can provide safe and quality health care, and that we ease current levels of staff burnout.	*Budget:* None. *Lead:* JPNC. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.
e) Secure proper compensation and benefits for nurses across the health-care continuum. Where appropriate, this should be achieved through collective bargaining.	The recent settlement between ONA and Ontario's hospitals is welcome progress for RNs in the hospital sector. Close attention to the salary issue remains an urgent need in the home-health care and long-term care sectors. Also, given the reality of competing health-care career choices for men and women, nurses' starting salaries must become more competitive if we are to attract the best and brightest into the profession. Financial incentives are also required for advanced education, in addition to years of experience. Adjustment of the salary grid should include substantial differences for evening and night shifts, as well as incentives for nurses working full-time, rather than part-time or casual hours. We should also explore incentives for nurses who are able to continue to contribute to the workforce beyond their eligible retirement age.	*Budget:* To be determined. *Lead:* Employers, nursing unions and professional associations. *Timeline:* Winter 2000. *Monitoring/Evaluation:* JPNC.
f) Develop and offer leadership training workshops for nurses in advanced practice roles.	Nurses in advanced practice roles (i.e., nurse manager, CNS, nurse educator) can influence the quality of patient care and quality of the work environment for staff. Educational workshops will be developed and offered with an emphasis on participatory and transformational leadership. This type of leadership has a demonstrated impact on staff retention. These workshops should be available also for RPNs.	*Budget:* $5,000. *Lead:* RNAO. *Timeline:* Summer 2000. *Monitoring/Evaluation:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 5 - continued		
g) Develop and widely distribute a discussion paper on the utilization and implementation of clinical ladders.	Clinical ladders provide a cost-effective framework to acknowledge and reward highly knowledgeable clinicians for their outstanding practice. They serve as a structural means of recognizing and developing clinical expertise and promoting career advancement. Clinical ladders are associated with higher recruitment and retention rates. We propose to develop and distribute a background document on clinical ladder utilization including mechanisms for its implementation.	*Budget:* $5,000. *Lead:* RNAO/RPNAO. *Timeline:* Summer 2000. *Monitoring/Evaluation:* JPNC.
h) Conduct a survey on nurse satisfaction.	Conduct a confidential survey with a representative sample of RNs and RPNs to determine role satisfaction. This will include nurses who have moved to the US or other provinces, or who have left the profession. To capture the true complexity of nursing, the work satisfaction survey will include: questions related to the work itself (intrinsic interest, variety, opportunity for learning, difficulties, creativity, responsibility, authority, opportunities for success, control/autonomy and scheduling); pay (amount, equity and method of payment); promotions (opportunities for advancement, fairness); recognition; benefits; working conditions; quality of supervision; management and administration.	*Budget:* $20,000. *Lead:* RNAO/RPNAO/ NRU/nursing union reps/OHA, OANHSS, ONHA, alPHa, CCACs. *Timeline:* Winter 2000. *Monitoring/Evaluation:* JPNC.
i) Conduct exit interviews.	Health-care organizations should conduct exit interviews specific to nursing staff as they provide insight into the strengths, weaknesses, opportunities and threats to nursing work and work satisfaction.	*Budget:* Within expected HR practices. *Lead:* Employers. *Timeline:* Ongoing. *Monitoring/Eval:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 6 – Promote life-long learning and improved access to educational programs. Nursing education must keep pace with the needs of nursing practice. Nursing practice must continuously integrate changes in society, health-care needs, new knowledge, and an evolving practice setting. The structured nature of nurses' work leaves little flexibility to participate in educational opportunities. We must support nurses to continuously upgrade their knowledge and skills.		
a) Develop a province-wide approach to prior learning assessment (PLA) credits for mature students.	Ontario colleges have had PLA credits in place for a number of years (first piloted in 1993). Some universities are currently developing PLA guidelines. PLA increases nurses' interest in pursuing formal education, particularly among mature nurses, since they receive some credit for informal learning and other life experiences.	*Budget:* $5,000. *Lead:* CAATS/COUPN. *Timeline:* Spring 2001. *Monitoring/Evaluation:* JPNC.
b) Incorporate new topics across the curriculum in basic nursing programs to meet population needs.	The nursing curriculum for RNs and RPNs must be regularly updated to meet the needs of Ontarians today, and reflect the needs of tomorrow. All graduates of nursing programs should be exposed to basic concepts required across the health continuum. Emerging needs include: 1) healthy aging; 2) cultural diversity and its impact on health-care provision; 3) information technology and computer literacy; and 4) primary health care.	*Budget:* Within regular curricula development. *Lead:* CCATS, COUPN. *Timeline:* Winter 2001. Monitoring/ Eval: JPNC.
c) Government's sponsorship of continuing formal education for nurses.	We commend government for its allocation of $10 million, on a yearly basis, towards nursing education and training. Support for ongoing education is considered by nurses a key recruitment and retention incentive. Higher education enhances the delivery of nursing care and staff moral. We ask that $5.5 million of the total training funds be allocated in the years 2000, 2001, and 2002, to respond to arising needs related to health-care restructuring. All nurses who are currently practising and wish to further their education should be able to apply. Training grants should be applicable towards certificate programs, college, baccalaureate, masters and doctoral studies all tied to areas of need. Criteria for this kind of financial support should include specific aspects aimed at retaining nurses in Ontario (i.e., funding tied to remaining in Ontario for at least two years).	*Budget:* $5.5 M (from the $8M set aside for nursing education and training). *Lead:* MOHLTC/RNAO/RPNAO. *Timeline:* 1999/2000, 2000/01, and 2001/02. *Monitoring/Evaluation:* JPNC.
d) Enhance the marketing of nursing associations' support for continuing formal education for nurses.	The financial assistance available through nursing associations must be well marketed and enhanced. The Canadian Nurses Foundation (CNF), and the Registered Nurses Foundation of Ontario (RNFOO) offer significant study awards for baccalaureate, master's, and doctoral studies. RNAO and RPNAO offer low interest loans of up to $2,000 and $1,000 respectively, to those who have been a member for at least one year. These and many other sources of financial assistance through associations, colleges and universities are listed each year in the RNAO Education Guide.	*Budget:* As per each funding source. *Lead:* CNF, RNFOO, RNAO, and RPNAO. *Timeline:* In place. *Monitoring/Evaluation:* Each association.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 6 - continued		
e) Employer sponsored nursing student loan program.	We encourage employers to offer low interest education loans as an incentive for nurses to continue their education and professional development. Criteria for loan applications should be tied to specific recruitment and retention incentives aimed at retaining the nurse in the organization (i.e., applicant completed one year of employment and is committed to remain in the organization until the loan is re-paid).	*Budget:* As per each organization. *Lead:* Employers/health-care organizations /foundations. *Timeline:* Fall 2000. *Monitoring/Eval:* JPNC through nurses' satisfaction survey (see strategy 5h).
f) Employer support for attending conferences and workshops.	Explicit financial support and flexibility with scheduling time off must be put in place to foster continuing education. Greater emphasis, access to, and support for short-term continuing education programs is essential for staff nurses to keep pace with new technology, the growing body of nursing knowledge, and an extremely demanding workload. Organizations that provide enhanced support for nurses to attend, participate in, and present papers at conferences and other professional learning activities benefit greatly. The organization benefits from improved nursing care, enhanced staff morale and a stronger commitment from nurses.	*Budget:* $2M (from the $8M set aside for nursing education and training). *Lead:* MOHLTC/ RNAO/ /RPNAO. *Timeline:* 2000/01 and 2001/02. *Monitoring/Eval:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 7 – Implement full utilization of and specialized support for nurses working in rural and northern communities (RNC). Most nurses live and want to work in their own communities. Nurses and nurse practitioners in rural, northern or under serviced areas need support to gain fair employment, and the specialized knowledge to best serve their communities.		
a) Allocate additional funding and create positions to ensure full utilization of NPs practising in RNC.	We commend the government for funding 85 RNs (EC) in under serviced areas. This move asserts the value of RNs (EC) and improves public access to primary health-care services. We ask that government continue with this approach by ensuring all RNs (EC) are fully employed within their scope of practice. Currently we have 150 unemployed and around 50 under-employed RNs (EC). Many of these individuals wish to practice in RNC. The value and effectiveness of the nurse practitioner is exceedingly well documented, and thus it is important to facilitate their widespread utilization.	*Budget:* $13 M. *Lead:* MOHLTC. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.
b) Based on community needs, offer free tuition to students entering basic or advanced nursing programs, if they are willing to re-locate and practice in an RNC upon graduation. This includes those who are willing to relocate to First Nation communities. These students must commit to staying and service that community for a period equal or longer than the length of the educational program.	This strategy is the same as the government's commitment to medical students.	*Budget:* To be determined. *Lead:* MOHLTC / Ministry of Training, Colleges and Universities. *Timeline:* 2001/02. *Monitoring/Evaluation:* JPNC.
c) Establish in the North, a distance education certificate program for practising nursing in RNC.	Similar to certificate programs in various clinical specialties, the practice of nursing in RNC also warrants specialty preparation. Both RNs and RPNs would gain from the additional preparation, and the greatest benefit would go to the people of rural and northern Ontario.	*Budget:* $5,000 for curriculum development. *Lead:* CAATS/COUPN. *Timeline:* Winter 2001. *Monitoring/Eval:* JPNC
d) Establish a Master's Program in Nursing in a northern university.	The needs of northern Ontarians require the services of advanced practice nurses. The absence of a local graduate program significantly limits the public's access to advanced practice nurses, as well as the ability of nurses to further their education and/or to remain working in a RNC.	*Budget:* $25,000 for curricula development. *Lead:* COUPN. *Timeline:* Fall 2002. *Monitoring/Eval:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 7 - continued		
e) Establish telehealth capacity to support nurses practising in RNC.	Telehealth capacity can facilitate the practice of nursing, enhance people's access to health-care services, and decrease the sense of professional isolation. All these factors may have a positive effect on role satisfaction and staff retention for nurses working in RNC.	*Budget:* To be determined. *Lead:* PCNO working with MOHLTC, Ministry of Northern Affairs and Ministry of Technology. *Timeline:* Spring 2001. *Monitoring/Eval:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 8 -- Foster a positive image of nursing. Long-term improvements in nursing recruitment and retention require a public image of nursing as an attractive career. The high regard and ability to influence that the public attributes to nursing must be shared. Strategic advertising, media relations and other types of marketing have a cumulative effect that impact on perceptions and decisions. These activities provide public ways to acknowledge and honour the value of nurses to the health-care system and to society.		
a) Aggressive media relations campaign.	• Television public service announcements. The series will consist of six 1½ to 2½ minute stories featuring six different aspects of nursing as a desirable and rewarding career choice. Each story will be distributed monthly by satellite to 18 television and 45 cable networks in Ontario. The same material could be distributed in VHS format for presentations and nursing career nights. • Radio public service announcements. The series will consist of six radio public service announcements focusing on nursing as a desirable and rewarding career choice. The series will be distributed to Ontario's 143 English radio stations. • Media kit. A media kit for distribution to the 350 plus community newspapers in the province that will contain nurse profiles, career columns and general interest features on nursing as an attractive career choice.	*Budget:* $57,000. • $28,000 (television). • $14,000 (radio PSAs). • $15,000 (media). *Lead:* RNAO/RPNAO. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.
b) Nursing career newsletter.	The College of Nurses of Ontario (CNO) will feature one issue of its bi-monthly publication *Nursing and You* to add a supplement focused on nursing as a career choice. This newsletter, with a distribution of about 60,000, is circulated to family physicians, Community Care Access Centres, hospitals, long-term care facilities, nursing schools and media. Additional copies of the supplement will be printed for distribution throughout the Ontario secondary school and public library system.	*Budget:* $40,000 ($20,000 per issue). *Lead:* CNO/ RNAO/ RPNAO. *Timeline:* Spring 2000, Spring 2002. *Monitoring/Evaluation:* JPNC.

Note: successful implementation of other Recommendations in this Plan of Action will positively impact on the image of nursing.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 9 -- Facilitate the match between employers and potential employees. Create frequent and accessible opportunities to ease the connection between nurses and potential employers in welcoming ways.		
a) Workplace open houses and staff nurse participation in recruitment efforts.	Enthusiastic practising nurses are the best recruiters for an organization. These nurses will often be more successful than designated recruiters in the human resources department. Inviting student nurses to visit on-site to meet practising nurses who are positive about their work is the greatest advertising possible. Practising nurses participating in recruitment teams could act as ambassadors of the profession and become frontline recruiters for the organization.	*Budget:* Absorbed by health-care organizations. *Lead:* Employers. *Timeline:* 2000-2001. *Monitoring/Evaluation:* JPNC through nurse satisfaction survey (see strategy 5h).
b) Career fairs.	Career fairs help RNs and RPNs enhance their work search skills and provide a unique opportunity for employers and potential employees to meet. This initiative originated with an event on May 13, 1998 under the auspices of RNAO, and had over 1,300 RNs in attendance. Four additional events sponsored by RNAO/RPNAO/MOHLTC have had over 2,500 RNs and RPNs in attendance. Their delivery across the province (London, Ottawa, Toronto, and Sudbury) encouraged participation of a wide range of employers, and offered equal opportunities to nurses and students.	*Budget:* $240,000 ($80,000 per year). *Lead:* RNAO/RPNAO. *Timeline:* 2000, 2001, 2002. *Monitoring/Evaluation:* JPNC.
c) CareerLine phone employment advertising service.	Sponsored for a period of six months by MOHLTC, the RNAO and the RPNAO have offered, since August of 1999, an employment advertising service through separate toll-free phone numbers. For the nominal fee of $25, employers can place a short job posting, for permanent full-time or part-time positions and gain province-wide access to nurses. New postings are recorded weekly. For the six-month period, the number of calls to the RNAO line was 1,625 with 96 positions advertised. The RPNAO line received 699 calls with 44 positions advertised. Although we envision that CareerLine will be gradually replaced by the CareerSite Web service, we will continue to offer the service as long as there is demand and it remains self-sustaining.	*Budget:* $35,000 during trial period. Self-sustained afterwards. *Lead:* RNAO/RPNAO. *Timeline:* 1999. Continue only if self-sustained. *Monitoring/Evaluation:* JPNC.
d) CareerSite Web site job registry and clearinghouse for employers and nurses.	RNAO and RPNAO will establish a Web site for employment advertisement for registered nurses and registered practical nurses around the province aimed at matching employers and nurses for permanent full-time or part-time positions. For a nominal fee, employers will place job postings that will be accessible world-wide. Nurses will be able to post as well, including their resumés, online. The budget requested is for set-up costs of the Web site; the implementation will be self-sustaining. CareerSite will be linked to, but distinct from, the NursingChoice recruitment Web site proposed in strategy 10 a).	*Budget:* Set-up: $30,000. Implementation: Self-sustaining. *Lead:* RNAO/RPNAO. *Timeline:* Summer 2000. *Monitoring/Eval:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 9 - continued		
e) Career counselling services.	Originally implemented by RNAO for its members in 1998, the nurse career counsellor handled over 2,000 requests for assistance during the first year of service. RNs taking advantage of this service had various levels of educational preparation, with the majority (47%) prepared at the diploma level, and 27% possessing baccalaureate degrees in nursing. As the demand for career counselling services continued to increase, the service was expanded to all RNs and RPNs in the province through sponsorship by MOHLTC. Besides general career counselling, nurses are asking for specific assistance in such areas as work search strategies, interview preparation and educational program advice. RPNAO's new career counsellor at its Career Development Centre has already handled numerous requests from nurses at all career stages including nursing students, new graduates, and experienced nurses.	*Budget:* $244,000 ($94,000, $75,000 and $75,000 annual amounts). *Lead:* RNAO/RPNAO. *Timeline:* 2000, 2001, 2002. *Monitoring/Evaluation:* JPNC through quarterly reports from RNAO and RPNAO.
f) "Nurses back home": USA jobs fair participation.	As a result of poor employment opportunities, a significant number of nurses have moved to the US. Ontario nursing representatives will attend US job fairs to market Ontario employment opportunities and recruit Canadian nurses back home. The nurse recruitment team will attend four events during the year: two close to the Canada-US border (i.e., Detroit, Buffalo) and two in southern states such as Florida and Texas which are popular work destinations for Ontario nurses. This program will include portfolios of job postings from health-care organizations, to be distributed to nurses in the US. The nurse recruitment team will bring back resumés of interested nurses and distribute these to the appropriate health-care organizations. Follow-up with the health-care organizations will be conducted to determine how many nurses were hired through this strategy.	*Budget:* $80,000 ($40,000 per year). *Lead:* RNAO/RPNAO. *Timeline:* Fall 2000, Fall 2001. *Monitoring/Evaluation:* JPNC/ Employers.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 10 – Attract high school and mature students to nursing programs. To stabilize the nursing workforce we must attract a steady flow of high-performing students into nursing programs. The profession needs to broaden its catchment to non-traditional students and males. Students are very interested in career planning, and nursing must develop a strategic approach to provide students and career counsellors with focused information about nursing as a career choice.		
a) NursingChoice recruitment Web site.	Cyberspace is a central recruitment tool for the young generation and the old one as well. A dedicated NursingChoice site will evocatively tell the story of nursing. The reach is global and immediate. Content will include photos and stories of nurses at work in a wide-range of settings and roles and will cover education needed, programs available, and opportunities. The site will link to others such as CareerSite Web site to be offered by RNAO and RPNAO (see strategy 9d), and the nurses@work site offered by the Canadian Nurses Association and Industry Canada.	*Budget:* $15,000. *Lead:* RNAO/RPNAO. *Timeline:* Summer 2000. *Monitoring/Evaluation:* JPNC by monitoring statistics of enrolment into nursing educational programs.
b) Print information campaign.	Print information is a powerful communications tool as it can be customized to its audience. Four booklets will be developed, one to match each of the following age groups: grades 5-6, grades 7-9 and grades 10-OAC, plus a poster for school bulletin boards. The fourth booklet in the series will be targeted to the general public, since parents play a major role in influencing the career decisions of their children. These publications will be widely distributed in schools and public libraries, as well as placed in the NursingChoice Web site.	*Budget:* $180,000 ($90,000 per year). *Lead:* RNAO/RPNAO. *Timeline:* Winter 2000, Fall 2002. *Monitoring/Eval:* JPNC by monitoring statistics of enrolment into nursing educational programs.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 10 - continued		
c) Career Awareness Program/Speakers Bureau.	This comprehensive program will create ready-to-go material for school career counsellors to create interest and enthusiasm towards nursing as a career choice, and demonstrate the wide range of opportunities available within nursing. The program will consist of: • A resource guide directed primarily to career counsellors and teachers complete with lesson plans and student activities to be undertaken before nurse guest speakers come to the classroom. • A video created specifically for students in "their age-related language" to create excitement and ignite their imagination. • A presenter's guide to provide nurse guest speaker with strategic ways to generate student involvement in presentation, as well as the tactical aspects of implementing the presentation. • Support material including slides and PowerPoint presentation for speakers plus evaluation material. • Establishment of a liaison office and officer at educational settings to improve outreach. • All the resources developed, including the video, will be placed on the NursingChoice Web site for downloading.	*Budget:* $120,000. *Lead:* RNAO/RPNAO. *Timeline:* Fall 2000. *Monitoring/Evaluation:* JPNC.
d) Nursing career events for secondary students.	Interactive nursing presentations change high school students' attitudes about nursing as a career option and attract high-performing and non-traditional students into the profession. This initiative must include a targeted effort to attract Francophone and First Nation students, as well as men and women from diverse cultural backgrounds. A nursing career event provides first-hand information on nursing careers. Career nights offer students an opportunity to identify with nurses' work and encourage them to pursue their student community involvement in a nursing setting. These events also contribute to public image of the nursing profession.	*Budget:* $20,000 ($10,000 each year). *Lead:* RNAO/RPNAO. *Timeline:* 2000, 2001. *Monitoring/Evaluation:* JPNC.

STRATEGY	DESCRIPTION AND RATIONALE	INSTITUTIONAL ASPECTS
Recommendation # 10 - continued		
e) Job shadowing program with appropriate remuneration for mentors. Where appropriate, this should be achieved through collective bargaining.	This program, co-ordinated by each professional association, will match interested students to nurses for a half-day visit in the nurse's workplace and experience nursing firsthand. This may lead to a one-to-one mentoring relationship between the student and an experienced nurse. This type of program has received very positive evaluations when implemented in other jurisdictions.	*Budget:* $52,000 ($26,000 per year). *Lead:* RNAO/RPNAO. *Timeline:* 2000, 2001. *Monitoring/Evaluation:* JPNC.
f) Ontario universities fair.	The annual Ontario Universities Recruitment Fair organized by Ontario universities is aimed at graduating high-school students and their parents. The fair is held mid-September each year at the Metro Toronto Convention Centre. Thirty thousand to 40,000 people attend over a three-day period. COUPN and CAATS representatives will co-host a booth at the fair to promote nursing as an attractive career choice, answer questions from students and parents, distribute material, and refer students to nursing programs.	*Budget:* $30,000 ($15,000 each year). *Lead:* CAATS/COUPN. *Timeline:* Fall 2000, Fall 2001. *Monitoring/Evaluation:* JPNC.
g) Secondary School Community Involvement Program (requirement to complete high school).	All Ontario secondary school graduates have to complete 40 hours of community experience. This is an excellent opportunity for high school students to become acquainted with the nursing profession and consider nursing as a career choice. RNAO and RPNAO will advertise this opportunity in secondary schools and will match students with nursing work settings.	*Budget:* $52,000 ($26,000 per year). *Lead:* RNAO/RPNAO/ employers. *Timeline:* 2000, 2001. *Monitoring/Eval:* JPNC

Supporting Analysis

Starting in this section, we present the detailed analysis and findings that lead to the recommendations and plan of action. The organizational framework we apply to examine the retention and recruitment of nurses focuses on the following critical areas. Each one of these areas is developed in a separate part of the document:

I. Integrating Research and Policy – Part I provides an overview of research findings on effective recruitment and retention strategies. We propose a comprehensive approach, incorporating research outcomes as well as the policy and organizational precursors to recruitment and retention.

II. The Policy Context – Key policy directions have not been conducive to the recruitment and retention of highly qualified, motivated nurses. Funding, health system restructuring, regulatory frameworks, human resource planning, political support – we must make sure all these support recruitment and retention.

III. The Work Environment – Poor working environments are central to recruitment and retention problems in Ontario. Under-utilization of nurses, casualization, poor compensation, understaffing, inadequate professional development opportunities, and participation in the workplace – these are some of the problems to address.

IV. The Labour Market – Growing health needs, falling nursing employment, shift to casual and part-time employment, poor enrolments in nursing programs, an impending nursing shortage – these are some of the disturbing trends in the nursing labour market. What we must do to redress them.

V. The Educational Environment – Nurses entering and practising within the profession require comprehensive educational preparation. There are long-standing issues in entry level and ongoing nursing education that are essential to attract and retain nurses within the profession.

The appendices in this *Report* include 1) the results of the working group rankings of strategies, 2) relevant government commitments, 3) a description of the consultation process, 4) the list of participants in the consultations, and 5) figures.

Part I - Integrating Research and Policy

This section provides an overview of research findings on effective recruitment and retention. The purpose is to validate the recommendations of the various focus groups and advance the development of Ontario-specific strategies. Learning from the strengths and weaknesses of existing research, we propose a comprehensive approach to recruitment and retention, incorporating evidence-based interventions as well as a policy framework.

Literature Review

Nurse recruitment and retention continues to receive attention in the professional literature. In the past 20 years, there have been several approaches to studying nurse recruitment and retention. These include: surveying nurses on what they want, application of mathematical models to predict and explain turnover in terms of demographics and organizational variables, and the landmark Magnet Hospital Study which identified organizations that were successful in recruiting and retaining nurses during a time of shortage and explored what these organizations did to attract and keep their nurses.[1]

Overall, the best recruitment strategies for increasing the supply of nurses are those that influence the image of nursing and the career choices of young people. These strategies are specific to the health-care organization and are based on extensive staff involvement within the health-care organization.[2] [3] Here we outline key findings for effective and ineffective recruitment and retention strategies. A detailed overview of the findings can be found in a separate literature review prepared by RNAO.

Recruitment of Students into the Nursing Profession

The following strategies were associated with a higher recruitment rate: television advertising, flexible class schedules (evening and weekend classes), financial support/loan forgiveness, minority student recruitment,[4] [5] nurse career literature packages,[6] interactive nursing career presentations,[7] positive portrayal of nursing by high school guidance counsellors,[8] mentor/shadow programs,[9] career fairs/days[10] and career counselling.[11]

Recruitment of Nurses to Health-Care Organizations

The most prominent strategy for recruitment of new graduates is for health-care organizations to have strong affiliations with the schools of nursing in their community.[12] Other effective recruitment strategies include a well-designed newspaper advertising campaign, career counselling/nurse recruitment centres, career days, job fairs and open houses.[13]

Retention of Nurses in Health-Care Organizations

The research findings for effective retention strategies can be grouped into four major categories: administrative, organizational, professional practice, and professional development variables.

Administrative aspects. Retention is enhanced by a satisfying work environment – one that has an atmosphere of caring and valuing. This is the key to the success of an organization and a critical factor in the retention of staff.[14] [15] Programs designed to recognize clinical expertise (including staff recognition and clinical ladders) also contribute to increased retention rates of nursing staff.[16] [17] Accessibility and visibility of nursing leaders and synergy between nursing staff and hospital administration are strongly recommended.[18] [19] The absence of the above features is associated with poor nurse retention.[20]

Organizational aspects. One of the most effective recruitment and retention strategies is an innovative compensation and benefit program. Successful components of such a program include: an annual full-time salary based on past experience and education, increasing salary and salary ranges (i.e., a steady increase of salary with a higher ceiling),[21] variable hours pay/shift differential pay and pay for performance.[22] Other organizational variables include open lines of communication,[23] participation in committees[24] and flexibility in scheduling and work status.[25] Non-competitive compensation level, wage compression[26] and trends towards casualization of the nursing workforce are all associated with poor retention.

Professional practice. A key retention strategy involves promoting autonomy and control over practice for professional nursing staff.[27] Additional professional practice variables include the implementation of models of care delivery that enhance staff nurses' participation in decision-making related to patient care[28] and appropriate staffing levels, skill-mix levels and workload[29] in order to provide safe and quality nursing care. Staff shortages and heavy workloads have been consistently linked to poor staff job satisfaction and higher turnover rates.[30]

Professional development. The provision of opportunities for professional advancement and development and access to continuing education by health-care organizations is another major contributor to the overall retention of nursing staff.[31] [32] [33] [34] Specific professional development strategies that have been successful include a comprehensive, multi-phase orientation, which encompasses general orientation followed by a unit/departmental orientation.[35] Intern, mentor and preceptor programs are also known to have a positive effect on job satisfaction and retention of nursing staff.[36] [37] Limited access to professional development and continuing education has been associated with higher turnover rates of nursing staff.[38]

Toward a Comprehensive Approach to Recruitment and Retention

This brief summary of the literature raises two limitations of current nursing recruitment and retention practices:

- *Focus on short-term crises rather than long-term planning:* The literature in the last two decades refers to wide swings of nursing employment during the period. Often, the focus on recruitment and retention occurs when the supply of nurses relative to demand becomes scarce or uncertain, responding to immediate concerns rather than long-term needs.
- *Focus on operational rather than structural solutions:* Most strategies deal with the operational level of health-care organizations (in particular, hospitals), a short planning horizon, and quick solutions. Few refer to recruitment and retention strategies that address structural deficiencies in nursing human resources.

While a thoughtful, long-range view is essential, recent structural changes demand close and immediate attention. A great challenge in recruiting new nurses is the shift in career preferences of female students entering college or university towards business, technology, law, engineering and medicine. Young and mature women and men have multiple career choices, and the barriers for women entering male-dominated professions have significantly reduced. This is a significant "push factor" toward other professions. These positive trends create a challenge for nursing, a traditional "female" profession.

As this *Report* shows, health-care funding cuts have inevitably made the work situation worse for nurses, and have made nursing a less attractive occupation. Policy and funding changes have negatively impacted the reality and image of nursing, thus impacting on recruitment and retention. Massive layoffs and a sharp rise in casualization of the nursing workforce signal that nursing is an occupation lacking importance and influence. Poor working conditions, heavy workloads, lack of professional development and inadequate compensation and benefits, all detract from the desirability of nursing as a career. This serves to weaken the "pull factor" towards nursing.

Assessment: A critical review of the literature shows that an approach to recruitment and retention focused on short-term management of crises is inadequate. We will fail the future if we continue to address the subject in this way. This *Report* recommends a comprehensive approach. We require action in direct activities of recruitment and retention, to attract students and to retain nurses in the workplace. In a context where both push and pull factors contribute to a long-term decline in recruitment and retention of nurses, we must also address the underlying structural conditions. We turn to these structural conditions in the sections that follow.

Part II – The Policy Context

Several policy directions taken by governments and health-care organizations over the past several years have been detrimental to the recruitment and retention of nurses. This section focuses on funding, system restructuring and reorganization, and human resource policies that have negatively affected nurses. These directions have taken place in a climate marked by high public support for the nursing profession and growing concern for the well-being of our health-care system. We acknowledge current efforts on the part of the provincial and federal governments to reverse some of these policy directions. We are all stakeholders of our health-care system and we must work collaboratively and assertively to support and encourage healthy public policies.

Funding Cuts

The effects of funding cuts have been particularly difficult for the nursing profession. Although different levels of government have started to reverse some of these cuts, the effects on nursing and health-care are more difficult to reverse.

Federal

The federal transfers for health-care come as part of the Canada Health and Social Transfer (CHST). In 1996-97, the CHST was created to merge transfers for health-care, post-secondary education and social services. It should be noted that the CHST does not specify how the transfer should be split among the various funded areas, but health-care was getting about 52.2% of the above transfers before the creation of the CHST.

In the process of creating the CHST, the federal government severely cut back total transfers. Transfers were $29.686 billion in 1995-96, dropped to 25.300 billion by 1997-98 and gradually rose back to $29.4 billion by 1999-2000 and $30.8 billion for 2000-01.[39] Over $12 billion cumulatively was cut from the CHST transfer in this period of time, even though the provinces were facing inflation and population growth.[40]

The 1998, 1999 and 2000 federal budgets re-invested in the CHST. The 2000 budget added $1 billion to the CHST for this fiscal year, and half a billion in the subsequent three years. These are one-time increases, and not part of on-going funding. For this fiscal year and the subsequent three years, this raises the cash portion of the CHST transfer to $15.5 billion. This remains lower than the $18.8 billion that went to equivalent transfers in 1993-94. When the value of the transfer of tax points to the provinces in 1977 is added in, the federal government puts the value of the CHST transfer at $30.8 billion for this fiscal year.

This brings the CHST to a level marginally higher than it was in 1995-96. However, it does not compensate for population growth, inflation or other sources of increased need (i.e., the related costs attached to ongoing system restructuring). For example, in the period 1995-99, population grew 3.87% and prices rose 4.07%.[41] This alone implies that CHST transfers would have had to rise over 8% simply in order to keep real per capital transfers from falling. So when CHST transfers went from $29.9 billion in 1995-96 to $29.4 billion in 1999-2000, in real per capita terms, the latter amount represents a 7.5% cut. The 2000 federal budget offers $1 billion more, which is a 3.4% increase. This does represent a real per capita increase (population growth and inflation will probably eat up about 2% of the rise), but still leaves the transfers lagging behind their 1995-96 levels.

These cuts significantly impact on the provincial and territorial ability to deliver health and social services. They also reduce the leverage of the federal government to enforce health-care standards.

It should be noted that the Province of Ontario does not consider the tax points to be a part of the federal contribution. By its reckoning, the transfer consists solely of the cash portion, which, at $15.b billion, is still below its $18.8 billion level of 1993-94

Provincial

Ontario's funding for its health-care system rose from $17.69 billion to $18.366 billion between 1994-95 and 1998-99.[42] In nominal terms, this was a 3.82% rise. Correcting for inflation and population growth, the real per capita expenditure on health fell by 6.7%, or $115 per person in constant 1999 dollars. This drop is significant, especially since it does not account for aging and growing acuity of patients, making the situation more serious than the $115 would indicate.

Assessment: Adequate, sustainable and equitable funding of the health-care system is paramount to achieving universal access and quality nursing care. Without adequate and sustained funding across the sectors and throughout the province, the system will become inefficient and we will neither keep nor attract the appropriate supply of qualified nurses in Ontario. The federal government should return to real per capita transfer levels that existed in the mid-1990s. The provincial government should raise its real per capita health-care expenditure to mid-1990s levels as well. Ultimately, the federal government should return closer to the 50-50 share of health-care expenses as per their initial understanding with the provinces.

System Restructuring

Restructuring and reorganization have been occurring for the past several years in all sectors. The manner in which change has occurred has significantly impacted Ontario

residents as well as the nursing profession. The most significant aspect of this process has been the shifting of health services from the publicly funded hospital sector to the community sector, which is funded by the government at a lower rate than the hospitals. Indeed, the community sector was already under-funded, even before patients were increasingly directed to it. Furthermore, the community sector is not covered under the *Canada Health Act*, and as such, might continue to expect inadequate funding.

For many patients, a shift to the community would be a desirable move, since it allows individuals to remain in their own environment. However, this shift has occurred with insufficient re-investment in human resources or program development. As a result, Ontarians have experienced less access to publicly funded services. Nurses have suffered massive layoffs in the hospital sector, with no significant compensating increase in employment at the community level (see Labour Market section for employment figures). Furthermore, the community-level jobs come with generally lower compensation packages.

Ontarians have experienced significant changes in health-care delivery in sectors other than hospitals and the community. The mental health sector, long-term facility sector, and rehabilitation sector have also undergone significant changes.

Changes in the mental health sector have been dramatic. While currently we have 60% of the care provided in the hospital sector and 40% at the community level, the goal is to move to 40% hospital and 60% community (from an original 80% and 20 % respectively).[43] Community-based mental health services are currently experiencing significant pressures from this rapid expansion of need and are given inadequate human and other resources to respond.

Long-term care facilities serve residents who have much more complex needs than ever before. The resident classification data reveal this trend. Between 1993 and 1996, there was an increase of almost 4,000 residents classified in the top three levels of care acuity, and a drop of almost 2,500 in the two least acute categories. The sudden change in resident acuity has placed significant stress on residents and on care providers, and has strained the resources within the sector.[44] Other indicators of need, such as the Case Mix Measure, have increased sharply in the long-term care sector – 9% between 1993 and 1999 alone.[45] This problem can be expected to increase as more chronic care hospitals close under the directions of the Health Services Restructuring Commission.

Rehabilitation services have also been shifted significantly to the community through a sharp decrease in the in-patient phase of these services. A two-tier system has evolved here, with private patients getting more comprehensive service than OHIP-funded patients.

The uncoordinated and often irrational restructuring process, combined with significant reductions in health-care budgets, resulted in the dismissal of thousands of nurses and the demoralization of even more. In spite of the obvious need for nurses in all sectors of the system, too many have been forced out of work and others feel forced to practice outside

of their designation in order to remain employed. Some RNs and many RPNs have taken unregulated care provider positions. Not only have nurses found themselves in settings that hinder professional practice, but for many, the devaluation of nursing has been the final straw. They have completely abandoned the profession.

Assessment: To preserve and strengthen quality patient care, health-care restructuring must occur in a co-ordinated and logical form. We must account and prepare in advance for the effects that changes in one sector have on other sectors. A coherent multisectoral plan that ensures adequate access, by Ontario residents, to nursing and other services, across all sectors is imperative. Stabilizing the nursing workforce is central to ensuring access and preventing further erosion of patient care.

Relaxation of Regulation and Downloading of Responsibilities

A tendency to relax regulations within the public sector, along with some downloading of funding, has also influenced nurses and nursing care. These policy changes have reduced the amount of nursing care delivered and have encouraged the delivery of care by unregulated care providers. Some specific examples are discussed in the following sections.

Long-term Care Facilities

In 1996, changes to the Nursing Home Act deleted the requirement that Nursing Homes have at least one RN on site 24 hrs-a-day. Also deleted was the requirement that nursing homes employ sufficient staff to provide each resident a minimum of 2.25 hours of care per day.

Community Health - Public Health

The delivery of public health services has undergone also considerable restructuring. In January 1998, Bill 152, *An Act to Improve Services, Increase Efficiency, and Benefit Taxpayers by Eliminating Duplication and Reallocating Responsibilities between Provincial and Municipal Governments in various areas and to implement other aspects of the Government's "Who Does What" Agenda* came into effect. Schedule D of this legislation downloaded 100% of funding responsibilities for public health services to local municipalities. Since that time, the provincial government has reclaimed 50% of this responsibility. It is reported [46] that health units have lost 20-45% of public health nursing positions over the last five to ten years.

Long-Term Care Community Services

Regulation changes to the *Long-Term Care Act* [47] have introduced official limits to the amount of personal care and nursing care that Community Care Access Centres (CCAC)

will provide. Although these limits to care are identical to policy guidelines previously in place, the fact that they are now set in regulation prevents nurses from always having the opportunity to provide the amount of care they know is needed.

Changes have also occurred in the criteria governing access to care in the community. Implicit within this regulatory approach is the assumption that families – particularly women – will do more. In fact, informal care by family, neighbours and friends already constitutes 90% of elder care and is provided mostly by women.[48] Shouldering unhealthy burdens, with less than adequate respite and without access to the knowledge, skills and expertise of nurses and other health-care providers, this informal caregiving situation is potentially a recipe for disaster.

Assessment: The regulation changes and downloading of funding have lowered standards of care. In certain sectors, less care is guaranteed and the use of unregulated care providers has increased significantly. The system is becoming much less efficient and less able to effectively handle the health-care issues that arise in each sector. Recruitment and retention suffer as nurses are faced with the stress and conflict of providing care in circumstances of declining resources and quality.

Privatization and Managed Competition

Privatization is another policy trend taking place in Ontario well ahead of the pace in the rest of Canada. For Canada, the portion of total health-care expenditures funded by the private sector has risen from 22.9% in 1976 to 30.4% in 1999.[49] For Ontario, the private sector share rose from 23.8% to 33.9% over the same period.[50]

Contributing to the pressures for increased privatization is the lack of access by many Ontarians to comprehensive, primary health-care services. Currently, our primary care sector is limited in scope of services it provides and in its accessibility. Access is almost non-existent during evenings, weekends and holidays. Access is also limited in many geographical areas. Primary care services are also poorly coordinated with other services, adding to the overall fragmentation of care. Thus, the needs of many Ontarians are simply not being met in an effective or efficient manner. When people cannot access the care they need in a timely fashion, the emergency room becomes the only available option. This leads to emergency room backlogs that further exacerbate access to urgent care.

Problems of access will continue to serve those who would like to advance the privatization agenda. However, as we have discussed elsewhere[51] privatization will not alleviate but rather aggravate our system ailments.

As pointed out in RNAO's discussion paper on the *Canada Health Act*[52] private funding of health-care is of great concern for nurses. A privately funded system creates a variety of problems:

- It limits access to those who can't afford to pay;
- It is unfair in its regressive redistributive effect and in its subsidization of those who can pay for the service (i.e., through tax deductibility of health insurance payments, which the Clinton administration calculated will cost the American federal government US $76 billion in 1999[53]);
- It delivers poorer health outcomes, in part due to the above two points;
- It is very costly and inefficient;
- It affords more limited possibilities for accountability;
- It offers less choice for most people; and
- It detracts from social cohesion.

The introduction of a comprehensive primary health-care system will address many of the true causes of the problems we are witnessing in our system. The Health Services Restructuring Commission's (HSRC) *Primary Health Care Strategy* is widely endorsed by the nursing community because it provides a real solution based on a comprehensive analysis, a concrete plan of action and financial sustainability. (The HSRC report is available in the following web site: http://www.hsrc-crss.org/e_menu_p2r.htm).

The HSRC strategy recognizes that primary health-care must be the foundation – the very core – of our health-care delivery system. It must be interdisciplinary care that is accessible 24 hours, 7-days a week, all year round. This strategy also recognizes the central role of nursing in the provision of primary health-care. The HSRC strategy is one that is flexible enough to incorporate, with specific modifications, most of the primary care models currently in existence.

The trend towards privatization is part of a stronger orientation towards the bottom line, which has contributed to the deterioration of working conditions for nurses. Even in the hospital sector where public institutions and public funding are still the norm, budgetary pressures are having negative impacts on health service delivery and nursing. Too often, the pressing nature of budget constraints leads to a short-run focus on cost cutting at the expense of the long-run welfare of patients and health-care workers. Financial goals are often more central to decision-making than quality of care.

A major cause of the increase in private sector share lies in the shift in much of the care from hospital services (covered under the CHA) to the community (not an essential service under the CHA). Individuals requiring home health-care are on average more acutely ill than ever before. CCACs are reporting increased difficulties in responding to the rapid rise in the volume of care required by their communities. Since funding has not kept pace with the increase in care needs, more and more patients are either paying for some of the services they require, or foregoing them.

Perverse hospital funding incentives have also led to contracting out of many services which might have been more cheaply done by the hospital, such as lab work. This contributes to the greater scarcity of funds to keep the health-care system going.

In addition to the shift of care from the hospital to the community sector, the community has also experienced a dramatic increase in competition for less than adequate resources. The implementation of managed competition, marked by a bidding process for service delivery in the home care sector, has led to significant pressures on all potential care providers to lower costs. Both not-for-profit and for-profit provider organizations are pressured to cut the amount and level of service delivered in order to compete for the public funds available from CCACs. All organizations are being forced to adopt a bottom-line mentality to avoid being out bid in the process. Furthermore, these organizations are finding that the bidding process is very costly and time consuming. Patients are upset by the loss of continuity of care provision, when existing health-care providers lose contracts.

Assessment 1: Primary health-care services enhance access and reduce the need for acute care. Privatization reduces access and compromises quality of care. The report of the Health Services Restructuring Commission provides an essential framework for primary health-care. Access to comprehensive primary health-care will assist in stemming the tide of privatization, and contribute greatly to continuity of care for Ontarians.

Assessment 2: Inadequate funding to community health-care services along with the managed competition process has damaged continuity of care for Ontarians. These problems have also increased the inequities in working conditions between nurses in home health-care and in other sectors. Moreover, even public institutions such as hospitals and other non-profit providers have adopted a bottom-line mentality that is distorting their original mandates and compromising the practice of nursing and their role satisfaction.

Absence of Health Human Resource Planning

Over the past few decades, the supply of nurses has fluctuated dramatically between acute shortages and dramatic policy-driven oversupply. Indeed, the change in supply was so rapid in the most recent fluctuation that nurses were being laid off at the very same time as acute shortages were predicted to be around the corner. Overall health human resource planning has largely been absent.

A report prepared for the Ontario Hospital Association[54] cites a lack of understanding of workforce issues as well as inadequate and incompatible data as important contributors to this lack of planning. The authors also point to the plethora of recent research linking nursing availability to quality patient care.

Assessment: We must engage in ongoing, comprehensive health human resource planning in order to avoid the wasteful cycles of employment expansions and contractions that have marked nursing's history over the past twenty years. Patient care suffers when the supply of nurses is out of synch with need. We will not retain nurses, nor recruit individuals into a profession that fluctuates dramatically between high and low employment.

Public Support

The steadfastly high public regard for the nursing profession in combination with many expressions of concern about changes to the delivery of health-care services has been duly noted by government decision-makers.

An Environics Poll commissioned by RNAO in November 1999 demonstrates once again the exceptional level of public support for the nursing profession. Seventy-five per cent (75%) of Ontarians think that nurses have more influence than doctors (19%) or hospital administrators (4%) on the quality of the day-to-day care they receive in hospitals. More than eight in 10 Ontarians believe that nurses are overworked. Six in 10 Ontarians say the amount of money invested by the Ontario government in nursing services has a major impact on the quality of the health-care system.[55]

The Environics Research Group has been tracking public attitudes to the health-care system since 1986 and has found steady erosion in satisfaction with Ontario hospitals over the past decade. Satisfaction levels declined more sharply after 1995 when the cuts began to take effect.[56]

The Ontario Hospital Association also found considerable dissatisfaction among patients about access to hospital services, particularly about staffing levels in hospitals.[57] A survey by Comquest Research, commissioned by the Ontario Nurses Association, found widespread public concern about the quality of health-care across all sectors and about the effects of cuts.[58]

These findings are echoed at the national level. A study by Graves et al. found Canadians to be very concerned about the state of their cherished health-care system and very concerned about the prospects of the system being able to continue delivering quality health-care.[59] This attitude was also evident in a national poll released in January 1999, confirming a continued rise in concern about health-care, along with a reduction in support for tax cuts.[60]

It is not surprising that the public is rallying around the health-care sector. At a time when individuals have been asked to give up much in the way of public services, the health-care system is one of the last things that they are prepared to sacrifice. In large part, this is due to the integral role played by universal health-care in our Canadian identity. It is also very

clear that the public recognizes and is particularly concerned about the health of nursing care and nurses within our system.

Assessment: Nurses have the support of the public as they mobilize to make sure health system changes go in the right direction. The public is concerned by increased threats to quality patient care arising from insufficient funding for nursing and other health services. There is much concern about the erosion of our most valued institution: the universal, publicly funded, comprehensive health-care system. The public is willing to pay to maintain and enhance it.

Political Recognition

In the recent past, governments have made key decisions that could undo much of the damage done to the profession.

At the provincial level, one of the first key decisions was the proclamation of the Nurse Practitioner (NP) role in 1997. The invitation from the Premier to meet with RNAO (March 1997) and the creation of the Nursing Task Force (April 1998), have also been positive signs of recognition for nursing.

The provincial government took a positive step in recognizing the current shortage of nurses. The Ontario government has acknowledged that the current level of nursing staffing is too low. It has accepted the recommendations of the Nursing Task Force that over 10,000 new permanent nursing positions need to be created, simply to catch up with where the rest of Canada was in 1997, in terms of nurse/population ratios.[61] Thus, there is an immediate need for an increase of 10,000 new nurses. In fact, the province has committed to creating 12,000 new permanent nursing positions by the end of 2001. These commitments were made during a series of public announcements on health-care in March 1999, and reiterated by the Progressive Conservative Party of Ontario in its *Blueprint for Ontario* election platform, and repeated once more in the Throne Speech in November 1999.

More recently, the Premier and the Minister of Health and Long-Term Care announced funding for 106 nurse practitioners. The 106 positions include 76 for underserviced areas, 20 for pilot projects in long-term care centres, five for aboriginal health centres and five for primary care networks.

The federal government has recognized the general problems in health-care, and has finally raised the CHST transfers to provinces. The increase in transfers has been significant, although transfers lag their 1995-96 levels in real per capita terms. However, the transfer rise has allowed the provinces to increase their health-care spending, which in turn allows providers to put more nurses back into a health-care system desperately short of nurses.

Assessment: To preserve and strengthen quality patient care, it is important that government policy has acknowledged the current problems within the profession, and is moving to address the underlying causes. The government of Ontario has taken significant steps in this direction. However, it is crucially important that the commitments be delivered on time, in particular the creation of 12,000 new permanent nursing positions. In the longer run, the government must continue to provide planning and stability for the nursing workforce, or risk a repetition of the boom and bust cycle in nursing employment.

Part III – The Work Environment

In virtually all settings, patient care needs have increased as the number of nurses has declined. An examination of these environments indicates that change has been considerable, within individual sectors, and in ways that span all sectors. Often, organizations faced with the need to rapidly reduce costs have looked first to their nursing budgets, a large and very obvious target. The characteristics of nurses' work environments have great implications for the supply of nurses. It is clear that the quality of the workplace is of critical importance to nurses.[62] It is also clear that the ability of nurses to provide quality care is key to the likelihood of nurses remaining in practice.[63]

Sector-Specific Issues

Acute Hospital Sector

In the acute care hospital sector, the decline in funding[64] has led to dramatic changes in the way care is delivered. Decreases in acute care hospital beds and a decreased length of stay[65] are problematic when they occur in combination with sharp reductions in nursing positions, and with limitations in the practice of remaining personnel. Nurses in the hospital sector are in extreme conflict. On the one hand, they are faced with the need to provide a much greater volume and intensity of care than they are able to deliver and on the other hand they remain responsible and accountable as professionals practising within the standards of the profession.

Home Health-care Sector

Shortened length of hospital stay has resulted in an increase in the volume and acuity of health-care needs at the community level (20-30% as reported by CCACs). This increase has been accompanied by the implementation of managed competition. The associated result is a cyclical contract bidding process for service delivery that has serious implications. These include: 1) a loss of continuity of care for long-term users of the system; 2) threats to the quality of care as bidders strive to cut costs; and 3) loss of skilled health professionals from the sector, as they respond to higher financial rewards, benefits, and overall working conditions, in other sectors in health-care. Nurses who do stay will face the dual problem of limited resources to practice and lower income, and the great risk of losing their jobs if their employers fail to win contracts. It is almost impossible to maintain a stable professional workforce with the uncertainty of a cyclical bidding process. In fact, this process has resulted in the highest level of casualization amongst home care nurses.

The outcome of the managed competition policy has been substantially detrimental for nurses' working in home health-care. As organizations strive to survive in this competitive milieu: nurses are being shifted from hourly rates to rates per visit; nurses' rates per call are being reduced; travel allowances are being reduced or eliminated; and no paid time is allowed for documenting care. Infrastructures for educational, professional or administrative support have been decimated for home health-care nurses. Nurses bitterly complain that they must reduce the level of service they deliver in order to make enough calls to become cost-effective (when on salary) or make an adequate living when paid on a per visit model. Most disturbingly, nurses report that they are continually in a rush and not in a position to supply the amount of care which their professional judgement tells them is necessary. [66]

Long-term care facility sector

Residents in long-term care facilities today are older, frailer and have more complex health-care needs than ever before[67]. As we are shifting the care of approximately 10% of the hospital population to long-term care settings, the health-care needs of the long-term care setting will continue to increase both in volume and in complexity.

The existing funding mechanism for nursing resources in long-term care facilities is built on an annual resident classification, a classification system that does not fully capture resident acuity. This system discourages these facilities from long-range planning of nursing resources and results in a casualization of nursing personnel. Furthermore, funding sources for staff development/education have been cut drastically. This limits the incentives that long-term care organizations can offer to nurses.

In addition, in an environment in which the number of knowledge workers should be increased based on residents' needs, many RNs and RPNs are being replaced with unregulated health providers, who lack the professional knowledge, skills, experience and accountability to safely respond to the needs of the elderly. This makes the provision of quality, holistic care a very difficult, if not impossible goal. In spite of recent improvements, the levels of funding in this sector have not kept pace with resident acuity or with the increased volume. The situation is especially disturbing as many of the elderly are not able to adequately assert their need for care.

Proper RPN, RN and NP utilization in long-term care will serve Ontarians well by ensuring that residents are safely and less invasively cared for in long-term care facilities. It will result in decreased human and system suffering of a "revolving door" between the long-term care facilities and hospitals' emergency rooms.

Public Health Sector

The public health sector has undergone significant restructuring over the past decade and public health nurses have experienced the brunt of many of these changes. The 1989 Ministry of Health *Mandatory Programs and Services Guidelines* (MPSG) identified standard public health services and also served to organize these services along program

lines rather than disciplinary or professional lines. As a result of this program emphasis, many senior nurse manager positions have been lost, along with nursing input at many decision-making tables.[68]

The downloading of public health funding responsibility to the municipalities from the province has also impacted public health nurses. Even though part of the responsibility for funding has subsequently been returned to the province, service levels have suffered. Specific numbers of public health nurses are not separately tracked by the College of Nurses or the Ministry of Health, but surveys of public health units indicate a loss of 20 to 45% of public health nursing positions over the past decade. [69]

The public health nurses who remain employed are unable to provide many of the essential services that were once the cornerstone of public health-care. Well-baby clinics and school nursing activities have all but disappeared. In addition, many health promotion groups, including those for the elderly, have been cut.[70] The public health nurse of today faces extreme conflict and uncertainty. In spite of ever-growing evidence that health promotion activities are critically important and in spite of the heightened need for these services by Ontarians, government commitment to these programs appears to be fading. The professional dissonance of this reality for public health nurses has meant widespread frustration and burnout.

Mental Health Sector

As noted in the recent Ministry of Health and Long-Term Care report, *Making it Happen: Implementation Plan for Mental Health Reform*, mental health services are "delivered through a continuum of health-care from highly specialized inpatient care and physician services, to home care and informal community supports." [71] The goal of current provincial reforms is for 60% of mental health-care funding to be spent on community services and 40% on inpatient services. Hospitals are currently cutting their bed ratios for mental health programs, while alternatively, the expansion of community-based systems is being explored but not necessarily implemented. As a result the gap between need and care has widened. Unlicensed, generic workers are replacing many nurses as the reforms roll out.[72] For example, those with chronic psychiatric disabilities have experienced a shift in their care towards less skilled, non-professional providers.

The World Health Organization's *Guidelines for the Primary Prevention of Mental, Neurological and Psychosocial Disorders* identifies that most mental and neurological disorders have several, interacting causes.[73] This complexity speaks to the need for care by an adequately prepared nurse.

The shift in care from facilities to communities with inadequate resources, and from nurses to generic workers has implications for the nursing profession as well as for quality of care. Nurses retained in the system will be caring for those with more acute, and possibly violent symptoms. Nurses in the community will be aware of those in the community who are not receiving needed care.

Underutilization of Nurses

An ongoing problem that spans all health-care sectors, is the underutilization of nurses: registered practical nurses (RPN), registered nurses (RN), and nurse practitioners (RN extended class or RN(EC)). As components of system-wide restructuring, RNs and RPNs have been replaced by less knowledgeable care providers. Employers have adopted workplace policies that restrict nurses from various aspects of patient care, or they have adopted models of care delivery that limit the nursing role. In these instances, employers replace or reclassify nurses with other categories of care providers. In effect, Ontario has experienced widespread deskilling of patient care. This is occurring at the same time as patients in each single sector have more acute, complex health-care needs.

In addition, many of the resources supporting nursing practice, such as advanced practice nurses, nurse educators and unit administrators, have been significantly decreased or eliminated. This deskilling of patient services fails to take full advantage of the skills, knowledge and expertise of nurses and leads to the erosion of quality care, decreased job satisfaction and nurse burnout. All of these have implications for recruitment and retention of nurses.

Nurses want and need to feel valued in their workplaces. Greater retention rates of nursing staff have been reported by health-care organizations that promote an atmosphere of caring for their nursing staff and that facilitate and promote excellence in practice.[74] Specific issues related to the underutilization of professional nursing staff are discussed below.

Registered practical nurses are sometimes forced to accept positions as unregulated workers in order to stay employed in their organization. Similarly, registered nurses have been forced to accept positions as RPNs or as unregulated workers in order to remain employed in their organization.

Too many RNs and RPNs have become casualties of the conflict between expanding demands for balanced budgets and the shrinking ability to provide quality care. Those who are practising are suffering from frustration, disillusionment and an overall decline in morale and burnout. All of these are related to job satisfaction, which in turn relates to higher turnover rates of nurses.

The plight of nurse practitioners within Ontario is another case in point. We have approximately 350 nurse practitioners who are qualified as RN(ECs) and are well prepared to perform an expanded nursing role in primary health-care settings. Less than half of these providers are currently able to practice to their full scope due to lack of funding opportunities. These practitioners are greatly needed and could do much to ease the current difficulties in accessing primary health-care services, particularly in under serviced areas.

There are also increasing numbers of acute care nurse practitioners, with master's degree preparation, who are performing within an expanded role in acute care, mental health, long-term care and other settings. The practice of these nurses is curtailed by an unnecessary layer of bureaucracy as they are, thus far, unable to acquire their RN(EC) designation.

If nurses are unable to find positions that reflect their scope of practice, they may depart for another jurisdiction or leave the profession. Underutilization of nurses also has serious implications for future graduates and potential students. Why would students want to invest in an educational program that is not likely to get them work? Furthermore, nurses will be discouraged from returning to school when there are few opportunities to utilize the additional educational preparation.

Some Canadian jurisdictions, such as British Columbia, have recently moved to correct a part of this problem. They have provided government funding to health-care facilities to provide refresher courses to reinstate LPNs (LPNs are equivalent to RPNs) and to educate unregulated workers to become LPNs.[75] This is particularly appropriate given the increasing complexity and intensity of care needs for patients in long-term and extended care.

All members of the health-care team need to have the opportunity to put their skills to use. The appropriate use of the right health-care worker in the right location is paramount to improving the quality and access to health-care in the province. It is wasteful, in human and financial terms, to invest in the education of needed health-care providers and then fail to ensure their full utilization in the health-care system.

Casualization

Increase in Part-time and Casual Positions

In all sectors, agencies have moved to increase their flexibility by reducing full-time positions and increasing casual and part-time positions. Data from the College of Nurses of Ontario show the sharp rise in the share of part-time and casual employment in nursing (see Figure 1 in appendix 5).[76] Between 1986 and 1998, the reported rate of casualization of nursing employment rose from 7% to 14.48% and dropped slightly to 14.2 % by 1999. In recent years, the reported part-time rate has risen steadily. It went from 31.6% in 1992 to 36.0% in 1999. The labour market trends described in Part IV provide a comprehensive picture of this trend. Casualization of nursing care has a direct impact on the access by the public to quality, professional nursing services. Casual nurses are unable to provide continuity of care to patients since they may only care for the client for a day, or a few hours, and then move on.

Impact of Casualization

Casualization and replacement of nurses with less prepared workers are examples of the diminished access to and the devaluation of professional nursing care. It is increasingly difficult for nurses to find permanent employment. For new graduates, the situation is extremely harsh, with very serious implications. The lack of permanent full-time positions means that recently trained nurses cannot consolidate their knowledge and skills. Furthermore, the increased rates of casual staff means that new graduates have reduced access to professional mentors. Their entry into the profession is marked by a very uneven, patchwork-type of experiences as they spend their formative time in different positions in many different employment settings.

There is no doubt about a direct link between the move to casual work and the difficulty in recruiting the brightest and the best students into nursing. In today's competitive market, students are looking for a career that will let them use their talents, bring them a good salary, and allow them opportunity for career development and advancement. A nursing career that only offers casual employment with little or no ability to participate in the full healing process of patients, no employment benefits, and no opportunities for professional growth, directly impacts on the ability to recruit people into nursing. This undoubtedly has huge effects on job satisfaction, which in turn relates to higher turnover and attrition rates. The casually employed nurse also cannot be impervious to the damage done to the continuity of patient care.

It is clear that the trend of casualization is a most inefficient option in the long run. The recruitment and retention implications, as a result of quality of care, efficiency, effectiveness and morale problems, are very costly. Indeed, the use of casually employed nurses is unlikely to be cost-effective even in the short run, with the increased costs of supervision, communication, co-ordination, and errors.

With respect to the last point, a major study published in the Canadian Medical Association Journal[77] shows a significant rise in reported errors for both hospital admissions and day surgeries between 1992 and 1997. The data were age and gender adjusted to control for these potential sources of incomparability between the two years. The conclusions of the study are as follows. Misadventures[78] rose from 18 to 30 per 10,000 for inpatients and 5.2 to 11.6 for day surgeries. Complications[79] rose from 330 to 500 per 10,000 for inpatients and 65.2 to 95.1 per 10,000 for day surgeries. Adverse drug reactions[80]rose from 104 to 162 per 10,000 for inpatients and 8.1 to 10.8 per 10,000 for day surgeries. The authors conclude that the only plausible sources of the change are either a change in rates and methods of reporting, or deterioration in the quality of care delivered. The authors state that they find the results troubling, and they call for further study.

Assessment: The work environment difficulties experienced by nurses in all sectors form a serious threat to quality patient care: replacement of nurses by unregulated care providers; increased patient acuity; and funding that has not kept pace with

need. Nurses faced with the reality of practising with inadequate numbers of professional personnel are soon disillusioned and experience burnout. The quality of patient care is sacrificed in these environments. Already, there is evidence of a decline in quality of care. The sustainability of the profession is also under threat as nurses leave and recruits fail to enter the profession.

Professional Development Opportunities

Professional development is crucial in all workplace settings and all sectors. Studies have shown that professional development has a significant, positive impact on staff satisfaction.[81] [82] Given the many opportunities and career choices for women today, nursing must offer its practitioners truly innovative and exciting opportunities for growth. Prospective nurses need to be assured that careers with progressive possibility await them.[83]

In many health-care settings, financial pressures have led to a sharp reduction in professional development opportunities. Faced with shrinking budgets, agencies in all sectors opted to reduce professional development costs in order to delay reductions to those providing direct care. The greater opportunities for professional development in the US is cited as one key reason for the large number of nurses leaving the province for the US.[84]

Support for continuing educational opportunities is one of the most important retention strategies for nurses. Funding of specific educational programs and flexible scheduling to facilitate attendance are priorities for staff nurses across Ontario. Indeed, nurses commonly report leaving a place of employment because they are dissatisfied with their organization's lack of support for continuing education.[85] Furthermore, a study of 16 hospitals that utilized concrete, continuing education programs demonstrated considerable success in attracting and retaining nursing staff during a severe nursing shortage.[86] [87]

Other avenues for progress, both for registered nurses and registered practical nurses, include formal as well as informal in-service programs, conference attendance and courses. The professional development needs of nurses must be seriously addressed.

Assessment: A work environment that facilitates the ongoing professional development of the nurses will be much more likely to deliver high quality patient care. In addition, this investment in nursing will demonstrate a commitment to the profession and encourage the retention of nurses as well as attract new individuals into the profession.

Decision-making Opportunities

One timely retention strategy is to increase the opportunities for decision-making among staff nurses. This is a strategy that has demonstrated an enhanced ability to retain staff.[88]

Some health-care organizations have implemented participatory management models. Participatory management creates an atmosphere in which staff nurses are empowered to collectively solve problems, provide input into current productivity measures and improve clinical processes affecting patient care.[89] Nurses have reported increased autonomy and decision making, feeling more valuable to the organization and that their opinions were respected as a result of implementation of a participatory management model.[90 91]

Increasing the amount of personal control nurses have over work and facilitating an autonomous climate for nursing practice results in increased job satisfaction and is linked to the provision of quality care.[92 93 94] Further, research shows that RNs who have the opportunity to work within flexible schedules or practice self-scheduling often report increased job satisfaction.[95] Flexible scheduling is especially important at a time when nurses are looking at opportunities for formal educational programs. While there is no RPN-specific research in this area, we would assume these same principles would apply.

Assessment: A work environment that facilitates increased decision-making of the nurse is an environment more likely to provide high quality patient care. In addition, it demonstrates a commitment to nursing, encourages the retention of nurses and attracts new individuals into the profession.

Compensation

Nurses have a range of concerns about compensation. One is the base wage rate, which is uncompetitively low in Ontario. The rate has just recently risen from $18.30 per hour to $20 per hour for unionized nurses in hospitals;[96] the rates in the non-hospital sectors are generally considerably lower. The Ontario base rate had been one of the lowest in Canada. Only Quebec, Newfoundland and Prince Edward Island had lower rates, while rates elsewhere are higher. For instance, the lowest rates in British Columbia and Alberta were $20.98 and $19.66 respectively. Government of Canada nursing contracts have much higher base rates.[97]

There is also a need to explore compensation differentials for evening, night and weekend shifts. It is also important to create incentives for nurses to work full-time versus casual hours. In addition there is a need to develop financial incentives related to continuing education of registered nurses and registered practical nurses.

Inequities in compensation across the various health-care sectors need to be addressed. Historically, home health nurses have been paid significantly lower wages than hospital

nurses have (in the range of three to four dollars an hour less). The current managed competition model that was introduced into the home health sector a few years ago has created even more of a gap in compensation for nurses in this sector compared to the hospital sector (five dollars less an hour).[98] The wages of those who practice in the long-term care facility sector lie between the hospital and the home health-care sector.

This discrepancy has resulted in an increased turnover of home health nurses. Furthermore, it has discouraged the experienced hospital nurse, the long-term care facility nurse and the recent nursing graduate from seeking work in the community setting. The nurse is more likely to have a more predictable wage and benefit package and a more stable work environment in hospitals. This is extremely problematic, as the community sector will experience the most growth in the next decade.

Assessment: Sector to sector inequity in compensation serves to undervalue the practice of nursing. Patient care is more likely to suffer because nursing compensation is much lower in the home health sector, one of the most rapidly growing sectors in the system. Again these inequities serve to discourage the retention of nurses as well as the entry of new individuals into the profession

Inter-professional Relations

The passage of the *Regulated Health Professions Act* (RHPA) in December 1993 promised a new era of co-operation among the health professions. One stated intent of this initiative was to "level the playing field" among the health professions by subjecting all to the same legislative framework and providing each group with identical opportunity to participate in changes within the health-care field. While this initiative has positively influenced the level of co-operation among the various health-care groups, it has not rectified long-standing power differences between groups. Furthermore, the current reality of cutbacks in all sectors has in some cases increased the tension between groups as resources become increasingly scarce. In spite of a legislative framework that offers more professional autonomy over nursing practice, nurses are also faced with an undermining of nursing roles in all parts of the sector.

There is an urgent need to establish more effective communication patterns and subsequently more collegial relationships between nurses and physicians in many parts of the province. In some areas, the reduction in availability of family physicians, in conjunction with the lack of funding options for nurse practitioners, has resulted in a serious decline in the availability of primary health-care services. This has served to increase the tensions faced by providers as they struggle to cope with woefully inadequate resources.

Overall, a nurse's own satisfaction increases with positive relationships between clinical leaders/ managers, co-workers, physicians and other unit/departments.[99] Collaborative practice between nurses and physicians is also associated with more effective

communication, trust and respect for each other's respective discipline and greater job satisfaction.[100] Moreover, improved communication between nurses and doctors can have a powerful impact on improving patient care and on overall organization effectiveness.[101] We must ensure that the structures are in place to facilitate the delivery of comprehensive, quality patient care. This will feed the creation of positive and productive relations among health-care providers that will, in turn, facilitate the delivery of much more effective patient care.

Assessment: The work settings that facilitate and encourage improved communication between professions are more likely to provide high quality patient care. Nurses practice within an increasingly interdisciplinary environment. In order to ensure quality patient care, the methods of, and opportunities for, communication must keep pace with the changing health-care environment. This will demonstrate a commitment to nursing, encourage the retention of nurses and attract new individuals into the profession.

Nursing Perceptions

The overall reduction in employment opportunities, along with the changes in the way care is organized in many health-care organizations, has resulted in sharp reductions in the quality of work and care in practice settings. In addition, many of the traditional resources supportive of nursing practice, such as nurse educators and unit administrators with nursing backgrounds have been eliminated.

The changes in the work setting, including the undervaluing of professional nursing services, have been associated by the nurses themselves with the erosion of quality care, decreased job satisfaction and burnout. All of these perceptions have implications for recruitment and retention of nurses as nurses want and need to feel valued in their workplaces. The literature reports that health-care organizations that promote an atmosphere of caring for their nursing staff and excellence in practice[102] have better recruitment and retention of nursing staff.

It is not surprising that nurses have been losing their commitment to the organizations in which they work, to the nursing profession and to the health-care system as a whole. Nurses have suffered from the conflict between the expanding demands for care and the shrinking ability to provide what they considered quality care. As a result, nurses are experiencing frustration, disillusionment and burnout. This conflict of values has been well documented in the literature. [103]

Assessment: It is clear that until decision-makers formally acknowledge the value of nursing to health-care delivery, until resources are invested in long-term, comprehensive planning, we are destined to hinder recruitment and retention efforts and, thus, repeat the dramatic supply problems of the past. The burnout currently

experienced by so many nurses is a direct product of the systemic problems, already discussed, that are occurring in an environment that has failed to value the nurse.

Part IV – The Labour Market

The labour market section will examine the trends in employment and need for nurses, and then proceed to a discussion of nursing supply. We present a variety of measures of all three variables, and show how the growing gap between need and employment opportunity has generated a worrisome shortage of nurses. This shortage threatens to widen from a gap to an unbridgeable chasm.

The Data

The data on nursing registration and employment come from the College of Nurses of Ontario. The registration data are comprehensive, but the employment data are based on self-reporting. The self-reporting rate has fluctuated between 86% and 94% over the years, but has been sufficiently high to give a reasonable picture of employment circumstances for nurses in the province. In recent years, the reporting rate has been rising, to over 94% in 1998 [see Figure 2—all figures are in Appendix 5]. This has the effect of making employment trends appear more positive than they actually are, as some of the apparently new nursing positions are merely existing positions being reported for the first time. *Thus the initial conclusions about declining access to nursing services are conservative.* For some measures, we will include adjustments to more closely capture the actual range of job loss among nurses.

The data on enrolments in nursing programs in community colleges and universities come from the Ministry of Training, Colleges and Universities for the province of Ontario. The individual colleges and universities submit them. Data on provincial populations come from the Canadian Institute for Health Information.

The data are used as given by the supplying bodies. These data give a partial picture of the labour market for nursing. There is a range of data currently unavailable to us that would be helpful in further clarifying the situation in this market (i.e., nursing hours worked, sick time rates, vacancies). In some cases, information critical to understanding this market is not collected, although it should be collected. However, all too often, the information is already collected but not readily available.

Assessment: The public is increasingly demanding accountability in all of society's institutions, both public and private. Accountability requires transparent reporting, which in turn requires reasonable access to relevant data. There is insufficient commitment to the collection and dissemination of this information by relevant authorities. Furthermore, there is significant room to improve the sharing of essential information in the health-care sector, both within and outside of government. While availability of data does not guarantee accountability, its

absence greatly reduces the level of accountability. A serious commitment to accountability implies a commitment to the collection, analysis, reporting and dissemination of relevant data. This is a challenge which public institutions at all levels must face.

Employment Trends

Employment does not Reflect Need

As we will discuss, there are many factors that contribute to the need for nursing services (as they contribute to the need for health-care services). In general, growth and aging of the population alone will raise the demand for nursing services. However, as we will now show, employment has been volatile and has recently been trending downwards in spite of steady growth in need. Nurses are being spread much more thinly and have become increasingly overworked. Sadly, need is frequently not matched by employment opportunities for nurses.

Falling Employment

Nursing employment has been falling in spite of growing population and growing need. Based on College of Nurses of Ontario figures:

- For Ontario RNs, declared employment fell from 82,069 in 1994 to 78,174 in 1999 (a drop of 3,895 positions – 3.414.7%).
- The number of RPNs fell marginally over the same period from 25,345 to 25,189 (a drop of 0.6%).
- Overall, total measured nursing employment dropped over this period by 4,051 (3.8%), from 107,414 to 103,363 [see Figure 3].

Reported Nursing Employment

Year	RNs	RPNs	Total
1994	82,069	25,345	107,414
1995	81,523	25,736	107,279
1996	81,736	25,766	107,502
1997	80,369	25,703	106,072
1998	79,267	25,597	104,864
1999	78,174	25,189	103,363
1994-99	**-3,895**	**-156**	**-4,051**

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

The fall in nursing employment is remarkable, when compared to the sharp increase in population. The significance of this is even more striking, when one considers that prior to 1994, nurses were already reporting that they did not have sufficient time to provide adequate patient care.[104] However, the measured drop in employment still appears to be low, given the anecdotal evidence that so many nurses have experienced job loss. The problem lies in using data that were not intended for this purpose.

It is important to correct for non-reporting, since these numbers understate the drop in employment for several reasons. As noted above, increased reporting rates tend to make the employment situation for nurses appear better than it is. The impact is potentially large, because the change in reporting rate is large relative to the change in reported number of jobs. The size of the understatement depends upon how many of the newly declared nurses were employed. (For an explanation, see endnote.[105]).

At this point, there is no data on the actual employment status of non-declaring nurses.[106] We can give ranges within which the employment changes lie [see Figure 4]. At an upper limit, between 1994 and 1999:[107]

- Measured RN employment would drop 5,147 positions.
- Measured RPN employment would drop 1,388 positions.
- Total measured nursing employment would drop 6,535 positions.

If on the other hand, one assumed that the unemployment rate in the reporting and non-reporting populations were the same, then the drop would still be significant (for comparison, the unadjusted figures appear in brackets):

- RNs would lose 4,838 positions (3,895 loss).
- RPNs would lose 1,032 positions (156 loss).
- Total nursing employment would be down 5,881 positions (4,051 loss).

Even if non-reporters were twice as prone to unemployment as were reporters, the corresponding understatement of job loss would be large.

A Shift away from Full-time Permanent Employment

The employment situation looks bleaker still when considering the split between full-time, part-time and casual.[108] While employment has fallen, the number of full-time jobs has dropped even faster.

- The measured number of full-time RN positions dropped by 3,194, from 42,328 in 1994 to 39,134 in 1999 (a 7.5% drop) [see Figure 5].
- For the RPNs over the same period, reported full-time positions fell by 237, from 12,365 to 11,869 (a 4.0% fall).

Reported Full-Time Employment			
Year	**RNs**	**RPNs**	**Total**
1994	42,328 (54.1%)	12,365 (51.5%)	54,693 (53.5%)
1995	43,367 (54.5%)	12,821 (51.9%)	56,188 (53.8%)
1996	42,599 (53.0%)	12,834 (51.2%)	55,433 (52.6%)
1997	40,006 (51.2%)	12,311 (49.9%)	52,317 (50.9%)
1998	39,155 (50.0%)	12,128 (48.3%)	51,283 (49.6%)
1999	39,134 (50.3%)	11,869 (47.4%)	51,003 (49.6%)
1994-99	**-3,194**	**-496**	**-3,690**

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

The percentages in the brackets represent the share of total nursing employment that is full time. The figures for declines in full-time employment are very conservative, because of the large increase in the reporting rate on full-time/part-time status (e.g., rising from 95.3% of RNs reporting employment in 1994 to 99.5% in 1999).[109] The share of RN jobs that are full-time dropped over the period from 54.1% to 50.3%; this has been dropping steadily over time (58.9% in 1986). RPNs suffered a smaller drop, from 51.5% in 1994 to 47.4% in 1999.

One could make corrections for non-reporting. Below are the 1994-99 changes in full-time positions, based on the assumption that the employment characteristics of the reporting and non-reporting groups are the same (for comparison, unadjusted figures appear in brackets):

- Now, the estimated number of full-time RN positions lost is 5,716 (3,194 loss).
- The estimated number of full-time RPN positions lost is 1,623 (496 loss).

The Drop in Full-Time Equivalents

Data on full-time equivalent positions (FTEs) are not available for nurses. Extending an approximation used by the Ministry of Health and Long-Term Care[110], this paper assumes that non-full-time nurses are working half-time. This allows us to arrive at a conservative estimate of the downward trend in nursing FTEs. The drop in employment becomes clearer [see Figure 6]:

- The number of estimated RN FTEs has fallen from 63,823 in 1992 to 58,563 in 1999.
- The number of estimated RPN FTEs has been more volatile. It has fluctuated widely, but with a general downward trend since 1987 (going from 20,130 to 18,491 in 1999).

Reported Full-Time Equivalents (Estimated)			
Year	**RNs**	**RPNs**	**Total**
1994	61,181	18,512	79,693
1995	61,928	19,019	80,948
1996	61,817	19,122	80,939
1997	59,636	18,746	78,382
1998	58,982	18,751	77,732
1999	58,563	18,491	77,054
1994-99	**-2,618**	**-21**	**-2,639**

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

As with numbers of jobs and full-time positions, the estimates are conservative, as they aren't corrected for non-reporting of data.

A Shift to Part-Time Employment

The amount of reported part-time nursing employment is alarmingly high. It has risen steadily, by 4,508 positions, between 1994 and 1999. This is remarkable, given that total reported nursing employment conservatively fell by 4,051 positions and that full-time employment also fell sharply – conservatively by 3,690 positions. The share of nursing employment that is part-time has risen to an astounding 36.2% from 31.9% in the 1994-99 period.

- RN part-time employment rose from 24,986 to 28,024 in the given period.
- RPN part-time employment rose from 7,703 to 9,173 over the same period.

In the following table, the numbers in brackets are shares of total employment.

Reported Part-Time Positions			
Year	**RNs**	**RPNs**	**Total**
1994	24,986 (31.9%)	7,703 (32.1%)	32,689 (31.9%)
1995	25,788 (32.4%)	8,255 (33.4%)	34,043 (32.6%)
1996	26,776 (33.3%)	8,482 (33.8%)	35,258 (33.4%)
1997	26,811 (34.3%)	8,642 (335.0%)	35,453 (34.5%)
1998	27,888 (35.6%)	9,042 (36.0%)	36,930 (35.7%)
1999	28,024 (36.0%)	9,173 (36.7%)	37,197 (36.2%)
1994-99	**3,038**	**1,470**	**4,508**

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

Casualization of Employment —Turning the Corner?

The degree of casualization of nursing employment has virtually doubled over the past decade, although the trend may now be reversing itself. From levels in the 7% range during the 1980s, it rose to the 14% range in recent years, most of it in the RN category. The following table shows recent trends. The terms in parentheses are the shares of total employment that is casual. The numbers are disturbingly high for a profession that knows the importance of continuity of care.

Reported Casual Positions			
Year	**RNs**	**RPNs**	**Total**
1994	10,992 (14.0%)	3,943 (16.4%)	14,935 (14.6%)
1995	10,471 (13.2%)	3,642 (14.7%)	14,113 (13.5%)
1996	11,038 (13.7%)	3,753 (15.0%)	14,791 (14.0%)
1997	11,394 (14.6%)	3,705 (15.0%)	15,099 (14.7%)
1998	11,307 (14.4%)	3,965 (15.8%)	15,272 (14.8%)
1999	10,655 (13.7%)	3,986 (15.9%)	14.641 (14.2%)
1994-99	**-337**	**43**	**-294**

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

Note that numbers for full-time, part-time and casual positions do not add up to total employment figures. This is because some of those nurses who report that they are employed do not specify whether they are employed on a part-time, full-time or casual basis.

Shifts in Employment between Sectors

Employment has shifted between sectors over the period 1994 and 1999.

- The hospital sector saw a substantial drop in employment (4,997 RN positions and 1,328 RPN positions lost).
- In long-term care, the private nursing home sector experienced rises in RN employment of 727 positions and in RPN employment of 890 positions.
- In the retirement home sector there were gains of 212 RN positions and 349 RPN positions.
- The public homes for the aged sector experienced a substantial drop (down 593 RNs and 102 RPNs).
- The home care sector gained 652 RN positions and 636 RPN positions.

For the reported distribution of total nursing employment, see Figure 7. Again, recall that the usual qualifier about using this self-reporting data applies.

Assessment: The strong downward trend in nursing employment, and the shift to part-time and casual employment are factors explaining the leap in job stress and dissatisfaction experienced by nurses in recent years. This is all the more problematic when one considers the steady growth and aging of Ontario's population. There is also a trend for employment to move out of hospitals and into the community sector, where wage rates are even lower. In the community sector, there is a trend away from care provision by public and non-profit institutions, and toward for-profit institutions. More exact measures of these trends await a commitment to data collection and dissemination. However, the existing data is sufficient to indicate a very strong trend.

Factors Influencing the Need for Nurses

Ontario has recognized that its current level of nursing staffing is too low. It has accepted the recommendations of the Nursing Task Force that it should invest $375 million on new nursing positions. This would be intended to deliver about 7,700 new RN positions and 2,541 new RPN positions. The objective of the spending was to bring Ontario up to the 1997 national average, in terms of nurse/population ratios.[111] Thus, there is an immediate need for an increase of over 10,000 new nurses. Hence, demand has risen by over 10,000 positions (In fact, the province committed to creating "nearly 10,000" new jobs during 1999, and 12,100 new nursing positions by the end of 2000/2001.[112]).

Population Growth

The population of Ontario has been rising at between one and 2% per year. Everything else being equal, nursing need would rise by the same rate; population growth ought to give rise to proportional increases in nursing employment. Statistics Canada predicts that the Canadian population will grow by 16.89% between 1998 and 2011. Ontario has been growing more rapidly than other provinces, so a baseline increase in nursing needs of 16.89% would be conservative. Ontario continues to be a magnet for immigrants, who are driving much of the population growth.

Aging of the Population

Furthermore, the Canadian population is aging. Statistics Canada predicts the share of the population over 74 to be 6.48% in 2011, up from 5.32% in 1998. This is critical, as a high percentage of total health-care expenditures are for people over 74.[113] Already, the share of care consumed by the elderly is increasing. For example, between 1995-96 and 1998-99, for those 65 and over, the share of separations rose from 29.47% to 32.34%, and the share of days of care rose from 50.04% to 52.43%.[114] As the Baby Boom bulge moves into retirement and beyond, the situation will worsen markedly.

The contribution of aging to real per capita health-care costs is conservatively estimated in the range of 1% per year.[115] While this is not as great as some might believe, it is significant, particularly when health-care cost control has become a major issue. The cumulative effect over a dozen years of annual 1% increases is not to be dismissed. Of particular interest to us here is the impact on nursing need. The Canadian Nurses Association has estimated that Canadian nursing need will grow twice as fast as the population in order to accommodate both aging and population growth.[116] Thus, if the population were expected to grow 16.89% then nursing need would grow by 33.78% – 16.89% to account for population growth and a further 16.89% to account for aging. The age distribution is sufficiently similar between Ontario and the rest of Canada for this estimate to hold for Ontario.

Rising Acuity

Patient acuity has risen, which requires more nurses.[117] The rise in acuity shapes and increases nursing need for a variety of reasons. First, the population has aged, as just noted; part of the acuity effect will be incorporated into the above aging effect. Second, advances in science are allowing people who require much assistance to live longer, thus requiring more nurses. Third, restructuring has changed the locus of acuity, even if it doesn't affect the level of need. Those who remain in the hospital sector need more intense care of all types. Furthermore, the public health, homecare, and long-term care sectors are all now dealing with more acute patients, particularly many of those who were formerly cared for in hospitals.

The Impact of Technology

Technology has an ambiguous impact on nursing demand. It does create new procedures, which requires nurses to train in new areas, and may create new nursing demand. As we have observed, technology also allows many high-need patients to survive. This is a good thing, but does require greater nursing intensity. Some new technologies are nursing-intensive. However, other technologies do economize on nursing services in several ways. For example, more sophisticated electronic monitoring allows nurses to monitor more patients than they could have done in the past. Another example would be surgical advances that involve less invasive procedures, thus reducing and at times eliminating hospital stays.

The net effect of technological change on nursing demand is not clear, but widespread reports of overworked nurses would suggest that any net positive nurse-economizing effect is very weak. Certainly, the caring component of nursing is subject to very weak benefits from technological change.

Cultural Diversity

Cultural diversity has been a reality in Canada and in Ontario for centuries. First Nation communities and French-speaking Ontarians have a long history of difficulties in accessing culturally relevant health-care services. Nurses who provide care in First Nation communities often report experiencing a clash of cultures. Issues include difficulty accepting nurses coming from outside of the community, the rejection of certain treatments, and the reality of practising in very isolated settings. In addition, many French-speaking Ontarians, who have lived all their lives in this province, are unable to access health-care services by French-speaking providers.

Added to the long-standing difficulties in providing culturally relevant care to First Nation and Francophone Ontarians is the great diversity of cultures from all over the world, as a result of so many individuals who have chosen to make Ontario their home. The health-care system, already stressed by cutbacks in funding and by growing need, also must deal with the very rapid changes in the cultural mix of Ontarians. Those providing and those receiving care must deal with communication difficulties at all levels: linguistic, cultural, etc. Some cultural minorities are marginalized for a variety of reasons, including a lack of contacts, a lack of economic and political power, and discrimination. These groups are vulnerable to greater illness and to difficulties in accessing health-care as readily as other Ontarians.

Even when cultural minorities do access the health-care system, there are challenges in making the system work for them. This is true at all levels of care across all sectors. In the literature on culturally appropriate care, certain key elements or functions emerge: cultural assessment, cultural knowledge, communication and partnership.[118] Jean Watson eloquently describes the essence of providing culturally relevant care in the following words:

> To care for someone, I must know who I am. To care for someone, I must know who the other is. To care for someone I must be able to bridge the gap between myself and the other.[119]

Education at all levels is part of the answer: health-care workers, health-care students (via curriculum changes adding multicultural content to programs), educators, and health-care managers all need to develop skills in delivering culturally appropriate care. Data collection on cultural diversity and health-care is another part of the answer (this would include getting an adequate cultural picture of the health-care workforce).

However, another very significant step can be taken at the human resources end: active recruitment of health-care professionals from underrepresented cultural groups. As financial barriers are prohibitive for many marginalized groups, some equitable method must be found to allow students of all means to have access to nursing education. These recruits would bring much of the cultural knowledge, communication skills and cultural assessment skills that we require. Furthermore, they could help their colleagues develop their own skills in this area, which would make "cultural upgrading" quicker and more efficient. Finally, they are a very visible assurance to diverse groups that their cultural and health needs will be addressed effectively.

The Net Impact on Need

Consider the year 2011 as a benchmark, and compare it to 1998.[120] Recall that 10,000 catch-up positions were needed immediately in 1998.[121] Recall also that by 2011, in Ontario, the number of nursing positions would have to increase by a net 16.89% (after retirements and other withdrawals from the system), simply in order to keep pace with population growth. As we pointed out above, by the reckoning of the Canadian Nurses Association, nursing employment would have to rise a further 16.89% to accommodate aging of the population. This would translate into about a 2.26% annual growth rate in nursing employment. This would be in line with internal Ministry of Health and Long-Term Care estimates showing that health-care spending will have to rise from a stated current level of $21 billion to approximately $40 billion in 2015.[122] These latter figures imply an annual growth rate of about 4.1%. Assuming wage inflation is less than 1.8% per year among nurses, (which has been true for many years), then the projected growth in needed nursing employment is conservative and well within Ministry projections.

As to departures from nursing, we have a range of estimates for age of retirement for nurses. The figure of 55 years is commonly used. A recent personal communication from the College of Nurses of Ontario yields a 1998 average retirement age of 58.5 for RNs and at 57.5 for RPNs. This gives us a more optimistic situation. Based on the latter figures, we might expect on average the following: those RNs over 45.5 years of age in 1998 and those RPNs over 44.5 years of age in 1998 would retire by 2011. This would roughly translate into about 42.74% of the RNs and 45.35% of RPNs employed in 1998 in Ontario.[123] This in turn would imply a loss of over 33,000 RNs and over 11,000 RPNs, for a total of over 44,000 nursing retirements.[124] Even if nurses all stayed until the

mandatory retirement age of 65, almost 20% of RNs and 17% of RPNs would retire by 2011, which would translate into a minimum loss of over 20,000 nurses.[125] [126] This is an unattainable minimum.

To sum up, the nursing demand will rise by 10,000 immediately (to 114,864, based on 1998 nursing employment; this is conservative). By 2011, need would rise a further 16.89% for population growth -- 19,400 nurses. Add to this another 19,400 for the effect of population aging (or half of this number -- 9,700 to get a conservative lower bound). To sustain this net increase of 39,100 to 48,800 nurses, we will need to replace nurses leaving the system, which could be another 20,000 to 44,000 through retirement (assuming more nurses don't leave due to other reasons such as unattractive working conditions, and assuming that none of the new recruits retire). Thus, there is a range of needed recruitment for nurses. At the low end, if we allow only for a partial increase in nurse employment to accommodate population aging, and if we are able to retain all nurses to formal retirement age, then we would only need to recruit 59,100 nurses. This is very optimistic, and provides minimal service. At the upper end, if we increase nursing employment to accommodate an aging population, and if nurses continue to retire at the current rate, then we would have to find 92,800 nurses:

Recruitment Needs for Nurses

Factor	Low Estimate	Higher Estimate
Base Increase	10,000	10,000
Population Growth	19,400	19,400
Aging Population	9,700	19,400
Replacing Retirees	20,000	44,000
Total	**59,100**	**92,800**

Of course, these figures are sensitive to the underlying assumptions. There is no allowance for acuity changes apart from those implicit in aging. On the other hand, improved retention strategies would certainly lower the need for recruitment (from the higher estimate). From above figures, a strategy that kept all nurses in nursing until their formal retirement age would raise the nursing workforce in the year 2011 by over 20,000 nurses. We can be sure to need to recruit more than 60,000 nurses.

Recruitment efforts must be substantial but not heroic. To recruit in the range of 60,000 to 90,000 nurses over 12 years will entail hiring between 5,000 and 7,500 nurses per year -- the kind of effort currently undertaken in Ontario. About 6,000 nurses per year were recruited in the late 1980s and early 1990s. These figures fell off drastically in the latter half of the 1990s [see Figure 8]. Notably, recruitment of Ontario graduate recruits fell to 3,066 by 1999. Ontario will have to both consider increasing the number of nursing

positions available in nursing schools, and find ways to attract graduates from inside and outside of Ontario.

Assessment: In order to adequately deal with the nursing shortage, we need to recruit in the range of 5,000 to 7,500 nurses per year. Improved retention strategies will reduce this number, but the level of recruitment will have to return to levels of a decade ago. We must also work to ensure that those recruited into the profession reflect the cultural diversity of the population at large.

The Supply for Nursing Services: The Numbers

Declining Numbers in the Nursing Sector

Nursing supply has fallen steadily over the past number of years in Ontario. There are many measures of nursing supply and nursing employment available, and they tell an interesting story.

Total Nurse Registration

Total registration of nurses in Ontario peaked at 150,416 in 1994. It dropped by 11,344 nurses, to 139,072 by 1999. This is comprised of a drop of 7,892 RNs and 3,452 RPNs [see Figure 9]. Total registration is a measure of short-run nursing supply.

Nursing Registrants in Ontario

Year	RNs	RPNs	Total
1994	113,823	36,593	150,416
1995	113,052	36,066	149,118
1996	111,486	35,392	146,878
1997	109,098	34,623	143,721
1998	106,829	33,781	140,610
1999	105,931	33,141	139,072
1994-99	**-7,892**	**-3,452**	**-11,344**

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

The Downward Trend in Nursing Registration

Here we examine the components of the downward trend in nursing registration. The change in numbers of nurses can be broken down into new registrants and non-renewing nurses. New registrants comprise new graduates and entrants from out-of-province. The number of new registrants peaked at 6,533 in 1991 (4,828 RNs and 1,705 RPNs). The general trend has been downward since that time, to a low of 3,908 (2,771 RNs and 1,137 RPNs) in 1999 – a 40% drop. This does not bode well for the future of nursing in the province. Registration from out-of-province also peaked in 1991 at 2,021 (1,843 RNs and 1,527 RPNs), and fell steadily to 672 in 1998 – a 67% drop (544 RNs and 128 RPNs). It rose somewhat in 1999 to 842. This is a particularly sensitive indicator of the relative attraction of Ontario to nurses.

While we lack very complete data on Ontario nurses leaving this jurisdiction to work elsewhere, available information suggests a significant outflow. At the national level, a large net outflow is reported. This includes a significant portion of the nursing graduate classes. Given that the situation has been tougher in Ontario than in the rest of Canada, there must be a significant outflow here. College of Nurses of Ontario figures show the number of nursing registrants working outside Ontario jumped 53.3% from 5,303 (5,023 RNs and 280 RPNs) in 1992 to 8,130 (7,697 RNs and 433 RPNs) in 1998. Given that nurses working outside of Ontario are not obliged to register in Ontario, there are certainly many more Ontario nurses working outside the province. The number of Ontario nursing registrants working out of province fell to 7,215 in 1999. One hopes that the recent change reflects a perception of improvements in work possibilities in Ontario.

New Graduates

New Ontario nursing graduates have always been a more significant source of entrants; their numbers peaked at 4,558 in 1993 (2,884 RNs and 1,674 RPNs), and have generally trended downwards since that time. Only 3,066 Ontario graduates registered with the CNO in 1999 (off 23% from 1993) (2,041 RNs and 1,025 RPNs). As nursing education takes some time to complete, the number of registering graduates would represent a lagged indicator of perceived employment attractiveness [see Figure 10].

Exits from Nursing

Far more significant from the point of view of total registration is the number of exits from the profession. The data on non-renewing nurses is very volatile, and is responsible for the overall volatility in the net change in nursing registrants. The graph clearly shows that every peak in the number of non-renewing nurses is matched with a trough in the change in the number of total registrants, and vice-versa. These swings closely match changes in circumstances in the nursing market. For instance, when the market worsens, the number of exits rises. The magnitude of exits is also much greater than that for new registrants. For example, between 1996 and 1998, well in excess of 7,000 nurses failed to renew registration every year – over 5,000 RNs and around 2,000 RPNs each year. Non-renewals

have risen from about 2% of total registrations in 1994 to over 5% from 1997 onwards. The percent non-renewal has been higher of late for RPNs (i.e., 6.3% in 1998, compared to 4.8% for RNs). There was a dramatic 122% increase in non-renewals, from 2,928 in 1994 to 7,380 in 1998. This was comprised of a jump from 2,349 to 5,216 for RNs and from 579 to 2,164 for RPNs. This trend is alarming, as it precedes the departure of the baby boom bulge in nursing ranks. We can expect an increase in non-renewals as increasing numbers of nurses retire.

There is a silver lining here. In 1999, the number of non-renewals fell from 7,380 to 5,446. This could reflect a reduction in pessimism about prospects for nurses in Ontario, as a result of policy changes towards nursing.

Nurses Seeking Nursing Employment

The overall supply of nurses is dropping, as is the number of nursing registrants without nursing employment (dropping from 20,838 in 1994 to 17,267 in 1999). Among those nurses lacking nursing jobs, there remains a significant number currently looking for work. In 1999, 5,072 nurses declared themselves to be seeking nursing employment. While this is down from 6,383 job seekers in 1997, it is still above historical levels [for data on nurses lacking nursing employment, see the following table and Figure 11].

The recent downward trend in job seeking has a disturbing correlative: an upward trend in the number of registrants who are not seeking nursing employment. This suggests that nurses are increasingly turning their backs on careers in nursing.

Combine these three facts: nursing employment continues to fall; the number of nursing registrants is dropping; while those who remain registrants are shifting away from seeking nursing employment. While many continue to seek work in nursing, others have increasingly turned away from Ontario and away from nursing. A reasonable inference would be that employment opportunity and work circumstance were significant factors in the latter decisions.

The following table shows recent trends among nurses who lack nursing employment. The numbers in brackets are the shares of total registrants who fall into the given categories.

Nurses Lacking Employment in Nursing			
Year	**Without nursing jobs**	**Seeking nursing jobs**	**Not seeking nursing jobs**
1994	20,838 (15.3%)	4,723 (3.5%)	12,024 (8.8%)
1995	20,183 (15.0%)	5,559 (4.1%)	10,744 (8.0%)
1996	18,504 (13.9%)	5,410 (4.1%)	9,285 (7.0%)
1997	18,909 (14.3%)	6,383 (4.8%)	8,381 (6.3%)
1998	19,426 (14.7%)	6,117 (4.6%)	8,822 (6.7%)
1999	17,267 (13.5%)	5,072 (4.0%)	9,239 (7.2%)
1994-99	**-3,571**	**349**	**-2,785**

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

Recall also that there is a growing pool of nurses having only part-time or casual work. Over 50% of employed nurses only have part-time or casual work. Many of these nurses would prefer full-time work. To its credit, the Ministry of Health and Long-Term Care has recognized that most nurses do not want casual employment. Recruiters should consider this pool of trained, working nurses as a significant part of the potential solution to the nursing shortage in the short run.

Assessment: As circumstances and opportunities for nurses in Ontario have deteriorated over recent years, nurses have been voting with their feet. They have been increasingly leaving the profession or moving to new jurisdictions. At the same time, fewer nurses each year have been entering the Ontario market, either as students or as migrants. Increasing numbers of nurses who are still registered are no longer interested in nursing. It will take a substantial commitment to nursing to permanently reverse the negative trend.

Enrolments in Nursing Programs

The key to the future supply of nurses in Ontario is the level of enrolments in Ontario nursing education programs. As noted above, the number of Ontario nursing graduates registering in Ontario has dropped sharply since 1993. The future looks even bleaker, as the number of nursing students has been trending downward over the same time period, with only a slight up-tick in 1998-99.

Autumn RPN enrolments dropped 22% from 1,441 in 1995 to 1,128 in 1997, before rising to 1,187 in 1998. However, if one considers new entrants, the drop is sharper. In 1997, first-year fall enrolments fell 34.6% below their 1994 levels. They recovered to 70.4% of their 1994 level in 1998. From the point of view of current interest, the numbers of new

entrants is a good indicator. From 1995, the number dropped 24.2% by 1997, before rising to 77.1% of its 1995 level in 1998 [see Figure 12].

Fall Practical Nurse Enrolments in Ontario Community Colleges

Calendar Year	Year 1	Year 2	Total	Year 1 as % of 1994	Entrants	Entrants as % of 1996
1994	1,380		1,380	100%		
1995	1,441		1,441	104.4%	1356	100%
1996	1,290		1,290	93.5%	1169.5	86.2%
1997	903	225	1,128	65.4%	1027.5	75.8%
1998	972	215	1,187	70.4%	1045	77.1%

Data source: Ministry of Training, Colleges and Universities, Ontario.

For RNs, the trend is similar: there were 5,734 university enrollees in 1995-96 and 5,171 in 1998-99 (this latter number was up marginally over the previous year, although this reflected a rise in part-timers and a fall in full-timers; this is not positive news) [see Figure 13]. At this point, we do not have figures that allow us to separate out post-RN students who are already nurses, but upgrading their certification. While the upgrading is desirable, these students cannot be considered new recruits.

At the community college level, total fall enrolments in RN programs continue to drop from 7,826 in 1994 to 4,733 in 1998 (a 40% decline [see Figure 14]). The one positive feature here is the 1998-99 reversal in first-year autumn enrolments, which went up to 1,987 from 1,626 the previous year. However, this is a far cry from the enrolment of 2,831 in the autumn of 1994 [see Figure 15]. Figures 16 and 17 demonstrate the sharp decline in enrolments in the second and third years of the RN programs.

As with RPN students, the number of new RN entrants is the most sensitive indicator of current interest in nursing programs. From 1995 to 1997, the number of new entrants dropped by 41.3%. The number of new entrants to RN programs recovered to 66.6% of its 1995 level in 1998. This remains a striking overall decline from 1995, the first year for which we have entrant data.

Fall Nursing Enrolments (RN) in Community College Programs

Calendar Year	Year 1	Year 2	Year 3	Year 1 as % of 1994	New Entrants	New Entrants as % of 1995
1994	2,831	2,542	2,453	100%		
1995	2,794	2,314	2,131	98.7%	3038.5	100%
1996	1,947	2,097	1,954	68.8%	2260	74.4%
1997	1,626	1,621	1,700	57.4%	1784	58.7%
1998	1,987	1,396	1,350	70.2%	2023	66.6%

Data source: Ministry of Training, Colleges and Universities, Ontario.

A more reliable indicator of enrolment is the number of full-time equivalents registered in school. Available figures show a steady decline in college RN FTEs from 1991-92 to 1998-99 (from 9,621 down to 5,207) [compare to total enrolments in Figure 14]. As community college programs closely reflect market realities, this is a strong indicator of falling employment opportunities for nurses. The only upturn in college RN programs is for first-year FTEs, which dropped from 2,794 in 1995 to 1,626 in 1997, before recovering to 1,987 in 1998 [see Figure 15; for second and third years, see Figures 16 and 17]. Practical nurse FTEs are not currently available to us.

Enrolment FTEs at the university level followed a steadily declining pattern at the BScN level. They dropped from 3,763 in 1995-96 to 3,201 in 1998-99.

In sum, we can expect a decline in nursing graduates for a few years, as current enrolments have fallen so far. A quick reversal of this situation is essential. Fortunately, the situation is not beyond repair. Figures just out for the new academic year show nursing applications to be rising. First-choice applications are up 22% at the university level and 9.1% at the college level.[127] These figures are still far off their 1995 levels, but the growth in nursing applications exceeds the growth of applications to all programs.

At this writing, we do not have figures available for 1999-2000 enrolments. However, we do have the number of confirmations for college nursing programs. Confirmations are down for both RN and RPN programs from 1998 (from 2,445 to 2,380 for RNs and 1,245 to 1,127 for RPNs). This trend runs counter to application totals. While confirmations do not translate one-for-one into enrolments, the trend is of concern. Rising interest in nursing training will not solve the nursing shortage if there are insufficient nursing seats. Already, there are reports from other provinces, such as Alberta, that there is a shortage of nursing seats.

Assessment: Nursing education enrolments have dropped precipitously, in response to a deteriorating employment situation. This situation has grave consequences for future nursing supply. There are signs that supply might be turning around, but this can only happen if employment prospects credibly improve and if there are sufficient new nursing seats. It will take time for the effects of a reversal to be felt, so strong corrective measures must be introduced immediately.

Preventing a Major Nursing Shortage

Nurse Employment Lags behind Population Growth

The population to practicing RN ratio has been steadily worsening. In 1987, the ratio was 122.5 people per RN. By 1999, it had risen to 147.7 people per RN – an 20.6% increase. In the process, Ontario acquired the worst ratio in the country.[128] The deterioration of the ratio for full-time RNs is much worse: it jumped from 210.0 to 295.1 – a 40.5% increase in the number of people per nurse.

For RPNs over the period 1987 to 1999, the population-to-nurse ratio worsened from 375.8 to 458.5 people per RPN – a 22.0% increase. The deterioration of the ratio for full-time RPN positions was even worse. It was 654.5 in 1987 and 973.0 in 1999 – a 48.7% increase [for ratios of population to nurses, see figure 18].

Competition from Other Jurisdictions

Competition from other jurisdictions for nursing services represents a further challenge to health-care providers. Of late, nurses have increasingly been leaving the province, although we lack exact measures. We do know that the fraction of Ontario registrants working out of province rose from 4.1% in 1992 to 6.1% in 1998, before falling back to 5.6% in 1999). The phenomenon was noted in the Brain Drain report released by the Conference Board of Canada on August 16, 1999. Nurses are over-represented among Canadians working abroad. A recent survey by Statistics Canada of the 1995 graduating class showed that almost one fifth of those who went to the US for work were nurses.[129] At this point, we don't know how many of them came from Ontario, but we do know that 57% of the 1995 college and university graduates who went to the US came from Ontario. Given the poor Ontario nursing job market at the time, and low base wage rates, it would be reasonable to guess that many of those moving to the US for nursing employment were from Ontario.

A recent study for the Canadian Nurses Association[130] confirms observed trends at the national level. Almost two thirds of graduates working part-time were doing so involuntarily, in spite of the fact that a quarter of all graduates found themselves working part time. Between 1995 and 1997, about 9.3% of nursing graduates moved to the US.

This compares with 1.3% of other graduates. Of the 9.3%, 61% lacked full-time positions in Canada. Graduates working as RNs were earning less in 1995 than graduates in all other occupations. Of the pool of graduates surveyed 2 years after graduation, nurses reported lower satisfaction than all other occupations.

The foregoing shows that the nursing crisis is a nation-wide phenomenon. However, the situation is worse in Ontario, where the nurse:population ratio is the lowest in the country. It is not only work circumstances that put Ontario at a competitive disadvantage. For a wealthy province with a higher cost of living throughout much of the jurisdiction, the base wage rate is surprisingly low. The current minimum rate has just recently risen to $20/hour from $18.30 in hospitals, for contracts between the Ontario Nurses' Association and the Ontario Hospital Association. Until recently, Ontario had a lower minimum than the equivalent minima in all but three provinces (Quebec, Newfoundland and PEI). As a comparison, the BC and Alberta minima were respectively $20.98 and $19.66. Government of Canada contracts had much higher minima. Much better circumstances – better wages, full-time employment and better professional development opportunities – await nurses moving to the US. The College of Nurses of Ontario has noted that opportunities for full-time work and professional development appear to be significant factors in nurses' moves to the United States.[131]

Many nurses report that they find that support for further training and education is better in American hospitals than it is in Ontario.

Job Stress and Sick Time

As previously discussed, nurses are suffering disillusionment and burnout within the current practice environments. Other than departures from the profession, this is also evident through the increase in sick time taken. The Ontario Hospital Association collects figures on sick time, but as of this writing, we have been unable to obtain them.

The Risk of a Major Nursing Shortage

The Ontario government has acknowledged that nursing employment in the province is far too low. It has accepted the recommendations of the Nursing Task Force that 10,000 more nurses must be hired. (As noted above, the government has committed to hire 12,100 more nurses before the end of 2001.). Given the trends noted above, there is a risk of a major provincial nursing shortage in the coming years. The Canadian Nurses Association predicts a shortage of nurses in Canada of between 60,000 and 113,000 by the year 2011, unless action is taken.[132] Ontario currently has the lowest nurse/population ratio in Canada. In 1998, there were 145.5 people per RN in Ontario, compared with 133.6 for Canada as a whole and 127.3 for the rest of Canada. That was about 9% worse than the national average and about 14% worse than the average of the rest of Canada. Ontario is also the second fastest growing province, after British Columbia. Thus, allocating to Ontario a share of the shortage in proportion to its current population would be quite conservative.

Given that Ontario has 37.76% of the population of Canada, this would translate into an Ontario shortage of between 22,655 and 42,670 nurses by 2011. Estimates in this report imply that 60,000 to 90,000 nurses would have to be hired by 2011, in order to keep Ontario at the nurse/population ratio that prevailed in Canada in 1997. This is the benchmark that the government accepted, and it is a very conservative one. However, meeting even this modest benchmark will require serious attention to recruitment and retention issues, as the numbers above show.

The Growing Deficit of Nursing Employment

While the above measures of nursing shortage are striking, they are small in comparison with the lag between nursing employment and population growth. Certainly, given that the population is aging and that acuity among patients is rising, it seems very conservative to seek to maintain population-to-nurse ratios. However, as we have seen, there has been a considerable deterioration of these ratios over the period for which we have data (1986-99). The effects of this deterioration can be seen very clearly if we compare nursing employment under constant population-to-nurse ratios with the actual nursing employment. The gap is a measure of the shortage of nursing employment. The chasm that has opened up between 1986 and 1999 is double the size of the proposed employment increase. Little wonder that nurses report being run off their feet, and little wonder that so many of these experienced health professionals are either leaving the country or are leaving the profession. The table below outlines the size of the various deficit measures.

We develop three measures of the nursing gap that has emerged since 1986. First, consider the growing shortage of nursing jobs (casual, part-time and full-time). RN employment was 75,935 in 1986. If the same population-to-nurse ratio were maintained, by 1999, RN employment would have been 92,919. Instead, it was 78,174, implying a 14,745 deficit (15.9%). Similarly, the deficit for RPNs had grown to 6,280 by 1999 (20.0 %). This gives a total deficit of 21,025 (16.9%), which is more than double the number of new nursing positions promised by the end of 1999 [for total nursing data, see Figure 19].

The picture is even more striking when we consider the second measure – full-time employment. The number of full-time RN positions actually fell from 44,338 in 1986 to 39,134 in 1999. To maintain the same population-to-nurse ratio, the number of full-time jobs should have risen to 54,255. Thus, the shortage of full-time RN jobs had grown to 15,121 positions (a 27.9% deficit). In similar fashion, the RPN deficit had grown to 5,954 full-time jobs (a 33.4% shortfall). In total, the 1999 deficit was 21,074 full-time positions (a 29.2 % shortage) [for total nursing data, see Figure 20].

Finally, we have estimated the number of FTEs.[133] The result is that 1999 RN FTEs lagged behind their 1986 proportional level by 14,790 positions (20.2%). RPN FTEs were 5,978 below their 1986 proportional level (24.4%). In total, there was an estimated deficit of 20,766 nursing FTEs, which is 21.2% below the 1986 comparator. Since the nurse:population ratio is at less than 80% of its 1986 level, nurses currently are expected to take care of more than 25% more members of the public than they were in 1986 [see Figure 21].

Note that for all the above are very conservative measures of the increased burden on nurses, as the public has aged and the level of acuity in the province has risen.

The Growing Employment Deficit in Nursing

Employment Type	Group	1986	1999 Employment at 1986 Ratio	Actual 1999 Employment	Deficit	% Deficit
Total Jobs	**RNs**	75,935	92,919	78,174	14,745	15.9
	RPNs	25,717	31,469	25,189	6,280	20.0
	Total	101,652	124,388	103,363	21,025	16.9
Full-Time Jobs	**RNs**	44,338	54,255	39,134	15,121	27.9
	RPNs	14,565	17,823	11,869	5,954	33.4
	Total	58,903	72,077	51,003	21,074	29.2
FTEs	**RNs**	59,945	73,353	58,563	14,790	20.2
	RPNs	19,996	24,468	18,491	5,978	24.4
	Total	79,940	97,820	77,054	20,766	21.2

Data source: College of Nurses of Ontario, *Annual Overview*, various years.

Assessment: No matter how the discrepancy between need and existing employment is measured, the gap has widened dramatically. Conservatively, nurses were expected to cover 25% more of the population in 1999 than they were in 1986. These statistics leave no doubt that nurses' sense of being spread far too thinly is well founded.

Recruitment and Retention Issues

It is evident that availability of employment and the prospect of employment are key factors in determining the supply of nursing services. The data for 1986-99 are clear. When Ontario employment prospects are better: nurses are attracted to the province; students are attracted into nursing programs; and nurses stay with the system. When the employment situation deteriorates: nurses leave the province; fewer nurses come to the province; fewer students enroll in nursing; and more nurses leave nursing. The recent commitments of more resources to nursing have had the predictable effect: applications to nursing programs are up sharply, and out-of-province nurses contemplate returning to Ontario. The concern is whether the supply response will be sufficiently rapid to meet increased demand in the near future.

Target Populations

There are six pools that will supply Ontario's nurses of tomorrow: currently employed full-time nurses; currently employed part-time nurses; Ontario nurses lacking nursing employment; Ontario nurses working out of province; other nurses working outside Ontario; and nursing students (and potential nursing students). The second largest pool (measured at 51,003)[134] contains those currently working full-time as nurses in Ontario. By ensuring that these nurses do not leave prematurely, we can greatly increase the actual volume of nursing services in the future.

The largest pool is the part-time and casually employed nurses (measured at 51,838), who could not only continue to work, but who could be called upon to work full-time. Based on the assumption that this pool is employed half-time, we could raise nursing services by a maximum of 25% by fully utilizing those nurses. This would amount to 26,000 more potential FTEs. Of course, not all of these nurses would be available for full-time work, but a significant portion of them is. Even recruiting 10-20% of them into full-time employment would translate into a very significant 2,600 to 5,200 increase in FTEs. The College of Nurses of Ontario found that 34% of RNs and 56% of RPNs for whom they had data in this pool would prefer full-time employment.[135] If this sample is representative, then over 20,000 casual and part-time nurses would be receptive to full-time employment. That could yield up to 10,000 FTEs from this pool alone.

Another large pool of potential nursing supply is unemployed nurses. CNO data show 17,267 nurses registered but lacking nursing jobs. One portion of this group offers limited prospects: those retired (2,956), those residing outside of Ontario (1,395 in 1998) and those who declared themselves not to be seeking nursing employment (9,239). While one would not focus major recruiting resources on these groups, if nursing employment circumstances in Ontario were to improve, one might in the future find potential recruits in this area. On the other hand, there were 5,072 Ontario nurses seeking employment in Ontario in 1999. These nurses should be prime targets for recruitment. CNO data found that, of the overall pool of nurses lacking nursing employment, 20% of RNs and 32% of RPNs cited lack of full-time employment as the reason for not working.[136] This would translate into 3,932 potential RN FTEs and 1,543 RPN FTEs (4,475 in total).

We do not have a measure of total number of Ontario nurses working outside of Ontario. We do know that in 1999, there were 7,215 of them who maintained their registration with the CNO. The simple fact that they have maintained their registration would suggest that many have not given up on coming back to Ontario. We have heard from a number of them, inquiring about the possibility of returning to Ontario. If 10% were drawn back, that would represent over 700 more nursing positions filled. There is a large pool of nurses working in other jurisdictions who might be attracted to come to Ontario. Only 842 came to Ontario in 1999 (21.5% of new registrants). This had been a more significant source of nursing supply in the past. For instance, in 1991, 2,021 nurses came from out of province, out of a total of 6,533 new nursing registrants (over 30% of the total). One should weigh carefully the options before pursuing this one aggressively. While "out-of-province" might be a source for more nurses, it has never been the dominant source of bodies.

Unless it is accompanied by immigration, the movement in could just as easily reverse itself. Furthermore, other jurisdictions might take umbrage at being raided. Nevertheless, outside recruitment might be considered as one tool to address the need to enhance cultural diversity within the health-care system. Of course, we are presently confronting aggressive recruitment of Ontario nurses from other jurisdictions.

Finally, Ontario nursing students represent the majority of future nurses in Ontario. Ontario nursing graduates comprised 78.4 % of new registrants in the province in 1999. Recruitment strategy must focus not only on currently registered students, but also on potential students in the future, and on access to nursing education. At current rates, the inflow from graduates is insufficient – only 3,066 in 1999. Five to seven thousand new nurses will be needed each year. At this point, falling enrolments threaten to leave a bigger gap. Most recent figures for total Ontario graduates are not encouraging. In 1997, 1,098 BScNs were earned, of which an unspecified number were post-RNs who already were part of the nursing supply. There were also 67 MAs and 69 diplomas/certificates granted by universities. Figures for college RN diplomas are not available, but the number of third-year nursing students had fallen to 1,350 by 1998. There have been less than 1,000 students enrolled in first-year programs in practical nursing in recent years. It would thus be optimistic to expect 3,500 nursing graduates in the next few years. Compared to a recruitment need of 5,000 to 7,500, this is inadequate.

In the next few years, perhaps half of the needed recruits can come from Ontario nursing school graduates. In the long run, the most viable alternative is to educate adequate numbers of nurses. This implies increasing seats in nursing programs. In the short run, there will be a shortfall in nursing graduates. The 2,000 to 3,000 other required recruits will have to come from other areas. As pointed out above, there is an abundance of potential help in the relatively short run – the pools of unemployed and underemployed nurses and of Ontario nurses working abroad.

To sum up, the immediate shortage of nurses could be readily met from existing pools of nurses. In 1999, there were over 5,000 nurses looking for work, with the potential for at least 3,700 FTEs. CNO data suggest that 4,475 FTEs could potentially come from this pool. Just 10% -20% upgrading to full-time status for the large pool of part-time and casually employed nurses would supply 2,600 to 5,200 more FTEs. CNO data suggest that this number could reach 10,000 FTEs. Drawing 10% of Ontario-registered nurses back into Ontario from abroad would yield 800 more filled positions. Recruitment from abroad in the past has brought more than 1,000 more FTEs than recent levels. All told, this represents a group of nurses upon whom one could reasonably count upon to fill 8,000 FTEs. As many as 16,000 FTEs could be available.

The simple creation of good permanent positions will be sufficient to attract many of them back. This strategy would also be the best single magnet for the increased enrolments required in nursing schools. The mere announcement of enhanced nursing spending caused a jump in applications to nursing schools. Announcements by themselves won't keep people in nursing, nor will they continue to generate lineups to apply for nursing programs. Nurses and potential nurses will wait for solid, credible changes.

Part V – The Educational Environment

The nursing educational environment is central to the recruitment and retention of nurses. Across the entire health-care spectrum patients are requiring increasingly complex care. Not only are patients more acutely ill than ever before, but care is being delivered in much more technologically complex, culturally diverse and rapidly changing environments. Nurses must possess the sophisticated knowledge and skills to think critically and respond effectively and efficiently. Educational programs are central to developing this ability. A high quality, comprehensive educational environment will attract prospective students to the nursing profession. In addition, facilitating access to ongoing educational opportunities at the post-basic and graduate levels, is key to retaining nurses. Nurses commonly report leaving a place of employment because they are dissatisfied with the lack of support for continuing education.[137] As evidence of the importance of continuing education access, sixteen hospitals that utilized concrete, continuing education programs successfully attracted and retained nursing staff during a severe shortage.[138]

Clearly, long-standing issues in entry level and ongoing nursing education must be addressed in order to attract and retain nurses within the profession.

Entry Level

The educational history of both RNs and RPNs includes the reality of dual exits from educational programs, into the profession. The RPN stream, although seen as post secondary education, has included programs in both colleges and secondary schools leading to a certificate. RNs have received their preparation in both colleges, leading to a three-year diploma, or universities, leading to a four-year honours degree.

This duality has had serious implications for recruitment into the profession. Those who guide students through their career choices have found these educational program differences to be confusing. To stakeholders outside the profession, this has sent an unclear signal regarding the value of educational preparation.

The recent decision from the College of Nurses of Ontario (CNO) provides a solution to this concern for RNs, and a partial solution regarding RPNs. The CNO Council recently approved new entry to practice competencies for RNs and RPNs effective 2005. This has resulted in new entry-to-practice education expectations for RNs. A four-year degree in nursing will be mandatory for all new entrants as of 2005 thus resolving the dual exit concern for RNs. The CNO did not recommend specific changes in RPN program length or location for future educational programs. Thus, the duality of exit concern remains unresolved for RPNs.

Assessment: The consensus on baccalaureate preparation as the single educational entry for RNs and the move towards agreement regarding preparation for RPNs are critical achievements. This will eliminate confusion and assist guidance counsellors in their work with prospective students. It also sends a strong signal that the nursing profession values formal education. It is imperative that these educational initiatives receive financial support to ensure their implementation.

Curriculum

The new entry to practice competencies for both RNs and RPNs provide guidance for the development of curriculum. Responding to future needs, RNs are expected to nurse increasingly complex clients throughout the age continuum, and across all subspecialties of practice. Clients can be individuals, families, groups, communities, and populations. There is greater emphasis on community, population health, and primary health-care as foundations of professional practice.[139]

Critical thinking, research utilization and clinical judgement enhance their profile, as well as the development of leadership and management skills. RNs require a sophisticated repertoire of nursing interventions to meet the advance of technology, and the communication skills to work with a multidisciplinary team.[140] Independence and interdependence of roles will be more challenging. This knowledge must be surrounded by the fundamental principles of holistic assessment, caring, and compassion for the human condition.

The new competencies for RPNs also direct a change in curriculum. Future RPNs will be expected to practise with new skills within a complex health-care environment. Entry level RPNs will be expected to care holistically and compassionately for stable clients, primarily individuals, families and groups, in all settings where nursing care is provided. They will also be responsible for additional nursing interventions, especially those that have traditionally been acquired through continuing education. Also, they will face enhanced expectations related to critical thinking and judgement based on their scope of practice and depth and breadth of education. Leadership skills need to be enhanced especially within the realm of long-term care settings, as well as functioning within a multidisciplinary team. The competencies reinforce the autonomous practice of the RPN within the scope of the nursing role. These new competencies clarify the differences between the scopes of both RNs and RPNs and encourage a uniform utilization of RPNs within the full scope of their practice across the province.

For nursing, the key emerging needs that must be reflected in all curricula are: 1) healthy aging in an aging population; 2) cultural diversity and its impact on health-care provision; 3) information technology and computer literacy; and 4) primary health-care. Schools should also seek closer links with service organizations (i.e., hospitals, home care agencies) both for curriculum development and to keep up with current needs.

Assessment: The nursing curriculum for RNs and RPNs must be regularly updated to meet the needs of Ontarians today and reflect the needs of tomorrow. All graduates of nursing programs should be exposed to basic concepts required across the health continuum.

Life-Long Learning

Nurses are expected to maintain competency throughout their career. Indeed, the College of Nurses of Ontario has made continuing competence, and therefore life-long learning, the fundamental underpinning of quality assurance.[141] The growing complexity of client's health-care needs and those of the Ontario health-care environment pressures nurses to keep up in different ways. Changing entry-level expectations for RNs will increase the demand for both degree completion and graduate level programs. There will also be an increased demand for certificate programs to enhance specialty knowledge and skills, such as community or primary health-care. RNs and RPNs will demand greater access to continuing education, short courses, and certificate programs to meet the required and emerging knowledge needs.

Access

There are many barriers to nurses accessing entry level and continuing education: family-work balance, financial, geographic, admission, lack of flexibility or portability of programs. To promote nursing education, these barriers must be tackled with appropriate strategies and programs.

Family and work responsibilities: Since most nurses are women, they face the challenges of balancing their work and family lives. At home, the "multiple hat syndrome" includes the emotional and financial expectations of caring for young or ageing families, while at the workplace, taking care of patients requires a growing physical, intellectual and emotional involvement. Engaging in ongoing education adds to the financial, intellectual and time requirements of this delicate balancing act. Focussed assistance, support, and creative and flexible program offerings are essential to support this balance. These needs are not just relevant for nurses already in the system, but also apply to prospective students, particularly as mature students enter the profession.

Financial barriers: These can be reduced with tuition assistance, including interest free loans, grants and tuition reimbursement. More bursaries and scholarships are required, as well as opportunities to access short courses and workshops while on paid salary time.

Geographic barriers: Distance education programs reduce the challenges of geographic access, especially for those who live in rural, remote or northern areas of the province. Courses and programs of all levels need to be provided through creative methods of

distributive learning (the newest term for distance education). This can include, but is not limited to, print-based methods, audio and video conferencing, and Internet and computer-mediated methods. While capital and start-up costs for these methods may at first glance seem very expensive, they are very cost-effective in the long run, especially when the best resources and curriculum development can be shared among many institutions.

Admission barriers: These can be addressed by assessing previous learning of prospective students in creative ways. Known as prior learning assessment and recognition (PLA), a variety of methodologies include challenge exams, performance tests and the presentation of a portfolio of learning accomplishments. For students who do not meet the traditional entrance requirements measured through high-school grades, these new methods affirm their capability for nursing education, and encourage them to enrol in nursing programs.

Lack of program flexibility: Many educational programs fail to take into account the work-life and lifestyles of nurses. A reversal of this reality is critical to removing barriers to education. Nurses and prospective students require courses offered at their workplace, or through flexible distributive learning. They require flexible schedules, including evening and weekend courses. Courses need to be offered in day, week or month long intensive or block formats, as well as the traditional academic term. Not only do nurses require flexibility, they also require *portability of credits* across the province to enhance their mobility and geographic access.

Ongoing education is essential to maintain competence, career mobility, and is directly linked to the nurse's personal sense of job satisfaction. Nursing education, and resolving the barriers to it, must be approached as a shared responsibility between governments, the educational sector, health-care organizations and nursing students. Professional associations and nursing unions also have a role to contribute. Strategies that increase the opportunities for nurses to access continuing education at the post-basic and graduate levels will increase the likelihood of their retention within the profession. The message of nursing as a life-long learning profession with many educational opportunities will undoubtedly increase the attractiveness of the profession to new students.

Support for collaborative university and college education programs has grown over the past few years. The provincial government, in response to recommendations of the Nursing Task Force, established the Nursing Education Implementation Committee, "to advise the Ministers of Health and Long-Term Care and Training, Colleges and Universities on strategies to ensure success in removing barriers to the development of collaborative college-university nursing programs".[142] The Implementation Committee Report was submitted to the Minister of Health and Long-Term Care and the Minister of Training, Colleges and Universities in July 1999 and released publicly in November. The nursing profession is anxiously awaiting the release of funds that will facilitate the successful development of collaborative programs throughout the province.

Assessment: The growing need for life-long access to education for nurses speaks to the urgent need to address the barriers encountered by the nurse in accessing education programs. Financial and other policy commitments are required to

overcome these barriers. Action on access issues will send a strong signal that nursing is valued as a key profession.

Clinical Placements

Educational programs are challenged to find appropriate clinical placements for nursing students in varied health-care environments. This will become a bigger issue as enrolments are increased to meet the demand for nurses. Faculty at various nursing programs are reporting this to be a major problem. Although student preceptorship is an integral part of practicing nurses' role, poor working conditions (see work environment section) make it extremely difficult for nurses to perform this responsibility. Nurses feel demoralized by their inability to carry out their role and stressed out by the additional demand, and students are often exposed to burned-out nurses who may not particularly want to serve as a preceptor. This creates a negative perspective all-around!

The implications are serious for nurses and for the recruitment of students into the profession and their retention within the educational programs. Community agencies, in particular, are being asked by colleges and universities for additional placements, as this is becoming a larger emphasis within curricula. Creating positive work environments is essential to facilitate excellence in patient care and ensuring positive experiences for students. A helpful measure is to provide incentives to practicing nurses to take on the supervision and guidance of nursing students, and to be enthusiastic preceptors.

Status of Nursing Programs

A discouraging trend observed in some Ontario university nursing programs is the downgrading of program status. For example, some Faculties of Nursing have become Schools of Nursing and in so doing, have lost their autonomous standing. At times, university program reorganization has resulted in the nursing faculty having to report to the Dean of Medicine rather than a Dean of Nursing. Moves such as these serve to undermine the status of nursing and nursing education. When subsumed under another professional Faculty, the message clearly is that nursing is the less important Faculty. Recruitment and retention of high calibre nursing faculty as well as the ability to attract the best and the brightest students into the profession will be compromised by this new trend.

Enrolment in Nursing Programs

The data on enrolments in nursing programs is presented in Part IV, Labour Market Trends. In that section, we identify the challenges that colleges, and to a lesser extent universities, have been facing in attracting qualified students into nursing programs. The

data indicate that there will be a shortfall in the supply of qualified RNs and RPNs in 1999 and 2000, even before new educational requirements come into play. Therefore, it is clear that consideration must be given to expanding program enrolment during the year 2000, in order to offset the expected reduction in supply.

Endnotes

[1] Schmeling, W.H. (1992). Recruitment and retention of nursing personnel, in Cowart, M.E. & Serow, W.J. *Nurse in the Workplace*,178-191. Sage Publications: Newbury Park.

[2] Moore, T.F. & Simendinger, E.A. (1989). *Managing the Nursing Shortage: A Guide to Recruitment and Retention.* Aspen Publishers Inc.: USA.

[3] Brown, B. (1998). 10 Trends for the new year. *Nursing Management 29(2)* 33-36.

[4] Bray, K.L.C. (1989). RN Recruitment and retention from a nurse recruiter perspective, in Moore, T.F. & Simendinger, E.A. *Managing the Nursing Shortage: A Guide to Recruitment and Retention*. Aspen Publishers Inc.: USA.

[5] American Organization of Nurse Executives (1987). *Student Nurse Recruitment Resource Kit.* Chicago.

[6] Wilson, C.S. & Mitchell, B.S. (1999). Nursing 2000: Collaboration to promote careers in registered nursing. *Nursing Outlook 47(2)* 56-61.

[7]Ibid.

[8] Al-Kandari, F.H. & Ajao, E. (1998). Recruitment and retention of nursing students in Kuwait. *International Journal of Nursing Studies, 35* 245-251.

[9] Wilson, C.S. & Mitchell, B.S. (1999). Nursing 2000: Collaboration to promote careers in registered nursing. *Nursing Outlook 47(2)* 56-61.

[10] Saskatchewan Registered Nurses Association (1998). *Report on survey of nursing students in Saskatchewan regarding recruitment to nursing November, 1997 – December, 1997.*

[11] Ibid.

[12] Schmeling, W.H. (1992). Recruitment and retention of nursing personnel, in Cowart, M.E. & Serow, W.J. *Nurse in the Workplace.* Sage Publications: Newbury Park.

[13] Ibid.

[14] Kramer, M. & Schmalenberg, C. (1988). Magnet hospitals: Part I institutions of excellence. *Journal of Nursing Administration 18(1)*. 13-24.

[15] Kramer, M. & Schmalenberg, C. (1988). Magnet hospitals: Part II institutions of excellence. *Journal of Nursing Administration 18(2)* 11-19.

[16] Song, R., Daly, B.J., Rudy, E.B., Douglas, S. & Dyer, M.A. (1997). Nurses' job satisfaction, absenteeism, and turnover after implementing a special care unit practice model. *Research in Nursing and Health 20* 443-452.

[17] Sampson, R. and Mercier, J. (1998). The professional transitions workshop cornerstones of practice. *Journal of Nursing Administration 28(1)* 25-29.

[18] Morrison, R.S., Jones, L. & Fuller, B. (1997). The relationship between leadership style and empowerment on job satisfaction of nurses. *Journal of Nursing Administration 27(5)* 27-34.

[19] Lassiter, S.S. (1989). Staff nurse retention: Strategies for success. *Journal of Neuroscience Nursing 21(2)* 104-107.

[20] Schmeling, W.H. (1992). Recruitment and retention of nursing personnel, in Cowart, M.E. & Serow, W.J. *Nurse in the Workplace.* Sage Publications: Newbury Park.

[21] Ibid.

[22] American Organization of Nurse Executives and American Nurses Association (1990). *The Nursing Shortage: Opportunities and Solutions Reward Strategies in Nursing Practice.* American Hospital Association: Chicago.

[23] Murphy, R., Pearlman, F., Rea, C. & Pupazian-Boyce, L. (1994). Work redesign: A return to the basics. *Nursing Management 25(2)*37-39.

[24] Skelton-Green, J.M.. (1996). The perceived impact of committee participation on job satisfaction and retention of staff nurses. *Canadian Journal of Nursing Administration 9(2)* 7-35.

[25] Schmeling. W.H. (1992). Recruitment and retention of nursing personnel, in Cowart, M.E. & Serow, W.J. *Nurse in the Workplace.* Sage Publications: Newbury Park.

[26] Ibid.

[27] American Organization of Nurse Executives and American Nurses Association (1990). *The Nursing Shortage: Opportunities and Autonomy in Nursing Practice*. American Hospital Association: Chicago.

[28] Massaro, T., Munroe, D., Shisler, L., White, R., Stone, A., Gambill, A., Shirkman, N. and Tittle, M. (1996). A professional practice model. *Nursing Management 27(9)* 43-47.

[29] Kramer, M. & Schmalenberg, C. (1988) Magnet hospitals: Part I institutions of excellence. *Journal of Nursing Administration 18(1)* 13-24.

[30] Stratton, T.D., Dunkin, J.W., Juhl, N. & Geller, J.M. (1995). Retainment incentives in three rural practice settings: Variations in job satisfaction among staff registered nurses. *Applied Nursing Research 8(2)* 73-80.

[31] Kramer, M. & Schmalenberg, C. (1988). Magnet hospitals: Part I institutions of excellence. *Journal of Nursing Administration 18(1)* 13-24.

[32] Kramer, M. & Schmalenberg, C. (1988). Magnet hospitals: Part II institutions of excellence. *Journal of Nursing Administration 18(2)* 11-19.

[33] Sovie, M.D. (1982). Fostering professional nursing careers in hospitals: The role of staff development, Part 1. *Nurse Educator Winter* 28-32.

[34] Sovie, M.D. (1983). Fostering professional nursing careers in hospitals: The role of staff development, Part 2. *Nurse Educator Spring* 15-18.

[35] Taylor Cooney, A. (1992). An orientation program for new graduate nurses: The basis of staff development and retention. *The Journal of Continuing Education in Nursing 23(5)* 216-219.

[36] Carey, S. & Campbell, S. (1994). Preceptor, mentor, and sponsor roles: Creative strategies for nurse retention. *Journal of Nursing Administration 24(12)* 39-47.

[37] Taylor Cooney, A. (1992). An orientation program for new graduate nurses: The basis of staff development and retention. *The Journal of Continuing Education in Nursing* 23(5) 216-219.

[38] Smeltzer, C.H., Tseng, S. & Harty, L.M. (1991). Implementing a strategic recruitment and retention plan. *Journal of Nursing Administration* 21(6) 20-28.

[39] Finance Canada.. *Federal Budgets, 1995-2000*.

[40] This calculation compares actual transfers with 1995-96 transfers as the base level.

[41] Statistics Canada (2000), *Cansim Database.*

[42] Bezanson, Kate and Louise Noce (1999). *Costs, Closures and Confusion: People in Ontario Talk about Health Care*. Caledon Institute of Social Policy, May 1999, p. 5. These expenditures were calculated from Ontario Ministry of Finance Public Accounts (1995-96 to 1997-98), the Ontario Budget (1995 to 1999) and Ontario Management Board Secretariat Expenditure Estimates (1995 to 1998). Figures are corrected for expenditures on land ambulances and public health which were clawed back from municipalities, but which nevertheless appeared as health expenditures. Figures from the Canadian Institute for Health Information (CIHI) are slightly different: they show a 5.63 % rise in nominal spending from $18.766 billion in 1994 to an estimated $19.823 billion in 1998. The slight discrepancy will relate to a variety of factors: CIHI uses calendar years and not fiscal years; CIHI's figure for 1998 is a forecast; and finally, it is unclear how CIHI corrected expenditure figures for things like land ambulances, as the Caledon study did. For CIHI data, see CIHI (1998), *National Health Expenditure Trends, 1975-1998*, p. 103.

[43] Government of Ontario. (1999) *Making It Happen: Implementation Plan for Mental Health Reform.* Toronto: Queen's Printer.

[44] LTC-MOH Classification data. Reported by Margaret Ringland, *Long-term care - A sector in transition.* Speech delivered at RNAO Conference. 1997

[45] Ministry of Health and Long-Term Care (January 2000). *The 1999 Levels of Care Classification– Provincial Summary Data*, (as excerpted by Margaret Ringland, Ontario Association of Non-Profit Homes and Services for Seniors). These data indicate a steady increase in the Case Mix Measure (a reflection of nursing and personal care requirements of residents). There is general agreement that this measure, though helpful, probably errs on the side of underestimating nursing/personal care needs of residents.

[46] Community Health Nurses' Interest Group. (1998) *Submission to the Nursing Task Force*.

[47] Ontario Regulation 386/99 made under the Long-Term Care Act, 1994. Filed July 6, 1999.

[48] Marshall, V. (1994). A critique of Canadian aging and health policy, in Marshall and McPherson (eds) *Aging: Canadian Perspectives*. Peterborough; Broadview Press.

[49] Canadian Institute for Health Information (1999). *National Health Expenditure Trends, 1975-1999*.

[50] Ibid.

[51] Association of Applied Arts and Technology of Ontario, Council of Ontario University Programs in Nursing, Practical Nurses Federation of Ontario, Ontario Nurses Association, Registered Nurses Association of Ontario, Registered Practical Nurses Association of Ontario (2000). *Nurses Warn about Privatization*. Background prepared for Queen's Park Press Conference. January.

[52] Registered Nurses Association of Ontario (1999). *The Canada Health Act: To Preserve and Protect*.

[53] Kuttner, Robert (1999). The American health care system – health insurance coverage. *The New England Journal of Medicine, Vol. 340 (1*).

[54] Baumann, A., O'Brien-Pallas, L., & Butt, M. (1999). *Issues in Resource Planning: A Report Prepared for the Ontario Hospital Association.* The Nursing Effectiveness, Utilization and Outcomes Research Unit.

[55] Environics Research Group Limited. (1999). *Image and Funding of Nursing Services in Ontario.* A Report Prepared for the Registered Nurses Association of Ontario.

[56] Environics Research Group (1997, 1998, 1999). *Government Spending Preferences and Perceived Quality of Hospital Care.*

[57] Ontario Hospital Association and University of Toronto (1998). *The Hospital Report '99: A System-wide Review of Ontario's Hospitals*.

[58] Ontario Nurses Association and Comquest Research (Nov 1998). *A Survey of Public Opinion on Health Care Issues in Ontario*.

[59] Graves, Frank L., Patrick Beauchamp and David Herle (1998). Research on Canadian values in relation to health and the health care system, in *Canadian Health Action: Building on the Legacy: Papers Commissioned by the National Forum on Health, Vol 5, Making Decisions: Evidence and Information*, Editions MultiMonde.

[60] Ekos Research Group (March 1999). How Ottawa spends, reported in *Canadians are losing interest in tax cuts: Vast majority see health-care system as more important than productivity.* Globe and Mail, March 16, 1999.

[61] In fact, the Nursing Task Force called for 10,241 new positions: 7,700 RN positions and 2,541 RPN positions.

[62] See Villeneuve, M.J., Semogas, D., Peereboom, E., Irvine, D., McGillis-Hall, L., Walsh, S., O'Brien-Pallas, L., & Baumann, A. (1995). *The workplace concerns of Ontario nurses: Final report*. Toronto, ON: University of Toronto & McMaster University Quality of Nursing Worklife Research Unit. As quoted in Baumann, et al *Issues in Resource Planning* (op cit.).

[63] ONA and Comquest Survey (op cit).

[64] Hospital funds as a percentage of the MOH budget has declined from 47 % in 1984/5 to 39 % in 1996/7. Ontario Hospital Association. (1998) *Meeting the Challenge.* Toronto.

[65] For hospitals overall, real per capita funding has dropped from $619.53 in 1991-92 to $472.87 in 1999-2000. Acute care hospital beds have gone down from 33,403 in 1990 to 19,872 in 1999. Length of stay has decreased 6.2 % over 5 years and 26 % over 9 years. The combination of the two implies a large drop in patient days, from 10,608,365 in 1989/90 to 6,676,612 in 1998/99. Ontario Hospital Association (1999), *Key Facts and Figures*, October. Toronto.

[66] For a more detailed discussion of these issues, please see Registered Nurses Association of Ontario (1999). *Reclaiming a Vision: Making Long-Term Care Community Services Work.*

[67] Ministry of Health and Long-Term Care (1999). *Level of Care Classification Results*. These data indicate a steady increase in the Case Mix Measure (a reflection of nursing and personal care requirements of residents).

[68] Community Health Nurses Interest Group (1998). *Submission to the Nursing Task Force.*

[69] Ibid.

[70] Rafael, A.R.F. (1998). From Rhetoric to reality: The changing face of public health nursing in Ontario. *Public Health Nursing.* As quoted in Community Health Nurses Interest Group. (1998). *Submission to the Nursing Task Force.*

[71] Government of Ontario. (1999). *Making It Happen: Implementation Plan for Mental Health Reform.* Toronto: Queen's Printer for Ontario.

[72] Registered Nurses Association of Ontario (1997*). Mental Health System Design: Client Service and System Expectations for Change.* Submission to The Thames Valley District Health Council.

[73] WHO. (1999). *Guidelines for the Primary Prevention of Mental, Neurological and Psychosicial Disorders.* (Doc.WHO/MNH/EVA/88.1) Geneva: WHO.

[74] Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part I institutions of excellence. *Journal of Nursing Administration 18(1*) 13-24.

[75] To assist LPNs who have not been practicing to their full scope and who may require a period of orientation and refresher education to effectively resume LPN responsibilities, the BC government has allotted funding for up to 2 weeks of the employer's wage replacement cost for each.

[76] The College of Nurses of Ontario (CNO) merges part-time casual and full-time casual into one category – casual. Nurses labeled full-time or part-time are permanent – "regular" in the vocabulary of the CNO. This document maintains the same categories.

[77] Hunter, Duncan and Namrata Bains (1999). Rates of adverse events among hospital admissions and day surgeries in Ontario from 1992 to 1997. *Canadian Medical Association Journal*, June 1, Vol. 160 (11), pp. 1585-86.

[78] Ibid. (Misadventures to patients during surgical and medical care are captured under ICD-9 codes E870 and E876).

[79] Ibid. (Surgical and medical procedures as the cause of an abnormal reaction of patient or later complication, without mention of misadventure at the time of the procedure, are found in ICD-9 codes E878 and E879).

[80] Ibid. (Drug, medicaments and biological substances causing adverse effects in therapeutic care are found in ICD codes E930-E949).

[81] Gustin, T.J., Semler, J.E., Holcomb, M.W., Gmeiner, J.L., Brumberg, A.E., Martin, P.A. & Lupo, T.C. (1998). A clinical advancement program creating an environment for professional growth. *JONA 28 (10)* 33-39.

[82] Sovie, M.D. (1982). Fostering professional nursing careers in hospitals: the role of staff development, Part 1. *Nurse Educator,* Winter 28-32.

[83] Sovie, M.D. (1982). Fostering professional nursing careers in hospitals: the role of staff development, Part 2. *Nurse Educator*, Spring 15-18.

[84] Risk, Margaret (1999), Correspondence with Judith Wright, ADM, Integrated Policy and Planning Division, Ministry of Health, on behalf of College of Nurses of Ontario, March 1.

[85] Pierce, S.F., Freund, C.M., Luikart, C., and Fondren, L. (1991). Nurses employed in non-nursing fields: Is nursing losing its best and brightest? *Journal of Nursing Administration 21(6)* 29-34.

[86] Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part I institutions of excellence. *Journal of Nursing Administration 18(1*) 13-24.

[87] Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part II Institutions of Excellence. *Journal of Nursing Administration 18(2)* 11-19.

[88] Skelton-Green, J.M. (1996). The perceived impact of committee participation on job satisfaction and retention of staff nurses. *Canadian Journal of Nursing Administration 9(2*) 7-35.

[89] Moss, R. and Rowles, C.J. (1997). Staff nurse job satisfaction and management style. *Nursing Management 28(1) 32-33.*

[90] Ibid.

[91] Song, R., Daly, B.J., Rudy, E.B., Douglas, S. & Dyer, M.A. (1997). Nurses' job satisfaction, absenteeism, and turnover after implementing a special care unit practice model. *Research in Nursing and Health 20* 443-452.

[92] Pierce, L.L., Hazel, C.M. and Mion, L.C. (1996). Effect of a professional practice model on autonomy, job satisfaction and turnover. *Nursing Management 27(2)* 48M-48T.

[93] Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part I institutions of excellence. *Journal of Nursing Administration* 18(1) 13-24.

[94] Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part II. institutions of excellence. *Journal of Nursing Administration* 18 (2) 11-19.

[95] Canadian Nursing Association (1998). *Registered Nurse Human Resources: Recruitment and Retention Issues: A Discussion Paper* 1-50.

[96] This increase was accomplished chiefly through the elimination of the bottom rung in the seniority ladder.

[97] Labour Canada (1998), *Major Hospital Agreements*, Human Resources: Ottawa.

[98] Nursing Task Force (1999). *Good Nursing, Good Health: An Investment for the 21st Century*. Toronto.

[99] Decker, F.H. (1997). Occupational and non-occupational factors in job satisfaction and psychological distress among nurses. *Research in Nursing and Health* 29 453-464.

[100] Ornstein, H.J. (1990). Collaborative practice between Ontario nurses and physicians: Is it possible? *Canadian Journal of Nursing Administration 10* 10-14.

[101] Farley, M.J. (1989). Assessing communication in organizations. *Journal of Nursing Administration* 19(12) 27-31.

[102] Kramer, M. and Schmalenberg, C. (1988). Magnet hospitals: Part I institutions of excellence. *Journal of Nursing Administration* 18(1) 13-24.

[103] See Hibberd, J. & Kyle M. (1994). *Nursing Management in Canada*. Toronto: W.B.Saunders.

[104] See for instance the Service Employees International Union (1994) *The Canada Nurse Survey*. This survey found that the respondents (85 % of whom were Ontario nurses) reported: that nursing staffing levels were inadequate; that nurses were not used appropriately; that short staffing was hurting the quality of patient care; that they were suffering from abnormally high levels of stress and stress-related illness; and that many (nearly two-thirds) were contemplating leaving their jobs, or leaving nursing entirely.

[105] There are four possible cases. Consider two nurses, A and B, who previously did not declare their employment status.

If Nurse A initially lacked nursing employment, and then declared his status, he could impact one of two employment statistics, depending upon his post-declaration status. If he became employed afterwards, then he would increase the employment count, which would give a correct picture of the direction of employment. On the other hand, if he remained unemployed, then there would be no distortion of the employment numbers. (However, measured unemployment would rise, which would give an incorrect picture of that statistic. Because we are relying on employment statistics to measure changes in employment, then this particular distortion is not germane to our argument.)

If Nurse B initially had nursing employment and then declared her status, then there are two possible impacts on measured employment. If she kept her employment post-declaration, then there would be no change in actual employment, but there would be a measured increase in employment, as her employment is now counted. On the other hand, if she loses her job post-declaration, then there is an actual drop in employment, but there is no reported change in employment. In either case, the data gives an incorrectly rosy picture of changes in employment.

Thus, the net distortion of measured changes in nursing employment depends upon the employment status of nurses before they declare their employment status. To the extent that they were employed, then there will be a one-to-one distortion of statistics. This is important because there has been a very large drop in the number of non-reporters. For example, between 1994 and 1998, there was a 5,882 drop in the number of non-declaring nurses (6,314, if one includes new registrants for whom employment data is not collected). Compare this with the measured drop in nursing employment of 2,550 for the same time period. There is a large potential for understatement of nursing job loss – by 5,882 in the extreme, in the unlikely event that all were previously employed. (For the purposes of this exercise, we omit new registrants. By including them, we would get an even larger measure of the potential understatement of job loss.) Of course, it is equally unlikely that all were unemployed, in which case there would be no distortion. There will be an understatement of job loss. The only issue is: how much?

[106] However, it is hoped that the College of Nurses of Ontario may be able to survey non-reporters to estimate employment status for that population.

[107] The upper range is obtained by assuming that all non-reporters were actually employed. This is highly unlikely, just as is the assumption that all non-reporters were unemployed, which would give the bottom of the range.

[108] As previously noted, the College of Nurses of Ontario merges its data on part-time casual and full-time casual into the same category – casual employment.

[109] As noted previously, the increase in the reporting rate means that previously unreported jobs appear to be new jobs, rather than existing jobs. This makes the trend appear better than it is. Recall that the pool of those reporting employment is already a subset of total registrants. Only 86 % to 94 % of registrants report at all on employment status.

[110] The Health Planning Branch of the Ministry of Health and Long-Term Care, assumed that part-time permanent nurses were working half-time on average. This paper extends that assumption to casually employed nurses – both part-time and full-time. We thank the HPB Director, Mr. George Zegarac, for clarifying the Branch approach.

[111] This is a modest request, given that this will still leave Ontario well behind the average of the rest of Canada. The reason for this is that Ontario had and has the lowest nurse:population ratio in Canada. Ontario is seeking to catch up to a national average that it helped to lower.

[112] Office of the Premier (1999), *News Release: Harris Exceeds Task Force Recommendation, Announces 12,000 New Nurses*, March 19, 1999.

[113] For example, see Health Canada (1996), *National Health Expenditures in Canada, 1975-1994: Summary Report*, Ottawa, Ontario.

[114] Health Services Planning Branch, Ministry of Health (1999), *Patients by Age Grouping.*

[115] Barer, Morris L., Robert G. Evans, Clyde Hertzman, and Mira Johri (1998), *Lies, Damned Lies and Health Care Zombies: Discredited Ideas that will not Die*, Health Policy Institute, University of Texas, Houston, March 1998, p. 4; Woods, Gordon Management Consultants (1984), *Investigation of the Impact of Demographic Change on the Health Care System in Canada – Final Report*, Prepared for the Task Force on the Allocation of Health Care Resources, Woods Gordon, Toronto; Boulet, J.A. and G Grenier (1978), Health expenditures in Canada and the impact of demographic changes on future government health insurance program expenditures, *Economic Council of Canada Discussion Paper #123*, Economic Council of Canada, Ottawa.

[116] Ryten, Eva (1997), *A Statistical Picture of the Past, Present and Future of Registered Nurses in Canada* (1997), Canadian Nurses Association. The calculation is based on 1993 usage rates in hospitals by age and gender. The author notes that while hospital usage may decline as people are shifted out into the community, the need for nursing will not decline, but merely follow the patients.

[117] For instance, the Long-Term Care Division of Ontario Ministry of Health reported that the Case Mix Measure for long-term institutions has risen 9% between 1993 and 1999.

[118] Watters, Nancy E. (1999). *Meeting the Nursing Practice Challenges of Cultural Diversity in Canada*, Canadian Nurses Association, Sept. 14, 1999.

[119] Jean Watson. As quoted in College of Nurses of Ontario (1999). Nursing in an ethnically diverse community, *Nursing and You: A Newsletter for the Public V. 1(2)* October.

[120] This is the year chosen by the Canadian Nursing Association in C.N.A. (1998) above.

[121] In fact, they were needed in 1997.

[122] Ibbitson, John (1999). Fiscal crisis looms if health-care costs continue to skyrocket. *Globe and Mail*, December 2, 1999, p. A4.

[123] These percentages are based on a linear interpolation between 5-year age cohort intervals (data is only available in quanta of 5 years each). There will be a distribution of actual retirement ages above and below the average. The calculation assumes that one can treat the population as if it behaves like the average, which is likely to slightly exaggerate the number of nurses estimated to retire by 2011, but not by a great deal.

[124] Based on the above estimated percentages of retirements, 33,880 RNs and 11,608 RPNs would retire by the end of 2011.

[125] Again, a linear interpolation was used between 5-year cohort intervals, to find the number of nurses over 52 in 1998 (and hence the number that would reach mandatory retirement age by 2011.

[126] However there is a considerable Baby Boom bulge in nursing employment. While these nurses start reaching their formal retirement age by 2011, the bulk of this bulge will only hit formal retirement in the ensuing decade.

[127] Data source: Ontario College Application Services and the Universities Branch, MTCU.

[128] According to the Canadian Institute for Health Information (CIHI), the Ontario RN:population ratio dropped from 784.5 per 100,000 to 687.3 between 1993 and 1998. The figures for Canada were much higher: 816.3 and 748.4 for 1993 and 1998, respectively. CIHI gets its nursing employment figures from provincial regulatory bodies, and adjusts them for nurses who work in several provinces to avoid double counting. Thus, there may be small discrepancies between nurse:population ratios in this report and the ratios in this endnote. (See CIHI (May 10, 1999, 8:30 a.m.) *Canada's nursing workforce aging, more nurses working part-time*, available at www.cihi.ca site.)

[129] Statistics Canada (1999), *The Daily*, August 27, 1999.

[130] Canadian Council on Social Development (2000), *Labour Market Integration of Graduates in Nursing in Canada, 1986-1997*. Report prepared for the Canadian Nurses Association.

[131] Risk (1999), op. cit.

[132] Ryten, E. (1997). (op cit.)

[133] The Health Planning Branch of the Ministry of Health assumed that part-time permanent nurses were working half time on average. This paper extends that assumption to casually employed nurses – both part-time and full-time. We thank the HPB Director, Mr. George Zegarac, for clarifying the Branch approach.

[134] Unless otherwise specified, figures in this section are for 1999, and are from the CNO. As discussed previously, the numbers are based on self reporting, and thus understate total numbers.

[135] Risk (1999), op. cit. Based on data from 35,000 of the nursing registrants for 1999.

[136] Risk (1999), op. cit.

[137] Pierce, S.F., et al (1991). Nurses employed in non-nursing fields: Is nursing losing its best and brightest? *Journal of Nursing Administration 21(6)*

[138] Kramer, M and Schmalenberg, C. (1988). Magnet hospitals: Part I and part II institutions of excellence. *Journal of Nursing Administration* 18(1) 13-24 and 18(2) 11-19.

[139] Bramadet, I. J., Chalmers, K., and Andrusyszen, M. A. (1996). Knowledge, skills and experiences for community health nursing. *Journal of Advanced Nursing 24(6)* 1224-1233.

[140] Lewis, M.., L. et al. (1997). Preparing nurses for tomorrow's reality. *Nurse Educator 22(1)* 12-16.

[141] College of Nurses of Ontario (1997) *Communique* 22(1).

[142] *Report of the Nursing Education Implementation Committee*. July, 1999.

Appendix 1 – Working Group Rankings

Agreed Ranking	Student Recruitment – Short Term Strategies
1	Print media marketing campaign including: brochures targeted to different age groups, poster, display, print public service announcements.
2	Electronic media marketing campaign including: "nursing as a career" video, radio public service announcements.
3	Liase with high school guidance counsellors and provide information about nursing as a career (i.e., newsletter, print material, etc.).
4	Speakers Bureau: nurses talking about nursing in schools, community groups, career transition programs supported by an interactive presentation package.
5	Media relations activities: media kit package including nurse profiles, career columns for teen magazine and community newspapers.
6	Interactive Web page for teenagers/adults.
7	Information package for career transition counsellors.
8	Travelling recruitment team consisting of one to two staff nurses supported by the clinical leader/manager, to visit local colleges and universities, possibly at registration time.
9	Career Days organized by nurses.
10	Offer a mentor in nursing program that encompasses clinical observation and basic nursing skills as either a course at high school or as an after school paid work experience.
11	"A Day In the Life of a Nurse" job shadow program.
12	Offer nurses career-counselling services.
13	Sponsor student to annual general meeting.

Agreed Ranking	Student Recruitment - Medium Term Strategies
1	Financial assistance targeted to nursing programs.
2	Prior Learning Assessment credits for mature students.
3	Workplace internships, mentorships and preceptor programs.
4	Co-op placement programs.
5	Linkages to public and secondary programs of annual learning plan for students that require community volunteer service.
6	Nursing student placements in community.
7	Volunteer opportunities to showcase nursing.
8	Culturally sensitive learning.

Agreed Ranking	Student Recruitment – Long-term Strategies
1	Special nursing student loan programs.
2	Re-entry programs for nursing as second career choice.

Agreed Ranking	RN/RPN Recruitment and Retention – Short Term Strategies
1	Improvement of workplace environment
2	Personalized approach to employer recruitment activities: RN/RPN employer representatives go directly to campuses, career fairs to establish direct personal links to individual nurses.
3	Foster working relationships based on respect.
4	Recruitment fairs.
5	* Develop a nurse career literature package that includes a list of Ontario's colleges, undergraduate and graduate nursing schools, provincial and national nursing associations (RPNAO, RNAO, RPNAO union representative, CNO, ONA and CNA), financial assistance (bursary and grants) and specialty certification, brochure and poster.
6	* Provide a multi-phase orientation including a general orientation followed by a unit level orientation.
7	Web site.
8	* Each health organization should have a nurse at the executive level (Director of Nursing/Chief Nursing Officer) that reports directly to the organization's Chief Executive Officer.
9	Workplace open houses.
10	* Patient unit managers need to be registered nurses.
11	Information package for career transition counsellors

Agreed Ranking	RN/RPN Recruitment and Retention – Medium Term Strategies
1	Employer support for continuing education.
2	Workplace internships, mentorships and preceptor programs.
3	Include staff nurses in committees and decision-making bodies both internal and external to health-care organizations.
4	Human resource incentives for upgrading and training
5	Involve nurses in strategies, development and implementation of standards of care, teaching plans and educational workshops and materials.
6	Career ladders (career advancement system) in employment setting.
7	Employer recruitment incentive: job security.
8	Employer recruitment incentive: professional development.
9	Creation of provincial retraining fund.
10	Increased recognition in workplace.
11	Have management styles and provide management training that foster autonomous nursing practice.
12	* Organizations need to foster effective communication channels (formal and informal) that reflect the autonomy and professional nature of nursing practice.
13	Employer recruitment incentive: relocation costs
14	* Organizations need to foster effective lines of communication between the multi-disciplinary health-care team.
15	* Establish a nursing practice and a nursing quality assurance committee in each organization.
16	* Patient care delivery models that foster autonomous nursing practice is recommended (i.e., primary nursing and total patient care nursing).
17	* Develop, implement and evaluate nursing job satisfaction surveys and exit interviews.
18	Expand recruitment strategies beyond traditional groups.
19	Develop bridge/remedial programs to encourage entry into nursing educational programs.
20	Ongoing health human resource planning.
21	Target nursing programs to recent graduates in other programs.

Agreed Ranking	RN/RPN Recruitment and Retention – Long-Term Strategies
1	Employment options (i.e., job sharing, guaranteed hours, flexible scheduling).
2	Have appropriate staffing levels and minimize or eliminate use of agency staff.
3	Lobby for wage grid model to establish equity across all sectors.
4	* Support for continuing education (tuition reimbursement, financial support, time-off, on-site programs, financial reward upon BScN completion i.e., bonus).
5	Continue research into skill mix and full utilization of RNs and RPNs.
5	* Adjust salary grid to reduce the number of steps on the grid but provide higher increases in each step and rewards directly related to continuing education.
7	Ministry of Health and Long-Term Care funding for recruitment and retention.
7	Lobby for RN/RPN to work at full scope of practice.
9	Nurse leaders need to be highly visible and accessible.
9	Collaborative practice models in workplace.
11	* Cafeteria approach to benefits.
12	* Rewards for unused sick time.

*Indicates strategies that were not mentioned in the Working Group meetings, but were itemized in the literature review as strategies of importance.

Appendix 2 – Government Commitments

The Government of Ontario committed in the *Blueprint for Ontario* election platform and in the 1999 Throne Speech to fully implement the recommendations of *Good Nursing, Good Health: An Investment for the 21st Century*, Report of the Nursing Task Force (NTF) January 1999. The *Blueprint* and Throne Speech also made a crucial commitment to create 12,000 new permanent nursing positions by the year 2001. The Plan of Action in this Report assumes full and timely implementation of these commitments, since they are essential to the recruitment and retention of nurses in Ontario. This appendix spells out the NTF commitments and the status of their implementation as reported by MOHLTC during March 2000. The appendix also lists the nursing and health-care commitments in the *Blueprint* platform.

Report of the Nursing Task Force

The columns on *Recommendation* and *Implementation* are taken verbatim from the NTF report. The column on *Update from MOHLTC* is new and was supplied by MOHLTC staff. Please go to the next page.

RECOMMENDATION 1

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
To immediately enhance health-care delivery through nursing services by stabilizing the nursing workforce and improving retention of existing nurses, it is recommended that the Minister of Health and Long-Term Care: Ensure that no further losses to aggregate professional nursing positions take place across all spectrums of health-care delivery, and Immediately invest, on a permanent basis, $375 million before the Year 2000 to create additional permanent front line nursing positions. The first $125 million of this investment should be made by March 31,1999 to create permanent and sustainable front line nursing positions across all sectors of the health-care system. It is further recommended that a specific portion of the $375 million be directed to the employment of trained and qualified nurse practitioners. While there may be areas of urgent need for nursing services in the short term, the remainder of the investment in nursing services ($250 million) will be determined by a method of funding nursing services that ensures health-care consumers receive appropriate nursing care regardless of the setting in which it is received (see recommendation 5).	The Task Force recommends that the Ministry of Health and Long-Term Care make an investment of $125 million no later than March 31, 1999 in areas of highest need and a further $250 million by December 31, 1999. Key nursing groups and employer groups should be consulted on appropriate investment areas. Lead: Ministry of Health and Long-Term Care. Timeline: Flow $125 million by March 31, 1999 and a further $250 million by December 31, 1999.	• Full $130 million for hospital nursing has been flowing in monthly installments to support permanent nursing positions. • Over $30 million additional nursing investments were made in hospitals to support emergency, neo-natal, priority programs, post partem hospital care for mothers, and other programs. • Full $27 million in annual funding has flowed in monthly installments to expand in-home nursing services. • Full $20 million in annual funding flowing to long-term care centres to increase the number of front line nurses. • The RFP for 106 nurse practitioners was completed and successful sites were announced on February 23, 2000. The allocation of the new nurse practitioner positions was as follows: 33 in underserviced areas in southern Ontario, 43 in underserviced areas in northern Ontario, five for aboriginal health access centres, and five for primary care networks. The annual funding for this initiative is $10 million. • Over $6 million has been invested in public health nursing to contact all mothers within 48 hours and offer a home visit by a public health nurse.

RECOMMENDATION 1 (CONTINUED)

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
		• $7 million funding to support recruitment, training, clinical guidelines and fellowships has also flowed to RNAO and RPNAO. • The government also provided $1 million in research funding for database research on nursing services, staffing mix and patient outcomes. In addition the government has funded the creation of an expert panel on nursing outcomes and the project lead and support positions. • The remainder of the $375 million is attributed to previous commitments which began flowing this year to support nursing in long-term care facilities, homecare, emergency and priority programs, nurse practitioners and nurse training. • The government also recently announced (December 23, 1999) an investment of $196 million in new funding to hospitals. This funding is directed to: Address population growth and demographic changes, assist in transitional issues as restructuring continues, and to support priority programs such as cardiac and cancer care, dialysis treatment and hip and knee replacements.

RECOMMENDATION 2

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
In order to improve patient outcomes and the level of nursing services provided to consumers, it is recommended that ongoing structured opportunities be provided for RNs and RPNs to participate in a meaningful way in decisions that affect patient care on both a corporate and an operational level. In addition, health-care delivery organizations must ensure that there is specific responsibility and accountability, at a senior management level, for professional nursing resources. It is recommended that this be achieved through amendments to relevant legislation. It is also recommended that the Ministry of Health and Long-Term Care works with health-care facilities and educational institutions to ensure nurses are prepared for their on-going leadership roles.	Amend the Public Hospitals Act and other relevant legislation to require that health-care delivery organizations in every sector of the system designate a nursing professional(s) with authority and accountability for professional nursing practice, resource utilization and for decisions that affect the health-care consumer. Direct health-care facilities and educational institutions to implement programs to prepare nurses for this leadership role. Lead: Ministry of Health and Long-Term Care. Timeline: Fall 1999.	• Nursing plans were requested and submitted by employers. These plans required the sign-off and participation of a senior nursing officer in each organization. • A letter has been sent from the Ontario Medical Officer of Health and Ontario Chief Nursing Officer to all Medical Officers of Health in Ontario requesting the creation of a nursing leadership position. • The Ministry of Health and Long-Term Care created a Chief Nursing Officer who is also part of the senior management team. • No legislative changes have been made to date.

RECOMMENDATION 3

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
To ensure that nursing resources are available to health-care consumers based on reliable, relevant and timely evidence, it is recommended that the Ministry of Health and Long-Term Care invest an additional $1 million annually for research to support a comprehensive nursing resource database. This database can be used to determine the appropriate number and skill mix of professional nurses and non-professional providers for optimal client outcomes.	The Ministry of Health and Long-Term Care to enhance funding to researchers and experts in the field of nursing resource allocation and planning. This investment should be structured to take advantage of the existing research capability and partnerships in this province such as the NRU, the Institute of Clinical Evaluative Sciences (ICES), the Canadian Institute for Health Information (CIHI), and the Centre for Health Economics and Policy Analysis (CHEPA), among others. The investment should be conditional on effective dissemination and regular reporting of findings to key stakeholder groups, such as employers, labour organizations and professional associations. Lead: Ministry of Health and Long-Term Care Timeline: to be made available by Spring 1999.	• The Ministry of Health and Long-Term Care has provided $1 million in annual funding shared between the Nursing Research Units at the University of Toronto and McMaster University. The funding is to support database research on nursing services, staffing mix and patient outcomes.

RECOMMENDATION 4

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
Continuity and quality of care is highly dependent on the retention of experienced and knowledgeable nurses and requires not only a sufficient number of permanent positions for RNs and RPNs but also a working environment that offers flexibility and professional satisfaction. It is therefore recommended that employers of nurses mount pilot projects to test alternative models of nursing care (e.g. flexible hours, environments that enable nurses to develop clinical skills, etc.) and that these models be evaluated to assess the impact on client outcomes and the working environment for nurses. To ensure ongoing access to continuity and quality of care by nurses in the community, and the recruitment and retention of nurses in this sector, it is recommended that the Ministry of Health and Long-Term Care, employers and nurses work together to address inequities in the remuneration of nurses for home nursing services. To heighten awareness of a career in nursing and to encourage young women and men to choose a career in Nursing, it is recommended that the professional nursing associations, with the support of the Ministry of Health and Long-Term Care, mount a comprehensive marketing and communications plan.	Provide employers with necessary resources and tools to enable them to undertake pilot projects to test alternative models of nursing environments for RNs and RPNs and evaluate the impact on client care outcomes, professional satisfaction for nurses, and financial viability. Develop tool kits for high school guidance counsellors, outlining opportunities for professional nursing. Develop a program for practising nurses to visit high schools and inform students about opportunities in nursing. Ensure that male role models are included in this initiative in order to tap into the potential interests of young men. Develop an advertising and marketing campaign to heighten public awareness of the value of professional nursing services. Lead: Registered Nurses Association of Ontario (RNAO), Registered Practical Nurses Association of Ontario (RPNAO), Ministry of Health and Long-Term Care (MOHLTC), Council of Ontario University Programs in Nursing (COUPN), Colleges of Applied Arts and Technology (CAATs) Timeline: Fall 1999.	• The Ministry of Health and Long-Term Care has provided funding to RNAO for the development of clinical guidelines for nursing practice as well as clinical fellowships. • The Joint Provincial Nursing Group has commissioned a study looking at remuneration of home nurses and will provide advice to the Minister of Health and Long-Term Care. • The Ministry has provided RNAO and RPNAO with $500,000 to develop a recruitment strategy and support recruitment efforts.

RECOMMENDATION 5

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
To ensure that health-care consumers have access to appropriate nursing services, regardless of the setting in which they receive them, a comprehensive method of funding nursing services should be developed by November 1999. This funding method should be: Responsive to the changing needs of the health-care consumer; Based on performance standards for nursing services that promote quality outcomes; and Based on health information systems that provide comprehensive and reliable data on nursing services, workload and productivity.	Establish a working group on funding, which would include comprehensive representation from various nursing sectors, to oversee this task. Conduct an inventory of existing funding mechanisms for nursing and other health services to determine appropriate measurements. Identify any gaps in measurement. Manage this project in parallel with work on nursing information systems. (see recommendation 6) Develop a new method of funding nursing services that ensures that health-care consumers receive the level of nursing care they require, regardless of the setting in which the care is delivered. (This should be done in conjunction with nursing information system work, outlined in recommendation 6). Ensure consultation and linkage with other key stakeholders. Lead: Ministry of Health and Long-Term Care Timeline: Minister to establish working group by February 1999, with expert representation from across the health-care sector. Model for funding nursing services to be developed by November 1999.	• The Ministry of Health and Long-Term Care has funded and established an expert panel to define the linkage between nursing services and patient outcomes. • The Ministry has recruited an executive lead, Dorothy Pringle, and a project manager.

RECOMMENDATION 6

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
To ensure that decisions are based upon the best information available, information systems used for health-care planning, delivery of services and funding must provide comprehensive data on health-care consumer status, nursing interventions and client outcomes. These information systems must include comprehensive and realistic information on nursing workload and productivity and should support client outcomes identified above.	Identify in each key sector of health-care, the current status of information systems that are used to inform decisions about funding, staffing for professional nursing services and consumer outcomes. Establish a working group to build on systems that are relatively well developed, and determine suitability for application across the spectrum of health-care facilities where nursing services are provided. The working group should include resources from Joint Provincial Planning Committee (JPPC), Canadian Institute of Health Information (CIHI), Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU), and nursing organizations. Make seed funding available to support on-going data development and establishment of pilot sites for data collection and information system development Lead: Ministry of Health and Long-Term Care Timelines: Establish working group by February 1999, with a report on potential pilot sites by June 1999.	• The Expert Panel on Nursing Outcomes is looking at developing new reporting requirements and information systems to support recommendation #5.

RECOMMENDATION 7

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
In order to ensure continued access to quality health-care services, we must support our existing educated and experienced RN and RPN workforce and ensure that health-care consumers continue to receive quality nursing services from professional nurses. In the future, to ensure that professional nurses have the right mix of knowledge, skills and experience, the following is recommended:		
a) Make the Bachelor of Science in Nursing (BScN) (or equivalent), the College of Nurses of Ontario (CNO) minimum entry-to-practice requirement for new RNs beginning in the year 2005, consistent with the CNO's recent recommendation on RN entry to practice competencies, and confirm that all RNs registered with the CNO before that time continue to be eligible under the new system.	Review CNO recommendation on competencies and education requirements. Establish a working group with key stakeholders to develop an implementation plan, including changes to regulations, appropriate funding mechanisms, education program evaluation and assessment, and RN supply requirements. Lead: MOHLTC, Ministry of Education and Training (MET), College of Nurses of Ontario (CNO) Timeline: CNO recommendations delivered in December 1998. Establish working group in February 1999 to plan for first intake of BScN-only students by 2002.	Recommendation #7a • Established the Nursing Education Implementation Committee to provide recommendations on implementing a collaborative college and university nursing program. • Committee submitted the report to the Minister of Training Colleges and Universities. • Awaiting government announcement regarding regulation and funding.

RECOMMENDATION 7 (CONTINUED)

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
b) Lengthen the college program for future RPNs from three to four semesters (pending completion of the CNO's work on competencies and education requirements for RPNs) and confirm that all RPNs registered with the CNO before that time continue to be eligible under the new system.	Await CNO recommendation on competencies and education requirements for RPNs. Establish subcommittee of working group, identified in subsection a, to develop an implementation plan. Lead: MOHLTC, Ministry of Education and Training (MET), College of Nurses of Ontario (CNO). Timeline: CNO recommendations are expected June to October 1999. Establish subcommittee of working group, referenced in subsection a, in the Fall of 1999.	Recommendation #7b • Competencies have been forwarded to the Ministry of Training, Colleges and Universities and Ministry of Health and Long-Term Care for review.
c) Remove barriers and add financial incentives for partnering between community colleges and universities to provide relevant, accessible and portable education programs for RNs and RPNs.	Working group, identified in subsection a, to develop a model and implementation plan for collaboration on basic education for RNs and advanced and continuing education for RNs and RPNs. The model will identify funding, the regulatory and organizational barriers to be removed, and the resources required to implement it. Lead: MOHLTC, Ministry of Education and Training (MET), College of Nurses of Ontario (CNO). Timeline: Establish a specific working group in February 1999 to report by Fall 1999.	Recommendation #7c • Same as 7a

RECOMMENDATION 7 (CONTINUED)

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
d) Provide a flexible environment through financial incentives for nurses and their employers, to ensure timely and affordable access to continuing and advanced education. This flexible environment should include designated funds to support and facilitate continuing and advanced education for nurses, including sabbaticals, job exchanges, etc.	Establish an incentive fund that both nurses and employers can access to support continuing and advanced education for nurses. Lead: MOHLTC. Timeline: See recommendation 5.	Recommendations #7d and e: • The Ministry of Health and Long-Term Care has provided $7 million to RNAO and RPNAO to support training, clinical guidelines, clinical fellowships and recruitment. RNAO and RPNAO are finalizing a recruitment and retention report to be submitted to the Minister.
e) Establish clinical models in practice environments to allow nurses to gain expertise in clinical areas and be recognized for these additional skills.	Nurses and employers will collaborate on proposals to access resources based on established criteria to be developed by the working group, identified in subsection a, to work with RNAO, RPNAO, CNO and other professional associations, labour organizations and educational institutions to identify and implement potential clinical models that will enhance patient care and improve nursing work life. Lead: Employers , RNAO, and RPNAO, labour organizations. Timeline: Clinical models to be established by Fall 1999.	
f) Provide sufficient financial resources to employers to support the ability of experienced nurses to teach new nurses.	Availability of financial resources to be tied to investments made in Recommendation 1. Lead: MOHLTC. Timeline: See recommendation 1.	Recommendation #7f • No action to date.

RECOMMENDATION 8

RECOMMENDATION (from NTF report)	IMPLEMENTATION (from NTF report)	UPDATE FROM MOHLTC
To ensure that these recommendations are continuously reviewed, evaluated and adjusted as required, to meet changing needs, we recommend that a process be established to monitor their implementation, effectiveness and outcomes. We further recommend that the Joint Provincial Nursing Committee be charged with this responsibility.	The Minister mandates the Joint Provincial Nursing Committee (JPNC) to be responsible for monitoring the implementation of the Task Force's recommendations and the evaluation of their effectiveness. The JPNC reports regularly to the Minister on the progress of implementation and if the recommendations are achieving the desired outcomes. It also suggests adjustments and enhancements, as required. Lead: JPNC Timeline: On-going, with quarterly reports to the Minister.	• The JPNC has been mandated to monitor the implementation. Progress and issues are identified, reviewed and discussed on a monthly basis. Surveys of employers have been circulated to obtain a status report of nursing positions created. Audits will be conducted of randomly selected employers

Blueprint Election Platform

Excerpts - Supporting Nurses

Hiring 12,000 New Nursing Positions:

> "Nurses are fundamental to our health-care system. Our new investments in community care depend directly on their skills and hard work. That's why we set up a task force on nursing and have accepted all of its recommendations. For example, we recently announced $375 million in funding this year to hire more nurses. Over three years, we'll have added twelve thousand more nurses for every aspect of our health-care system, from hospitals to home care. That's just one step in our plan to support nursing in Ontario."

Chief Nursing Officer:

> "In order to give nurses a greater voice in hospitals, we'll insist on the creation of a Chief Nursing Officer as a key executive position in hospitals."

Nurse Practitioners:

> "We also think a lot of basic health-care services are provided just as well by nurse practitioners, and that more of them could be employed, particularly in providing primary care services in underserviced areas of Ontario. So, we'll increase funding for nurse practitioners and take an aggressive approach to getting more of them into practice across the province."

Excerpts - Supporting Health

Canada Health Act:

> "Our government is fully committed to the principles of the Canada Health Act, including universal access to a publicly funded health-care system. You and your family need to know that medical care will be available when and where you need it."

Health-care Funding:

> "In order to meet future health-care needs, we will increase funding for health-care a guaranteed 20% in our next term. Based on the latest 1998-99 figures, this will mean nearly $4 billion a year more for your health care by 2003-4."

Patients' Bill of Rights:

"We'll introduce a Patients' Bill of Rights to guarantee the people of Ontario excellent health care. The Bill will include the rights to:

Guaranteed access to health services. (See box at right)

Access to complete information on your own health, including all of your records, doctor's notes and test results as well as the right to a clear explanation of all procedures, drugs and options for treatment.

Treatment with respect -- respects for the privacy of your health issues and records, as well as respect for your personal dignity and safety.

Hospitals will have their funding directly tied to how well they live up to their service obligations to you under the Patients' Bill of Rights."

Hospital Report Cards:

"Patient satisfaction is just one measure of how well hospitals are doing their jobs. We also want to know if they are operating efficiently, how their service levels stack up against other hospitals, and where there is room for improvement. Surprisingly, no Ontario government has ever regularly measured these basic indicators of hospital performance.

We'll use patient surveys along with regular and random audits to test how well our hospitals are doing and publish the hospital report card results in your local newspaper.

The lowest-scoring hospitals will get the help they need to improve their services to people. We'll form teams of health-care efficiency and service experts to work with the weaker performers to revamp their systems, and we'll involve staff from the top-performing hospitals in helping the less successful hospitals learn to do better."

Appendix 3 – Consultation Process

When we initiated the consultation, two working groups were created, representative of a broad cross-section of nurses, to identify strategies for the recruitment and retention of nurses, and to position nursing as a rewarding career choice for students. Through roundtable discussions and breakout sessions, representatives from staff nurses, employers, student nurses, school counsellors, educational institutions, educators, career transition counsellors, regulatory college, unions, and provincial ministries of health and long-term care, and of education and training, deliberated on recommendation 4 from the provincial Nursing Task Force report (the list of participants in all the consultations is in appendix 4).

The goal for the RN/RPN recruitment and retention working group was to focus on concrete and successful strategies aimed at ensuring Ontario has adequate numbers of highly qualified and motivated nurses to serve the public. The goal for the student recruitment working group was to focus on concrete and successful strategies to encourage high school, college, university, and mature students, to make nursing their career choice. These two working groups met separately on June 14, 1999 and developed a list of strategic solutions for the short, medium, and long-term. Their efforts were supported by an extensive literature review related to the recruitment and retention of nurses.[1] The groups then prioritized these strategies through a mail-out questionnaire. As many of the strategies were interrelated, and because of the clear consensus on many of the strategies suggested during the discussions, all the participants were asked to rank the strategies for both working groups. Based on this ranking, a plan of action was developed with specific recommendations that have been incorporated into this report. The working groups met jointly for a second time on November 3, 1999. This time their role was to review the pre-circulated draft report to determine if their original discussion was reflected clearly and as intended.

In addition to the two working groups, several focus groups were conducted from mid-October to mid-November, 1999. Each group was asked to discuss the pre-circulated draft report. The goal was to ensure that the report and its recommendations reflect the realities and needs of different geographical areas, as well as urban, rural and isolated settings.

Focus groups comprised of registered nurses and registered practical nurses were held in rural Ontario, Ottawa, and in Northern Ontario. Participants in these focus groups were asked to review and validate the recommendations contained within the nursing recruitment and retention report, noting any circumstances or situations that would impact on the implementation of the recommendations, based on their geographical location and their unique knowledge. Three additional focus groups were held: interdisciplinary focus

[1] Registered Nurses Association of Ontario (1999). *Nursing Recruitment and Retention Literature Review*. Prepared by RNAO's Centre for Professional Development. Available on request.

group, human resource focus group and educator focus group. These individuals were invited to review the report and recommendations and offer feedback based on their particular perspectives. The Boards of Directors of RNAO and RPNAO also had the opportunity to review a draft of the report.

Finally, the Ministry of Health and Long-Term Care organized sectoral meetings for the hospital, long-term care and community care sectors to review and validate the entire report. Unfortunately, the hospital sector declined the invitation due to their labour negotiations with the Ontario Nurses Association (ONA).

Overall, participants in the consultations strongly agreed with the broad recommendations in the report. Participants acknowledged the effort to develop a document with significant breadth and depth, and contributed numerous ideas, feedback, suggestions, and practical criticism. The extensive consultation served to clarify and sharpen the analysis and add important strategies to the action plan.

The draft report was presented for endorsement and feedback to the Joint Provincial Nursing Committee (JPNC) on November 30, 1999 and January 31, 2000.

Appendix 4 – Participants

Working Groups

All dates refer to the year 1999

RN/RPN Recruitment and Retention Working Group – June 14 and November 3

Bernita Borgh, RN, Vice President of Resident Services, Don Mills Foundation for Senior Citizens, Administrator, Thompson House, Toronto

Jacqueline Choiniere, RN, MA, Director, Policy, Practice & Research, Registered Nurses Association of Ontario, Toronto

Karen Cobb, BA, Research Associate, Service Employees International Union (SEIU), Toronto

Naomi Cornelius, RPN, Director, Professional Practice and Education, Registered Practical Nurses Association of Ontario, Mississauga

Kathy Ellis, BScN, MA (Ed), Co-ordinator, Nursing, Centennial College, Scarborough

Kim English, RN, BN, Practice Consultant, College of Nurses of Ontario, Toronto

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Patricia Haycock, RN, BA, CNNC(C), Staff Nurses Interest Group, Registered Nurses Association of Ontario, Toronto

Angie Johnson, RN, Ontario Nurses' Association, Whitby

Kelly Kay, RPN, Director, Career Development Centre, Registered Practical Nurses Association of Ontario, Mississauga

Nancy Lefebre, RN, MScN, Vice President – Knowledge and Practice, St. Elizabeth Health Care, Markham

Peggi Mace, Director of Communications, Registered Nurses Association of Ontario, Toronto

Marg McAlister, Vice President – Operations, ComCare Health Services, London

Marion Megesi, BScN, RN, Manager – Public Health Nursing, Durham Region Health Department, Whitby

Diane McLeod, RN, BScN, MES, Senior Director – Central Region, Victorian Order of Nurses of Canada, Toronto

Trudy Molke, RN, BScN, Practice Consultant, College of Nurses of Ontario, Toronto

Trish Nesbitt, RPN, President-Elect, Registered Practical Nurses Association of Ontario, Mississauga

Susan C. Plewes, RN, CIC, Executive Assistant/Health Policy Advisor, Office of the President, Ontario Hospital Association, Toronto

Margaret Ringland, BScN, RN, Director of Regional Relations and Professional Services, Ontario Association of Non-Profit Homes and Services for Seniors, Woodbridge

Marianne Ritchie, RPN Student, Registered Practical Nurses Association of Ontario, Mississauga

Anita Robertson, RN, BAAN, MPA (cand.), Director of Resident Care, Ontario Nursing Home Association, Markham

Barbara Thornber, Executive Director, Registered Practical Nurses Association, Toronto

Carol Townsend, Nursing Project Manager, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

Sue Williams, RN, BNSc, MEd, President, Registered Nurses Association of Ontario, Toronto

Lynn Woolcott, RN, Clinical Manager, Regent Park Community Health Centre, Toronto

Student Recruitment and Retention Working Group – June 14 and November 3

Felicia Alleyne, Vice Chair, Provincial Nursing Students Group, Registered Nurses Association of Ontario, Scarborough

Adrian Cornelissen, Career Transition Consultant, Mossop, Cornelissen and Association, Toronto

Naomi Cornelius, RPN, Director of Professional Practice and Education, Registered Practical Nurses Association of Ontario, Toronto

Denise Dietrich, RPN, BA, Practice Consultant, College of Nurses of Ontario, Toronto

Irene Gresdal, Secondary School Project, Ministry of Education and Training, Toronto

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Phil Hedges, Second Vice President, Ontario School Counsellors Association, Delhi

Susan Jenkinson, RN, BA, Practice Consultant, College of Nurses of Ontario, Toronto

Angie Johnson, RN, Ontario Nurses' Association, Whitby

Kelly Kay, RPN, Director of Career Development Centre, Registered Practical Nurses Association of Ontario, Mississauga

Renee Kenny, RN, BA, MEd, Chair, Nursing Programs, Centennial College of Applied Arts, Scarborough

Peggi Mace, Director of Communications, Registered Nurses Association of Ontario

Rosalind Mielke, First Vice President, Ontario School Counsellors' Association, Peterborough

Lorne McDougall, PhD, Director of Nursing, Lakehead University, Thunder Bay

Barbara Morrison, Professor, Health Sciences (?), Confederation College, Thunder Bay

Trish Nesbitt, RPN, President-Elect, Registered Practical Nurses Association of Ontario, Mississauga

Marilyn Parsons, RN, BNSc, MHSc, Assistant Professor, School of Nursing, McMaster University, Hamilton

Marianne Ritchie, RPN student representative, Registered Practical Nurses Association of Ontario, Mississauga

Nancy Sagmeister, Consultant, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

Barbara Thornber, Executive Director, Registered Practical Nurses Association, Toronto

Carol Townsend, Nursing Project Manager, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

Sue Williams, RN, BNSc, MEd, President, Registered Nurses Association of Ontario, Toronto

Focus Group

Loyalist College Nursing Students (First Year) Focus Group – October 19

Rural Ontario RN/RPN Focus Group – October 25

Jeanette Diebel, RPN, Walkerton

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Peggi Mace, Director of Communications, Registered Nurses Association of Ontario, Toronto

Anne McKenzie, RPN, Waterloo, Wellington, Dufferin VON, Holstein

Liz Ruegg, RN, Coordinator, Patient Care, Palmerston and District Hospital, Palmerston

Isabel Pridham, RPN, Palmerston and District Hospital, Palmerston

Mark Sanderson, RN, Louise Marshall Hospital, Louise Marshall Hospital/Palmerston Hospital, Mount Forest

Donna Vines, RN, Listowel Memorial Hospital, Listowel

Ottawa area RN/RPN Focus Group – October 26

Deanne Barber, RPN, VON Ottawa-Carleton, Ottawa

Sharon Cavar, RPN, Queensway-Carleton Hospital, Ottawa

Elizabeth Diem, RN, PhD, Assistant Professor, School of Nursing, University of Ottawa, Ottawa

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Bonnie Hall, RN, MScN, Clinical Nurse Specialist, Geriatrics, Queensway-Carleton Hospital, Ottawa

Donna Leafloor, RN, Nursing Research Assistant / Coordinator-Clinical Pathways, Ottawa Hospital – Civic Campus, Ottawa

Lisa Little, RN, Nursing Recruitment and Retention Officer, Ottawa Hospital, Ottawa

Peggi Mace, Director of Communications, Registered Nurses Association of Ontario, Toronto

Gaye Moffatt, RN, BScN, MEd, Owner/President, GEM Health Care Services Inc., Ottawa

Jeanne Robertson, RN, Operations Director-Paediatrics, Children's Hospital of Eastern Ontario, Ottawa

Sue Wright, RPN, Administrator/Counsellor, Ottawa Stroke Association, Ottawa

Northern Ontario RN/RPN Focus Group – October 28

Sheila Arsenault, RPN, Rouge Valley Health System, Ajax & Pickering Health Centre, Ajax

Debra Bennett, RN, BA (ACS), Director of Patient Care, Manitoulin Health Centre, Little Current

Yvonne Boomhour, BScN, Executive Director, Victorian Order of Nurses, North Bay

Lynda Dukacz, RN, BA, MBA, Director – ER/Critical Care/Rehab, Timmins and District Hospital, Timmins

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Joanna Horne, RN, Executive Director, Victorian Order of Nurses, Sudbury

Michelle Humber, RN, Education Coordinator, MICS Group of Hospitals, Lady Minto Hospital, Cochrane

Gwen Iburg, RN, Professor, Sault College, School of Health Sciences, Sault Ste. Marie

Nancy Jacko, Program Director, Medicine Care Centre, North Bay General Hospital - Scollard Site, North Bay

Vickie Kaminski, RN, Vice President - Clinical Programs, Sudbury Regional Hospital - Laurentian Site, Sudbury

Sandra Laclé, Director of Health Promotion, Sudbury and District Health Unit, Sudbury

Peggi Mace, Director of Communications, Registered Nurses Association of Ontario, Toronto

Patricia Maxwell, RN, Supervisor of Nursing, St. Joseph Hospital, Elliott Lake

Dawn Norling, RPN, Oncology, Sault Area Hospitals, Sault Ste. Marie

Joanne Norlen, RN, BScN, Assistant Executive Director, Patient Care Services, Lake of the Woods District Hospital, Kenora

Gladys Rangaratnam, Dean, School of Health and Human Services, Cambrian College, Sudbury

Ellen Rackholm, RN, PhD, Director - School of Nursing, Laurentian University, Sudbury

Therese Savignac, RN, Coordinator - ER/OR, West Nipissing General Hospital, Sturgeon Falls

Majorie Thomas, RN, Director of Nursing, West Parry Sound Health Centre, Parry Sound

Jacqueline A. Thoms, RN, Northern Outreach / Community Development Coordinator, Health Sciences Education Resource Centre, Laurentian University, Sudbury

Marilyn Travaglini, RN, Director - Child, Maternity and Surgical Services, Sault Area Hospitals, Sault Ste. Marie

Donna Tremblay, Dean, Health and Human Sciences, Sault College, Sault Ste. Marie

Interdisciplinary Focus Group – November 16

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Signe Holstein, CAE, Executive Director, Ontario Physiotherapy Association, Toronto

Peggi Mace, Director, Communications, Registered Nurses Association of Ontario, Toronto

Ethel Meade, Health Issues Committee, Older Women's Network, Toronto

Human Resources Focus Group – November 16

Margaret Bachle, RN, MBA, Vice President, The Credit Valley Hospital, Mississauga

Kathy Craddock, RN, Recruitment Resource Nurse, Saint Elizabeth Health Care, Markham

Dennis Fong, Manager, Human Resources, Community Care Access Centre, Toronto

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Peggi Mace, Director, Communications, Registered Nurses Association of Ontario, Toronto

David Mahy, Director, Employment Services, Baycrest Centre for Geriatric Care, Toronto

Emma Pavlov, Vice President, Human Resources, University Health Network, Toronto

Barbara Pope, CMC, CHRP, Barbara Pope & Associates, Toronto.

Rhonda Watson, CHRP, Human Resources Consultant, Sudbury Regional Hospital, Sudbury

Educators Focus Group – November 18

Linda Buschmann, Project Officer, Program Quality Unit, Colleges Branch, Ministry of Training, Colleges and Universities

Betty Cragg, RN, EdD, Director, Faculty of Health Sciences, University of Ottawa, Ottawa

Paula Donahoe, RN, BScN, MEd, Professor, School of Applied Arts & Health Sciences, Centennial College, Scarborough

Gail J. Donner, RN, PhD, Professor and Dean, Faculty of Nursing, University of Toronto, Toronto

Patricia Duxbury, Professor of Nursing, Mohawk College, Hamilton

Carl Gray, RN, BN, MA, Coordinator, Practical Nursing Program, Department of Health Sciences (Nursing), Confederation College, Thunder Bay

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Peggi Mace, Director, Communications, Registered Nurses Association of Ontario, Toronto

Lorne McDougall, RN, MN, Ed.D, Director, Lakehead University School of Nursing, Thunder Bay

Paula Price, BScN, MEd, Chair, Faculty of Health Sciences, George Brown College, Toronto

Barbara Thornber, Executive Director, Registered Practical Nurses Association of Ontario, Mississauga

Mary Lou Trowell, Coordinator, Practical Nursing Program, Cambrian College, Sudbury

Micki Walters, BScN, MAEd, Director, Health and Human Studies, Durham College, Oshawa

Sue Williams, RN, BNSc, MEd, President, Registered Nurses Association of Ontario

Sectoral Meetings

Ministry of Health and Long-Term Care Long-Term Care Sector Focus Group - November 9

Bernita Borgh, RN, Vice President of Resident Services, Don Mills Foundation for Senior Citizens, Administrator, Thompson House, Toronto

Jacqueline Choiniere, RN, MA, Director, Policy, Practice & Research, Registered Nurses Association of Ontario, Toronto

Nadine Cross, RN, MHSc, PhD (cand.), Assistant Professor, School of Nursing, York University, Toronto

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Peggi Mace, Director of Communications, Registered Nurses Association of Ontario, Toronto

Pamela McKintuck, RN, BA, Professor, Continuing Education, Nursing, Humber College, Head of Continuing Education in Health Sciences for Ontario, Toronto

Margaret Ringland, BSc, RN, Director of Regional Relations and Professional Services, Ontario Association of Non-Profit Homes and Services for Seniors, Woodbridge

Anita Robertson, RN, BAAN, MPA (cand.), Director of Resident Care, Ontario Nursing Home Association, Markham

Barbara Thornber, Executive Director, Registered Practical Nurses Association of Ontario, Mississauga

Carol Townsend, Nursing Project Manager, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

George Zegarac, Director, Provincial Health Services Branch, Ministry of Health and Long-Term Care, Toronto

Ministry of Health and Long-Term Care Community Care Sector Focus Group – November 9

Jacqueline Choiniere, RN, MA, Director, Policy, Practice & Research, Registered Nurses Association of Ontario, Toronto

Susan Donaldson, Chief Executive Officer, Ontario Association of Community Care Access Centres, Scarborough

Doris Grinspun, RN, MSN, PhD (cand.), Executive Director, Registered Nurses Association of Ontario, Toronto

Nancy Lefebre, RN, MScN, Vice President, Knowledge and Practice, St. Elizabeth Health Care, Markham

Peggi Mace, Director of Communications, Registered Nurses Association of Ontario, Toronto

Pamela McKintuck, RN, BA, Professor, Continuing Education, Nursing, Humber College, Head of Continuing Education in Health Sciences for Ontario, Toronto

Diane McLeod, RN, BScN, MES, Senior Director, Victorian Order of Nurses of Canada –Central Region, Toronto

Barbara Thornber, Executive Director, Registered Practical Nurses Association of Ontario, Mississauga

Carol Townsend, Nursing Project Manager, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

Susan D. VanderBent, BA, BSW, MSW, MHSc, CHE, Executive Director, Ontario Home Health Care Providers Association, Hamilton

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Carol Fine, MAL, Nursing Education

Cynthia Crawford, MAL, Socio-Political Affairs

Linda O'Brien-Pallas, MAL, Nursing Research

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Lesley Bell, RN, BScN, Chief Executive Officer, Ontario Nurses' Association

Brad Graham, Assistant Deputy Minister (Acting), Integrated Policy and Planning, Ministry of Health and Long-Term Care

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Beth Horsburgh, Professor, School of Nursing, Windsor University

Paul Howe, RPN, Vice President – RPN, College of Nurses of Ontario

Angie Jones, President, Practical Nurses Federation of Ontario

Renee Kenny, Chair – Nursing Programs, Centennial College, Scarborough

John King, Assistant Deputy Minister, Health Care Programs, Ministry of Health and Long-Term Care

Linda LaHay, RPN, President, Registered Practical Nurses Association of Ontario

Mary MacLeod, RN, President, College of Nurses of Ontario

Margaret Risk, RN, BScN, MScN, Executive Director, College of Nurses of Ontario

Nancy Sagmeister, Consultant, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

Peggy Smyth, Consumer Representative, Sault Ste. Marie

Allison Stuart, Director – Hospital Programs, Ministry of Health and Long-Term Care

Barbara Thornber, Executive Director, Registered Practical Nurses Association of Ontario

Carol Townsend, Nursing Project Manager, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

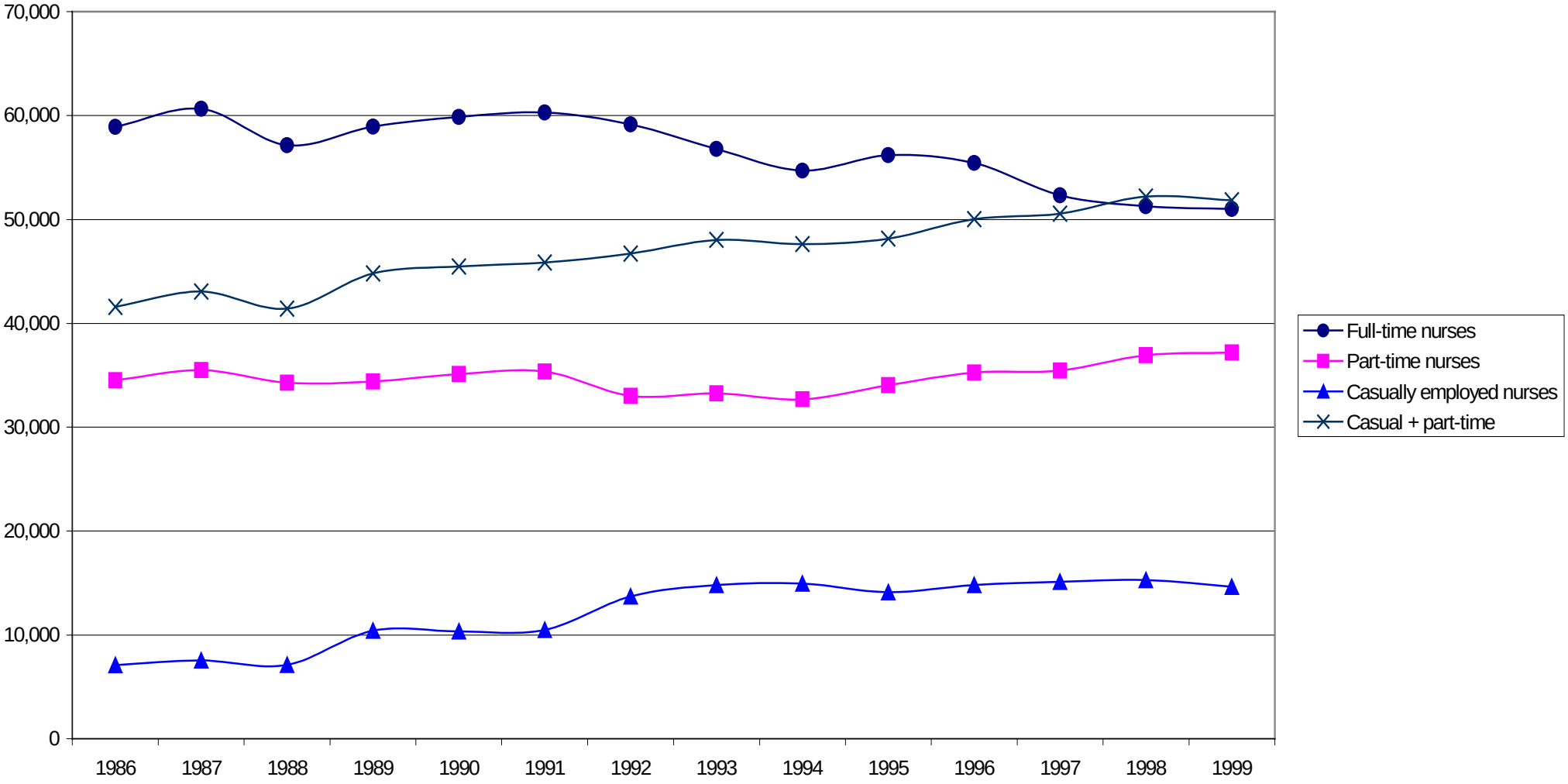
Barb Wahl, RN, BA, President, Ontario Nurses' Association

Sue Williams, RN, BNSc, MEd, President, Registered Practical Nurses Association of Ontario

George Zegarac, Director, Provincial Health Services Planning Branch, Ministry of Health and Long-Term Care, Toronto

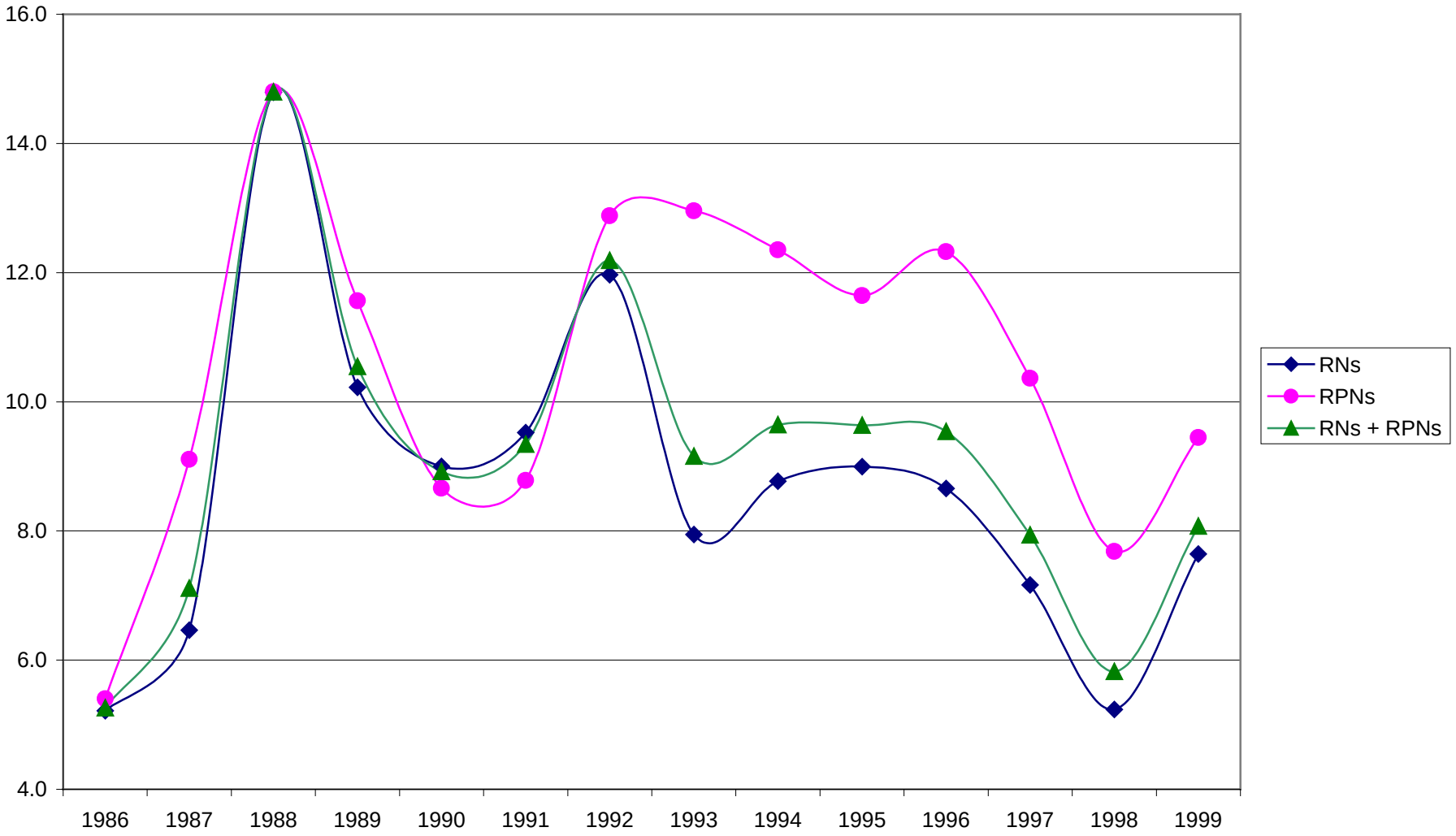
Appendix 5 Figures

Figure 1: Increasing Trend to Casualization in Ontario Nursing Employment



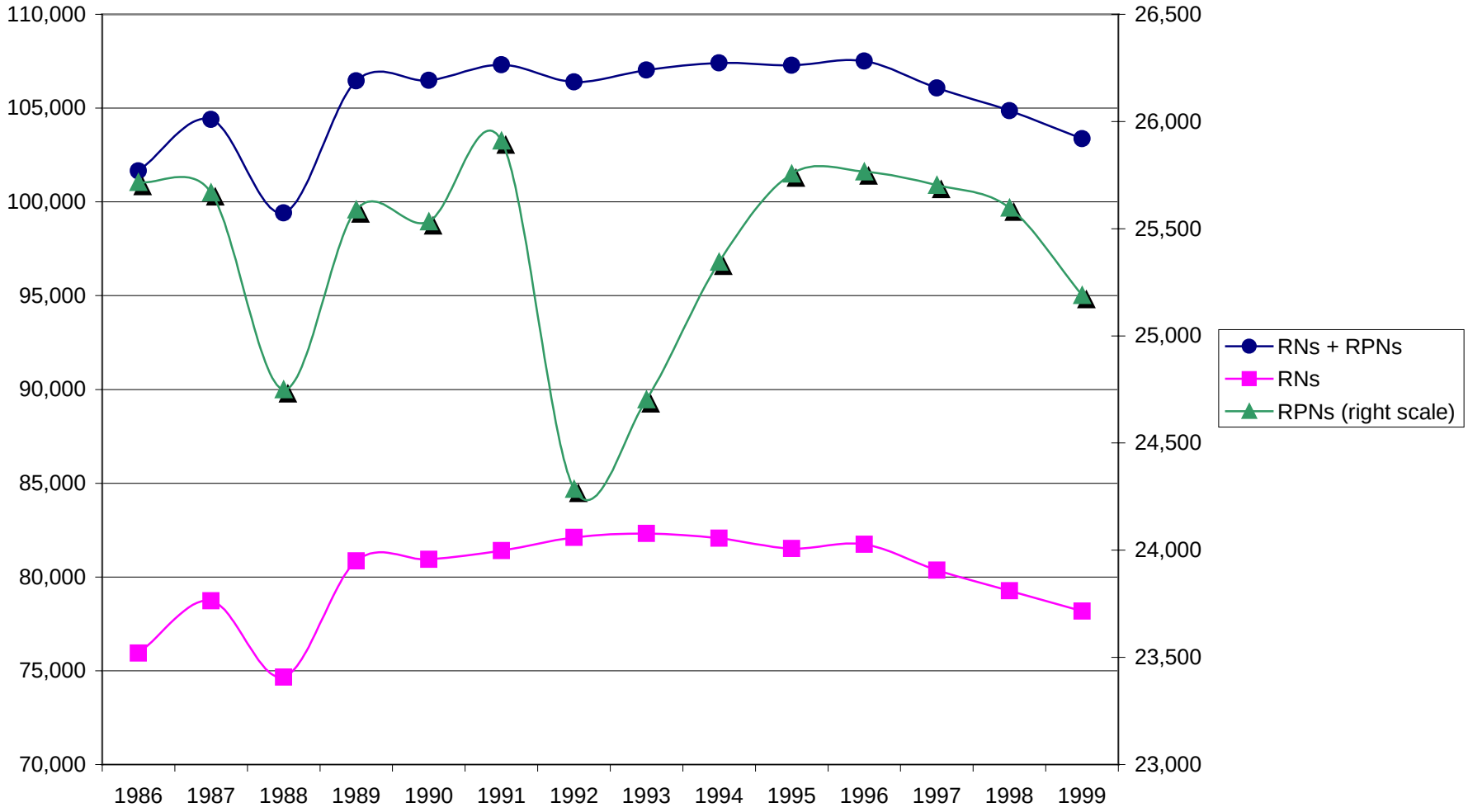
Data source: College of Nurses of Ontario

Figure 2: CNO Percent Non-Reporting Rate for Employment Statistics



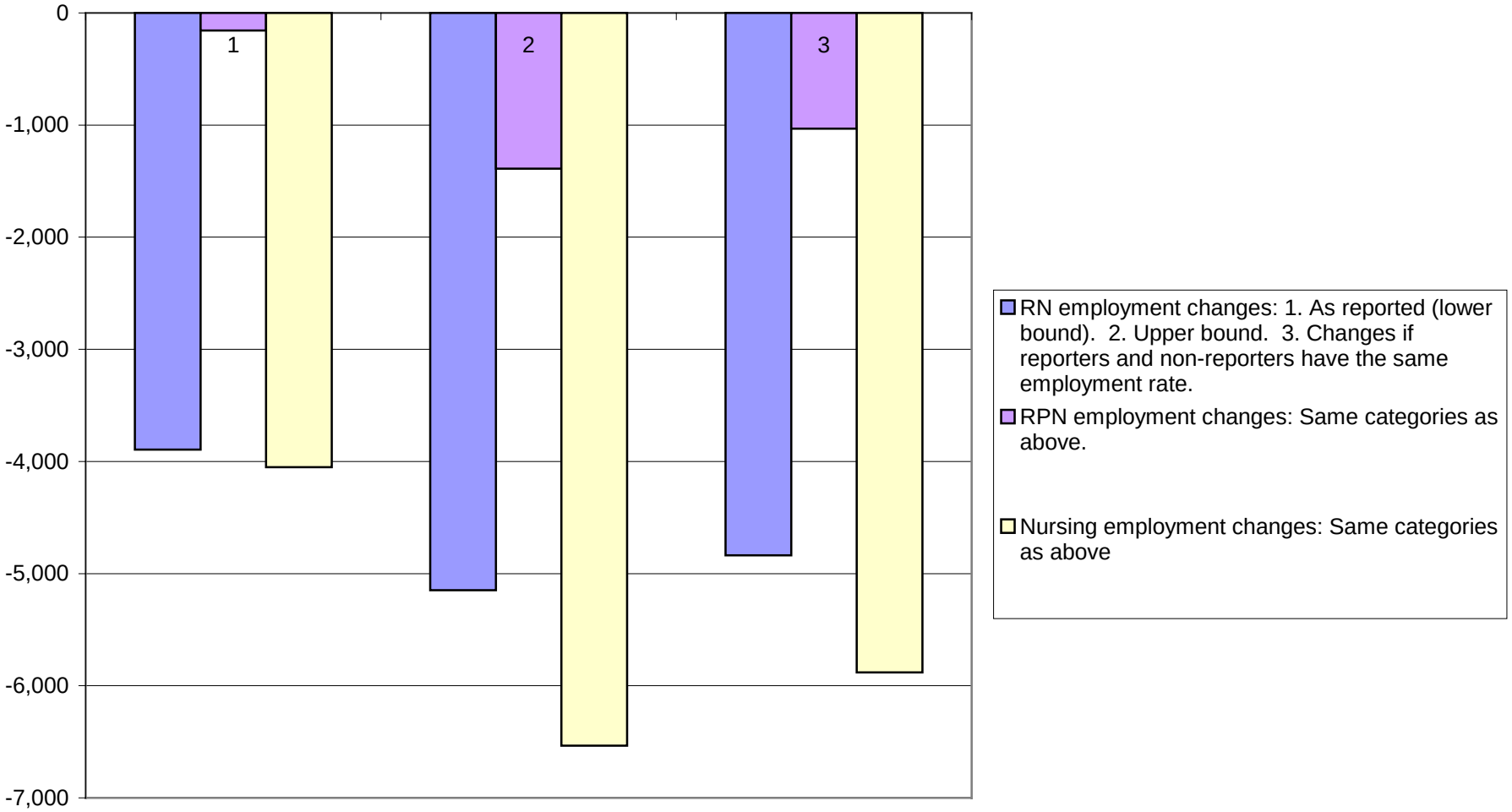
Data source: College of Nurses of Ontario

Figure 3: Nursing Employment in Ontario
Note: RPNs on right scale



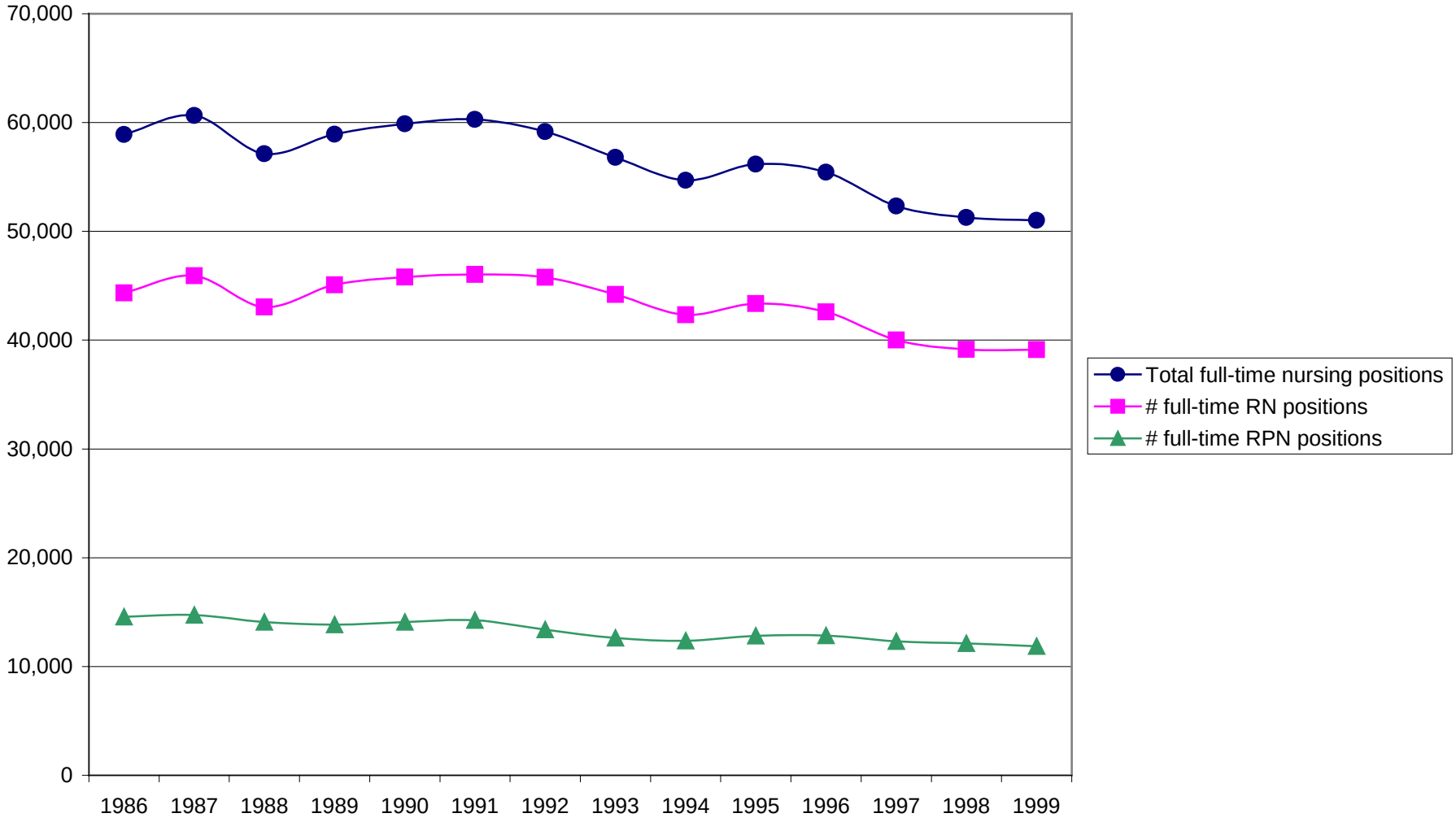
Data source: College of Nurses of Ontario

Figure 4: Measuring Employment Changes in Nurses in Ontario between 1994 and 1999: Various Scenarios



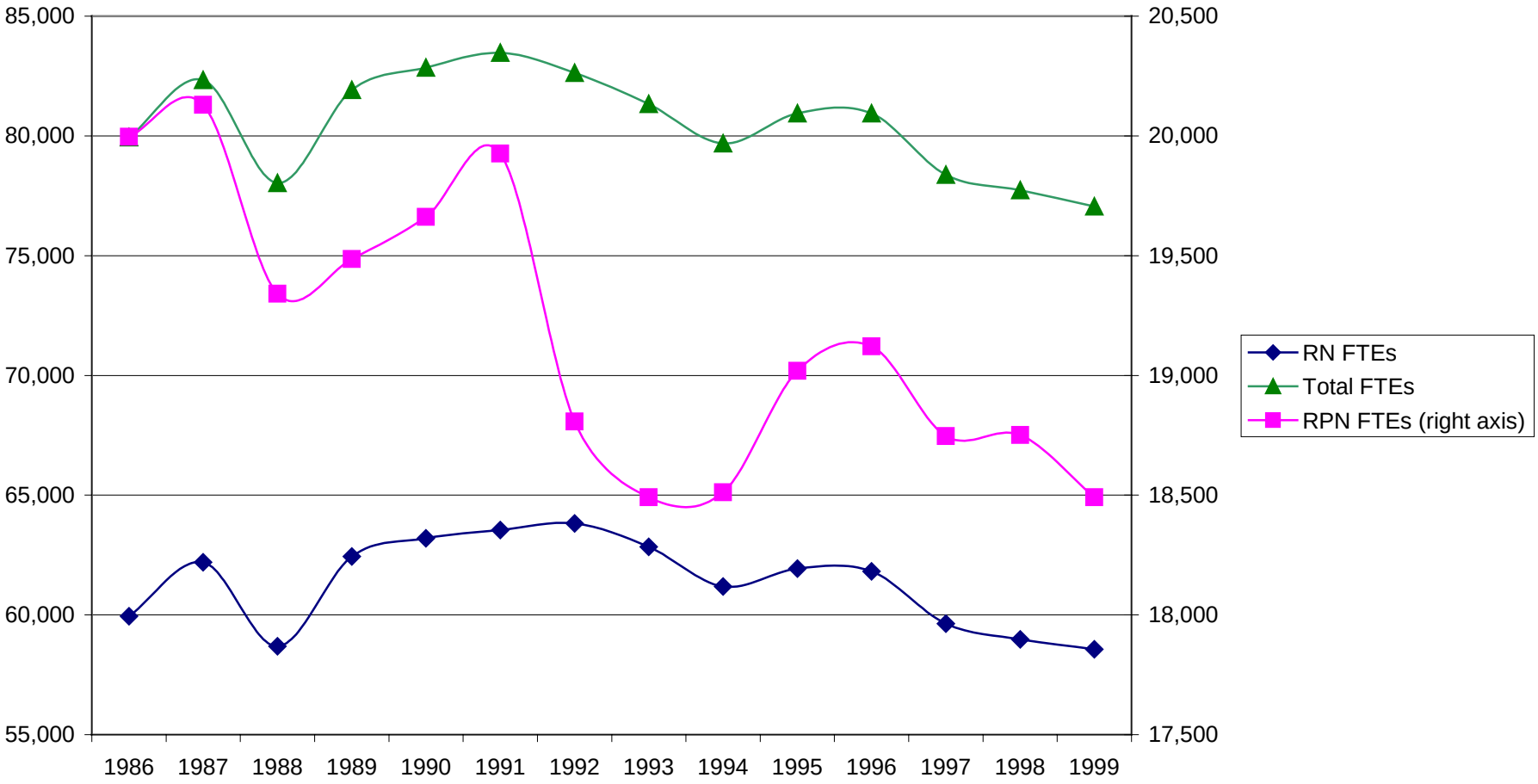
Data source: College of Nurses of Ontario

Figure 5: Number of Reported Full-Time Nursing Positions in Ontario



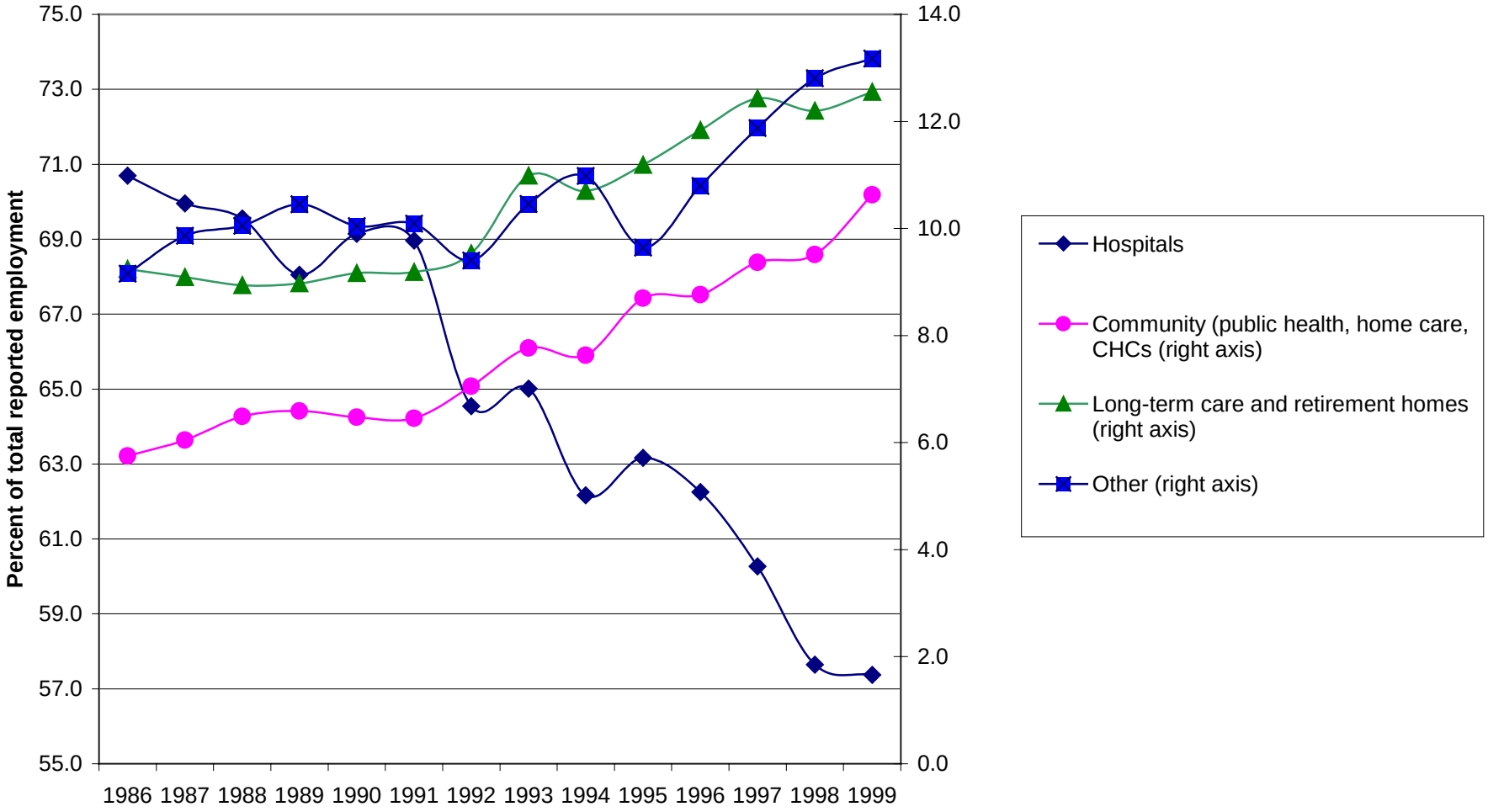
Data source: College of Nurses of Ontario

Figure 6: Trends in Employment of Ontario Nurses: Number of Estimated FTEs
Note: RPN FTEs on right scale



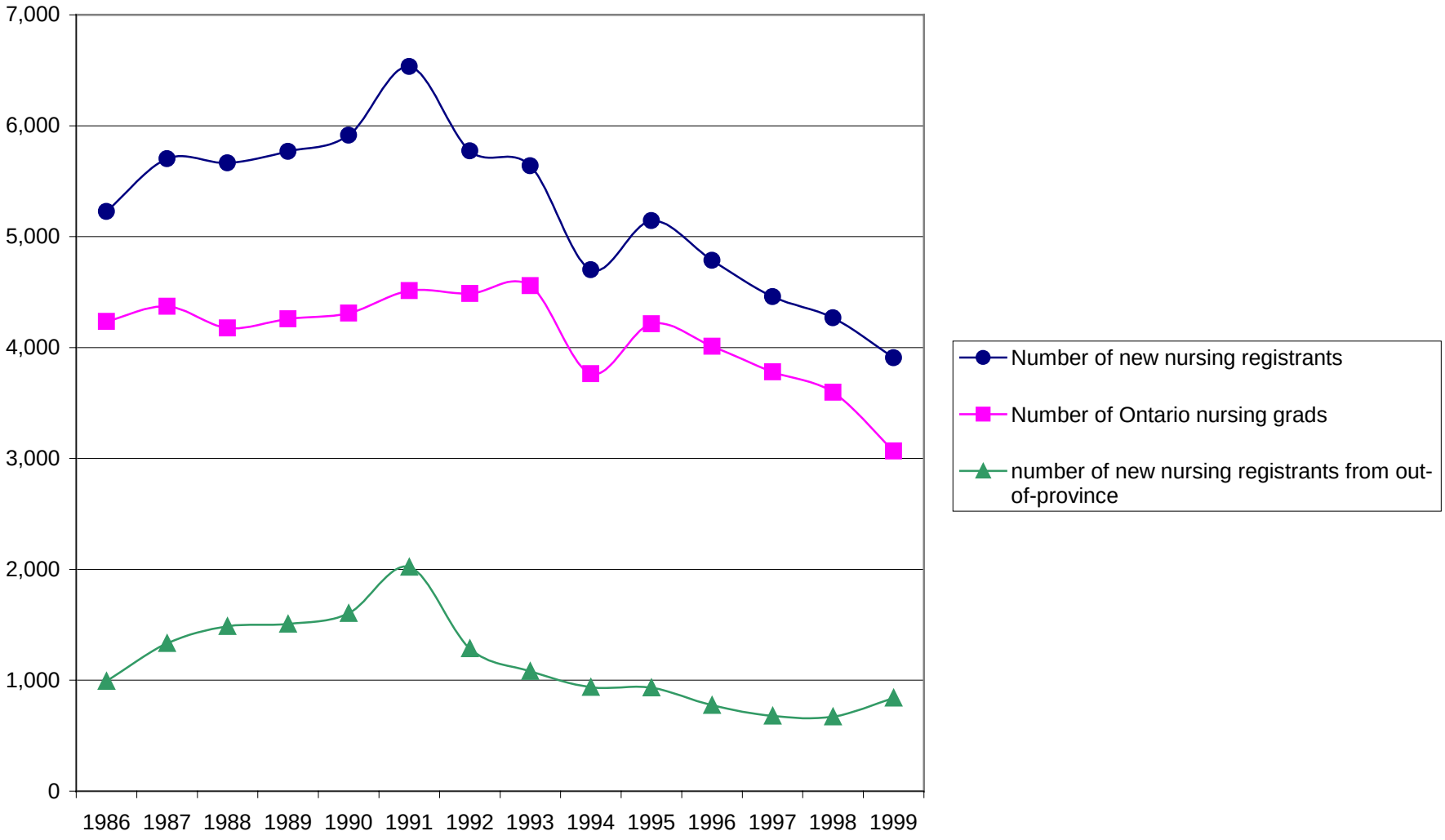
Data source: College of Nurses of Ontario

Figure 7: Sectoral Distribution of Nursing Employment, Ontario, 1986-98
Note: Final three variables on right scale



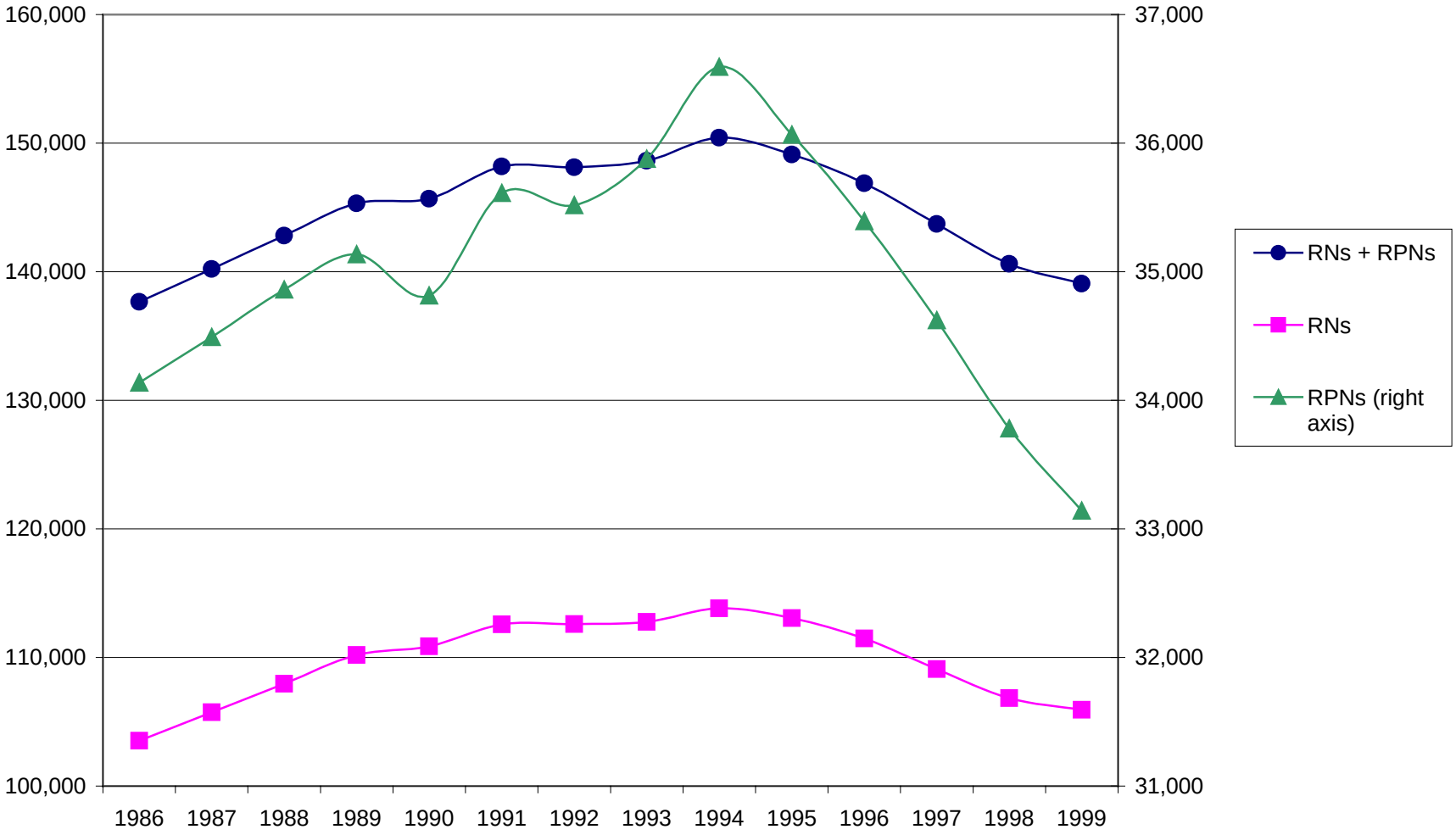
Data source: College of Nurses of Ontario

Figure 8: Nursing Recruitment in Ontario



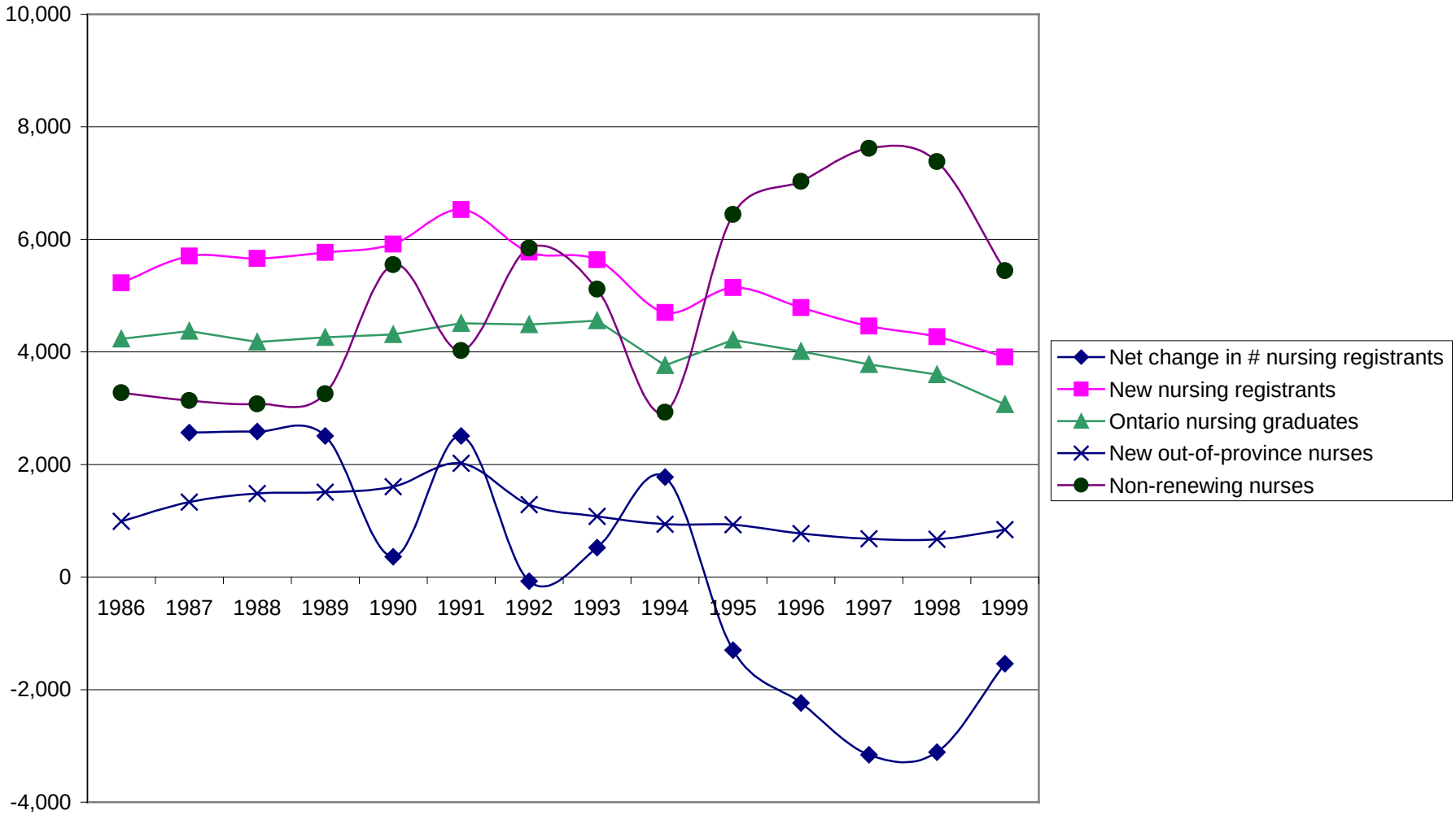
Data source: College of Nurses of Ontario

Figure 9: Total Ontario Nursing Registrations with the CNO
Note: RPNs on right scale



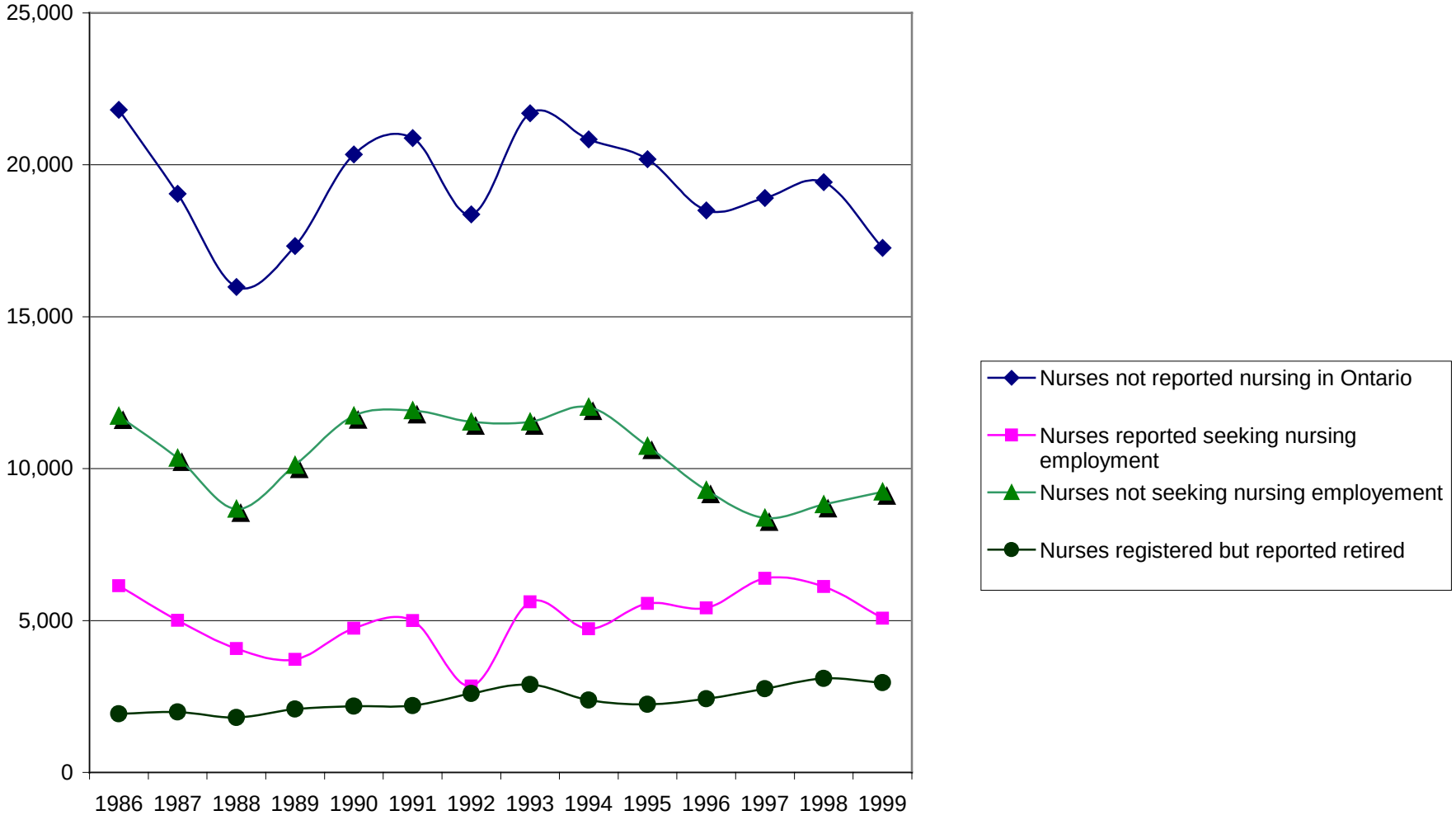
Data source: College of Nurses of Ontario

Figure 10: Trends in Supply of Ontario Nurses



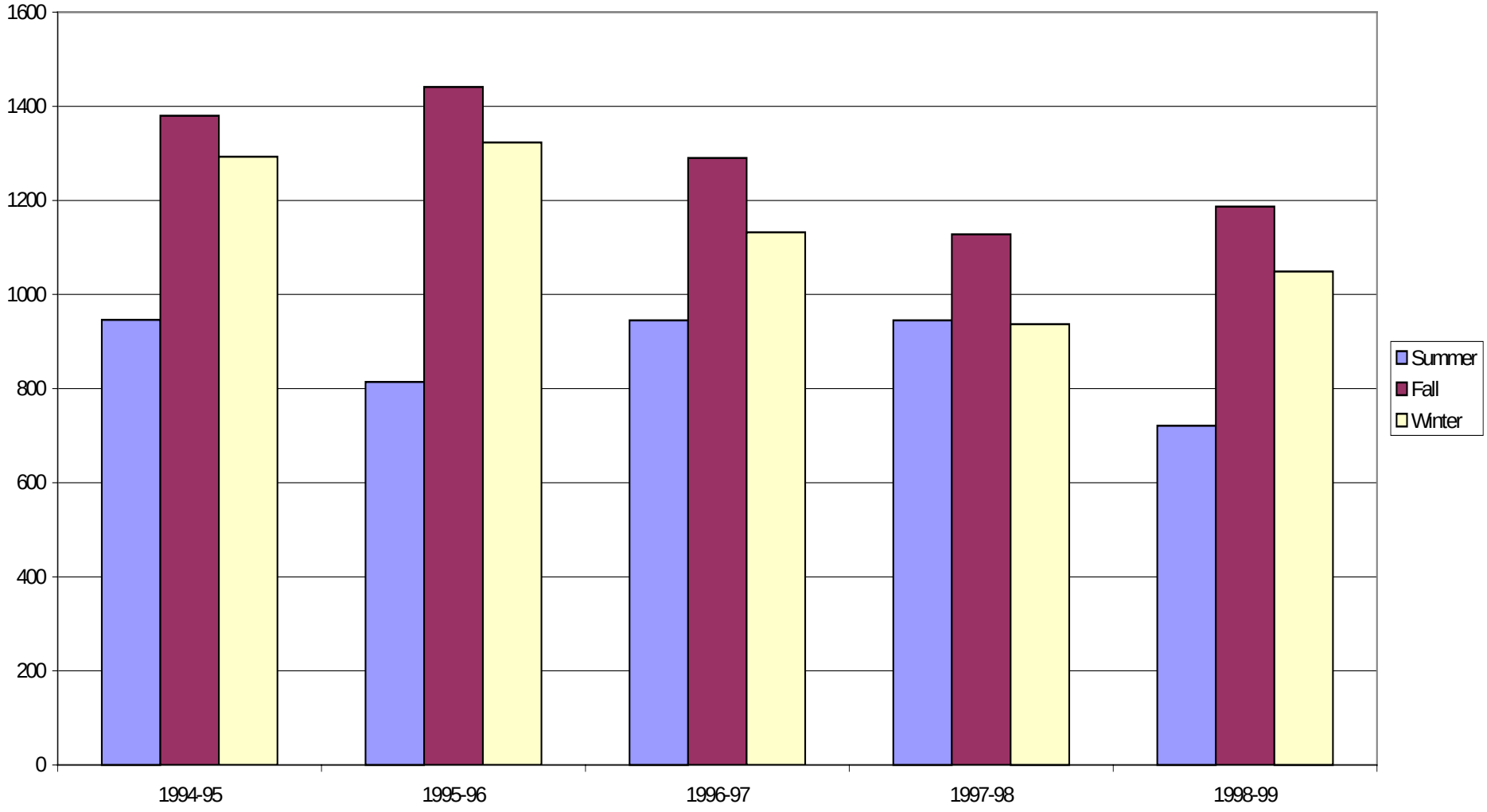
Data source: College of Nurses of Ontario

Figure 11: Ontario Nurses Lacking Nursing Employment in Ontario



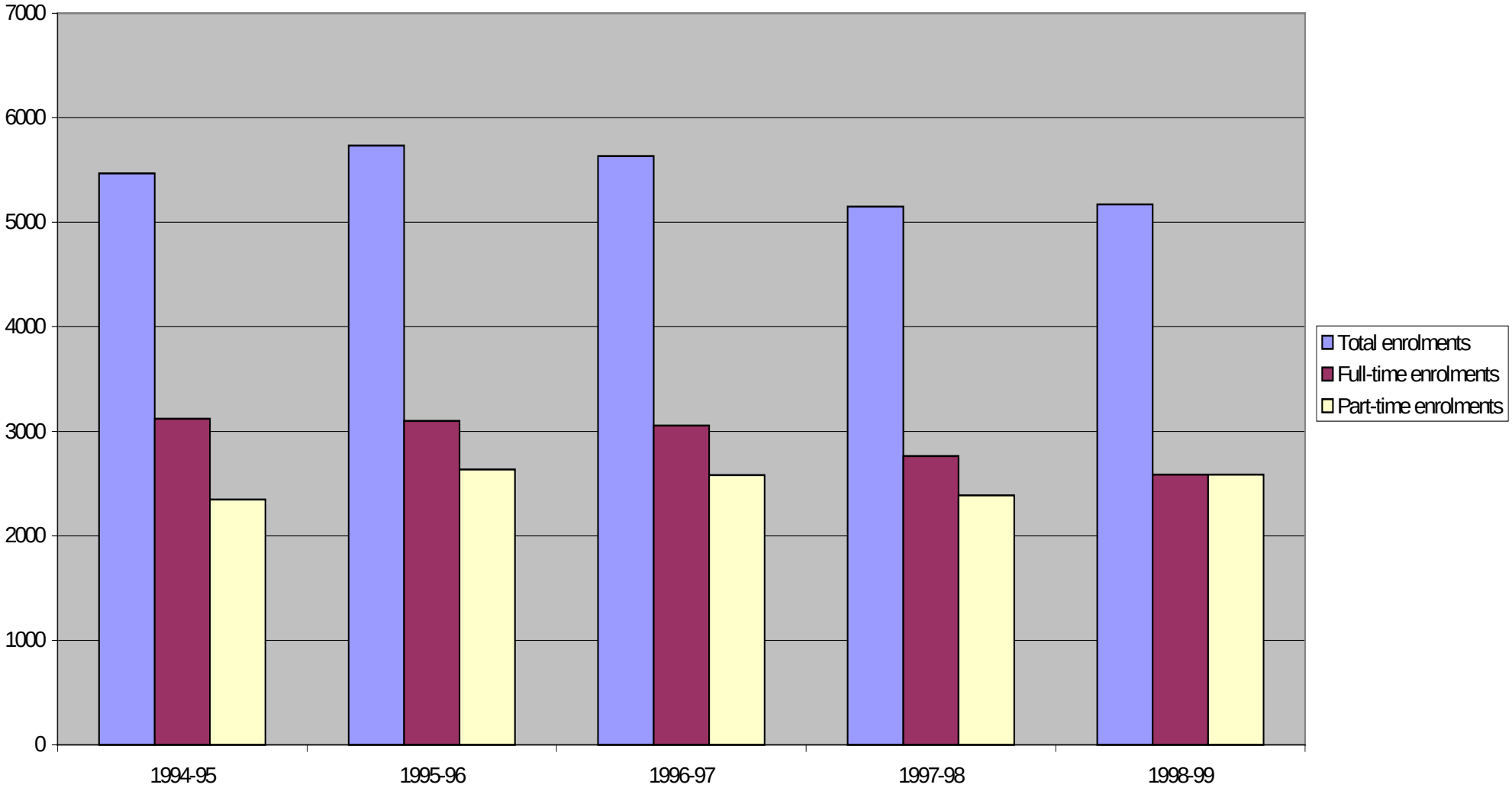
Data source: College of Nurses of Ontario

Figure 12: Practical Nurse Enrolments in Ontario Community Colleges



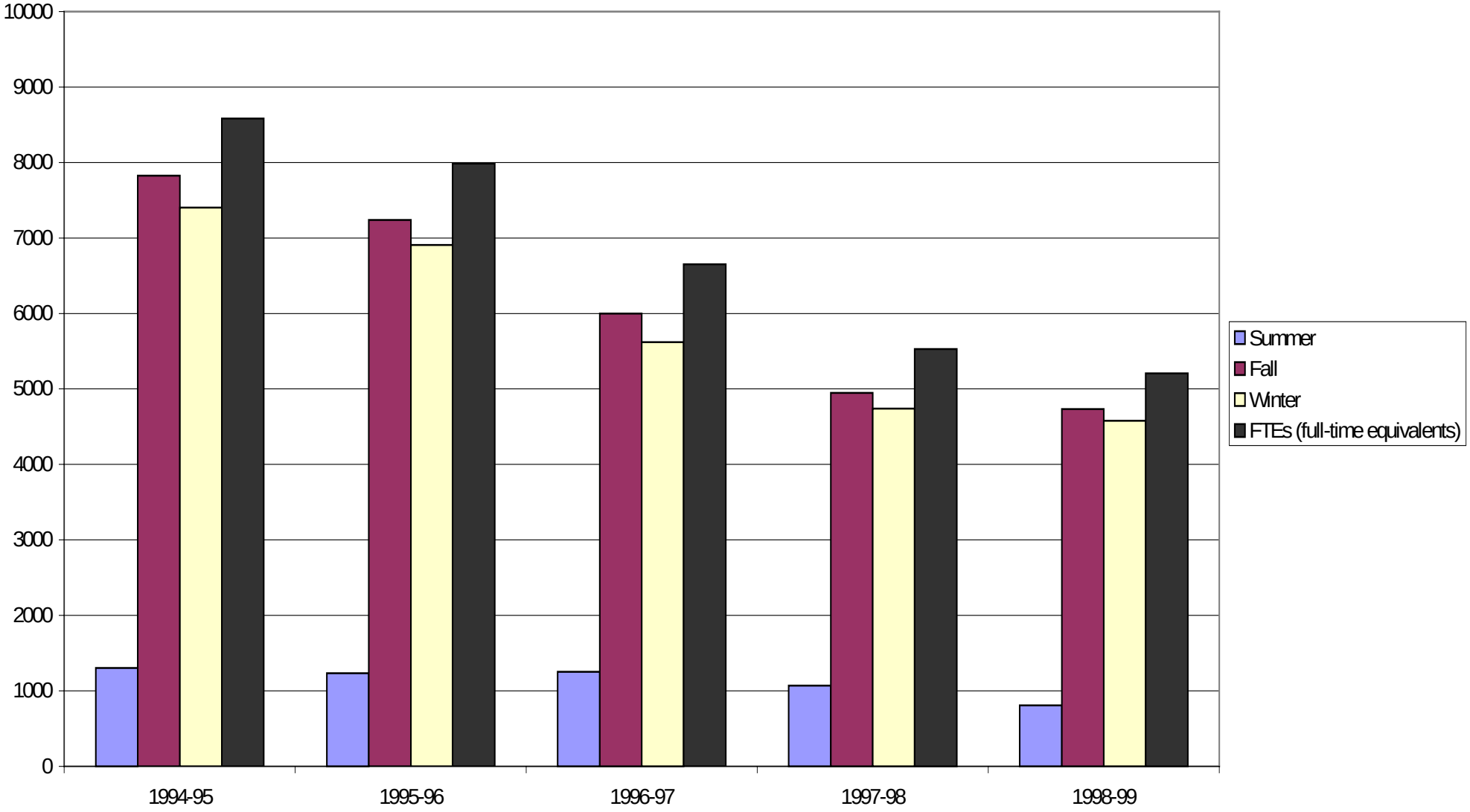
Data source: Ministry of Training, Colleges and Universities, Ontario

Figure 13: University Nursing Enrolments



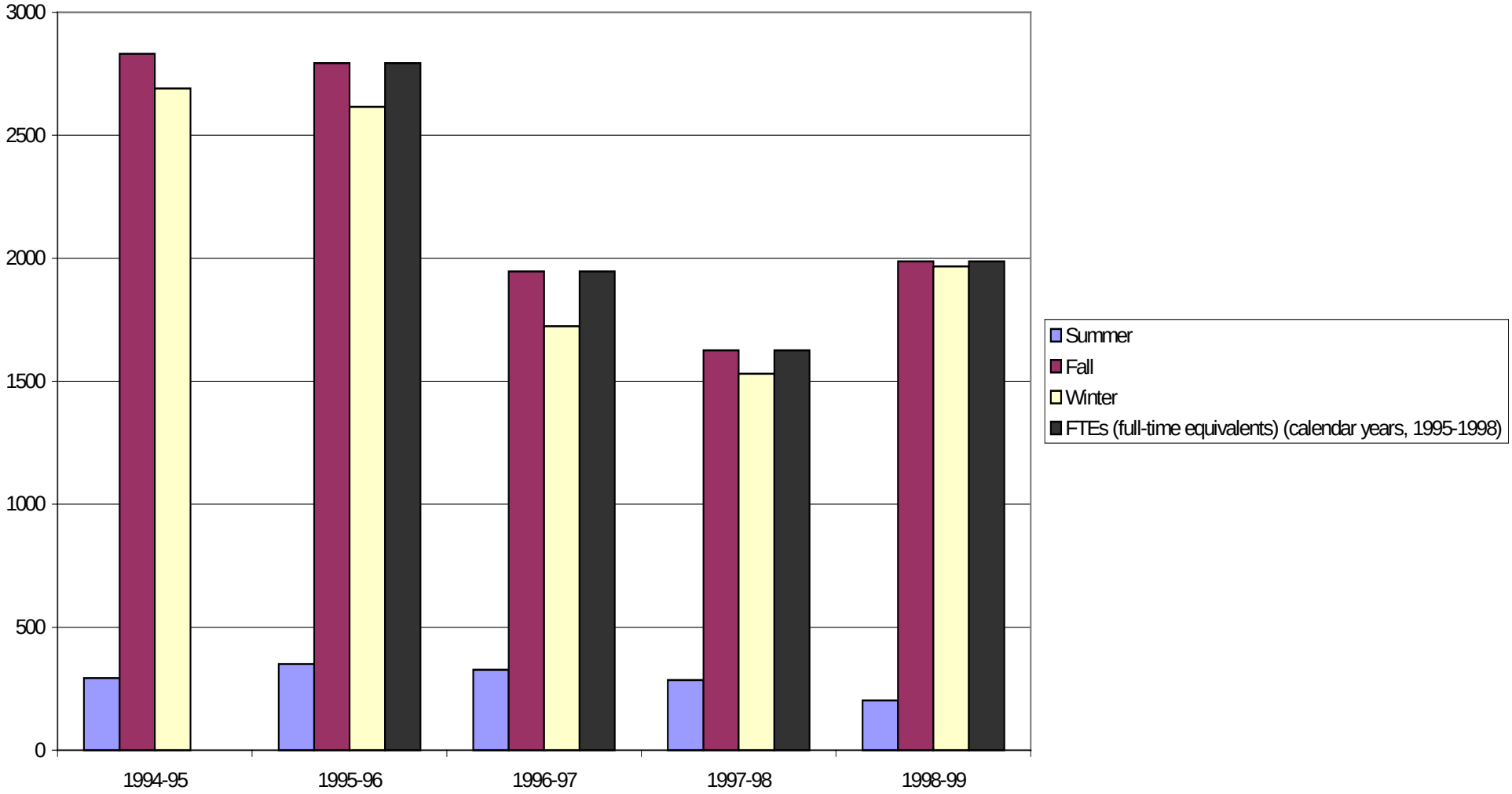
Data Source: Ministry of Training, Colleges and Universities, Ontario

Figure 14: Enrolments in Ontario College RN Programs



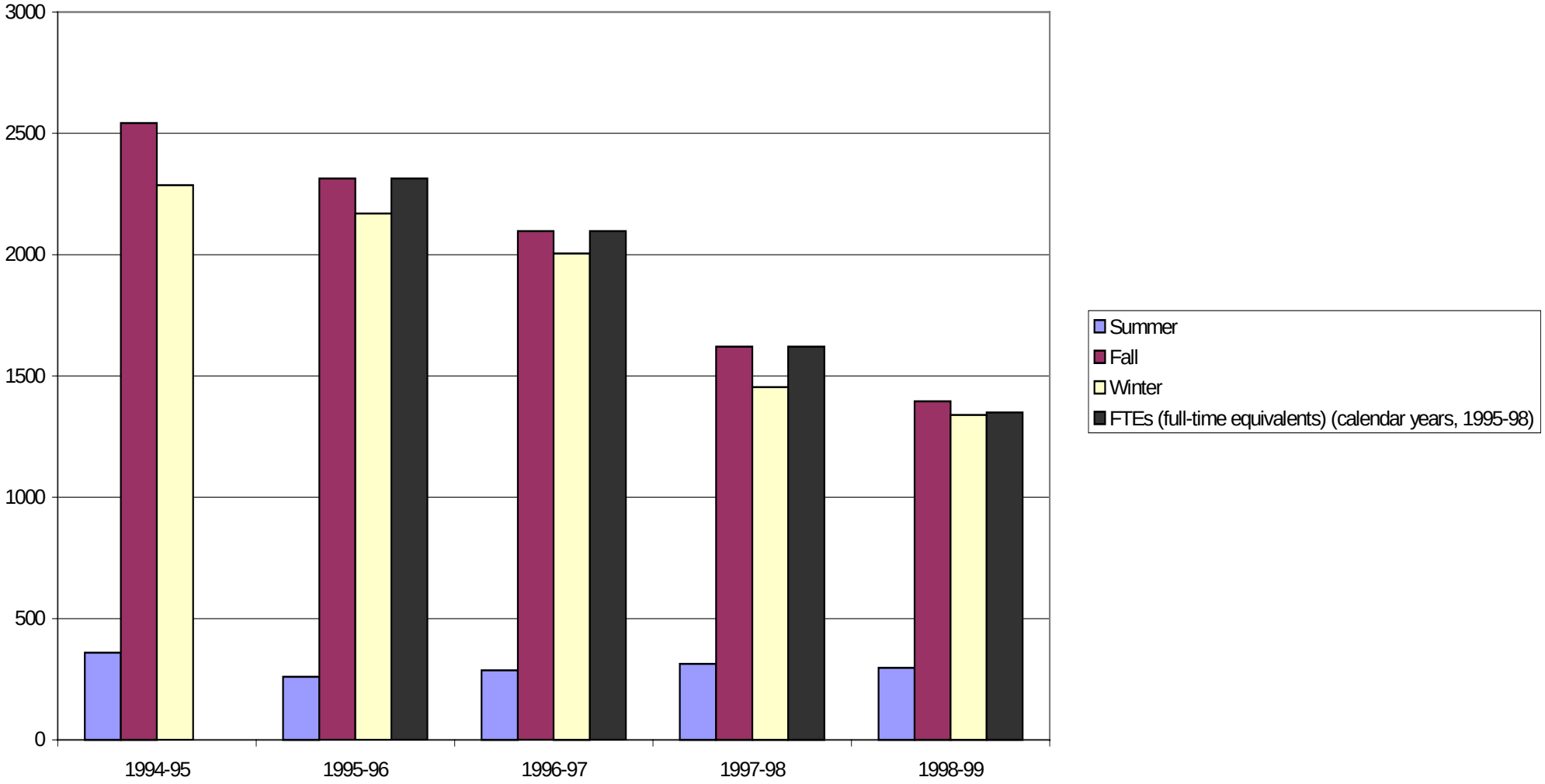
Data source: Ministry of Training, Colleges and Universities, Ontario

Figure 15: First-Year Enrolments in Ontario College RN Programs



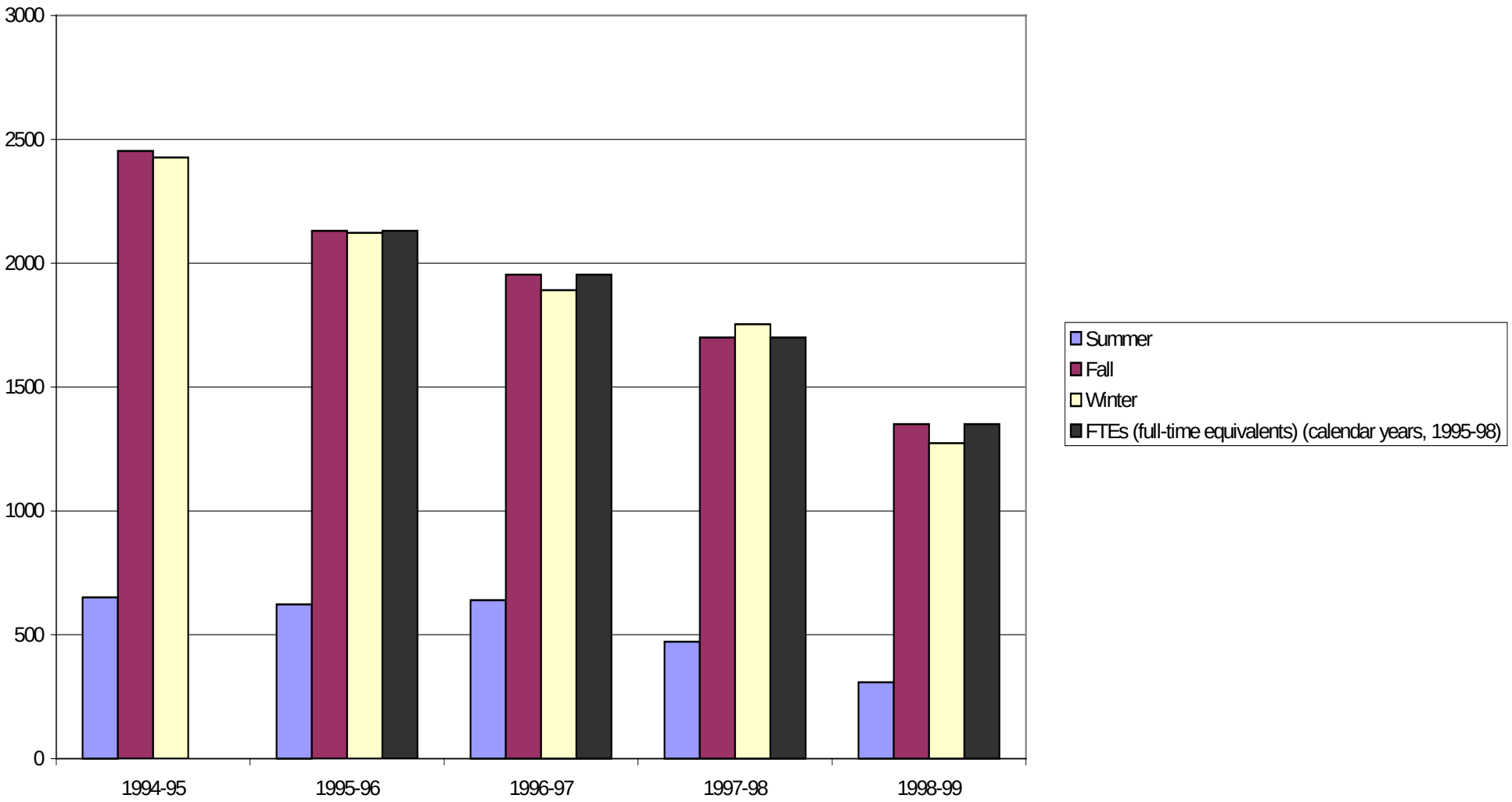
Data source: Ministry of Training, Colleges and Universities, Ontario

Figure 16: Second-Year Enrolments in Ontario College RN PRograms



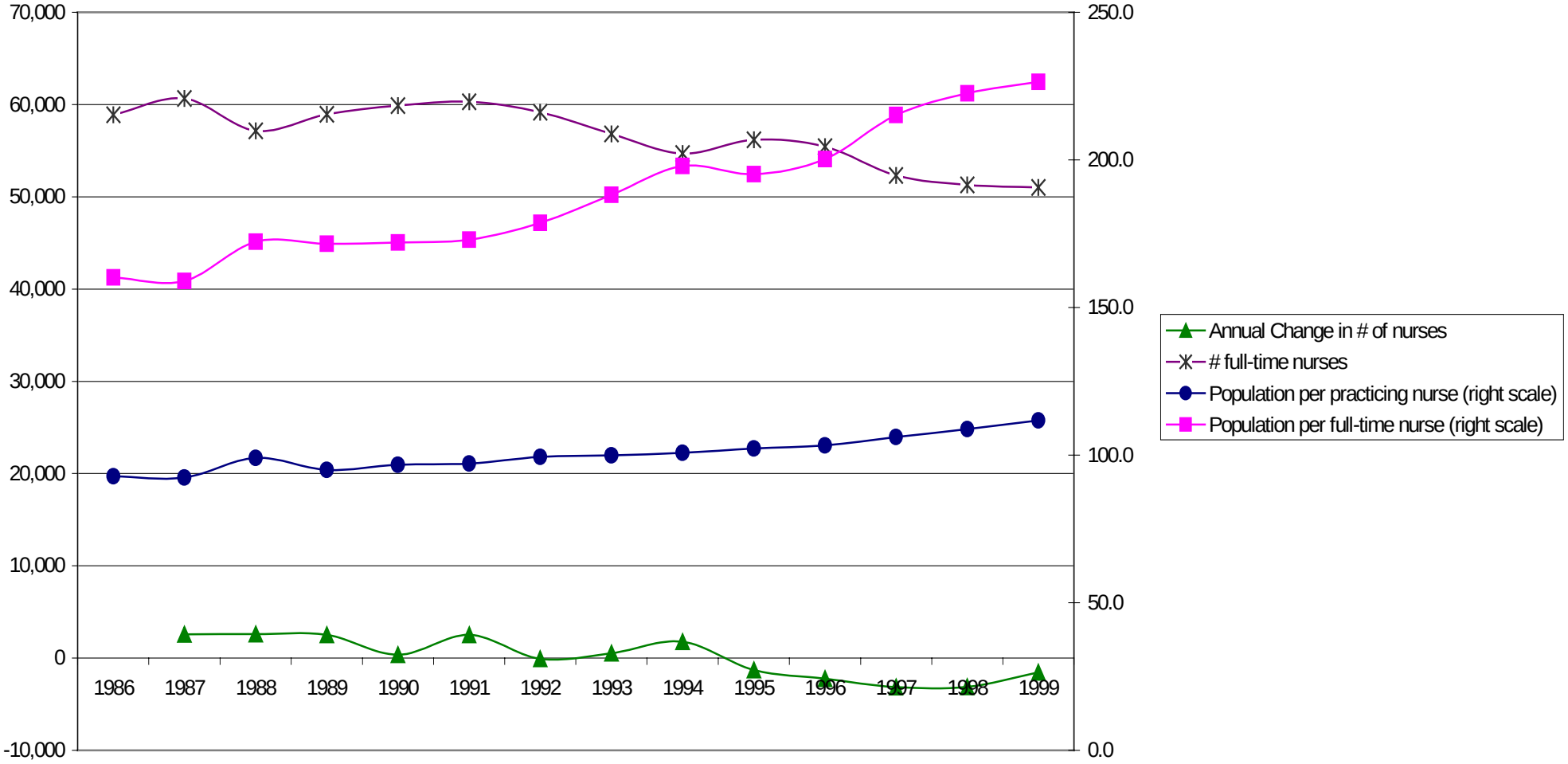
Data source: Ministry of Training, Colleges and Universities, Ontario

Figure 17: Third-Year Enrolments inOntario College RN Programs



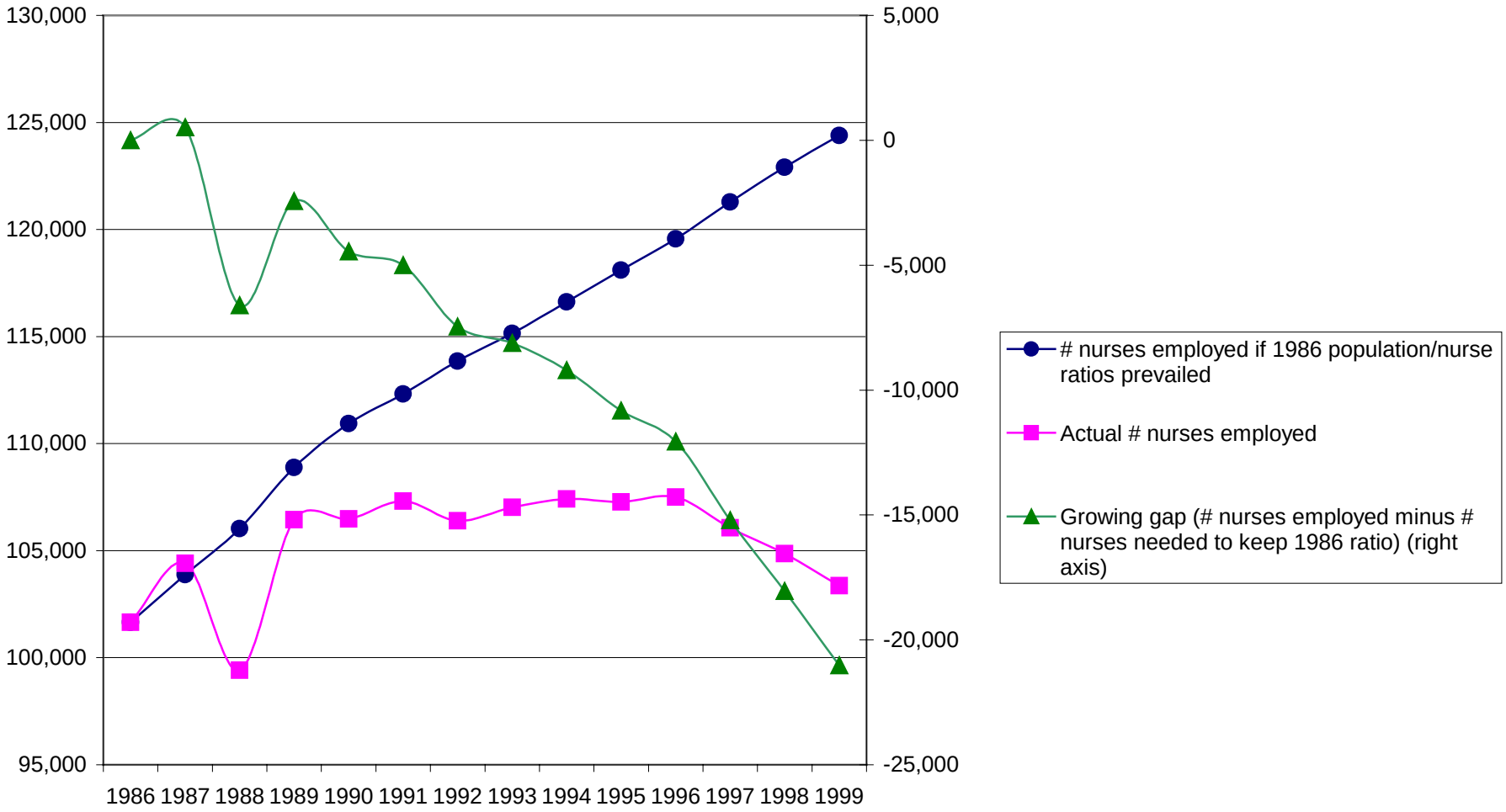
Data source: Ministry of Training, Colleges and Universities, Ontario

Figure 18: Population to Nurse Ratios compared with Nurse Registration for Ontario
Note: Last two variables on right scale



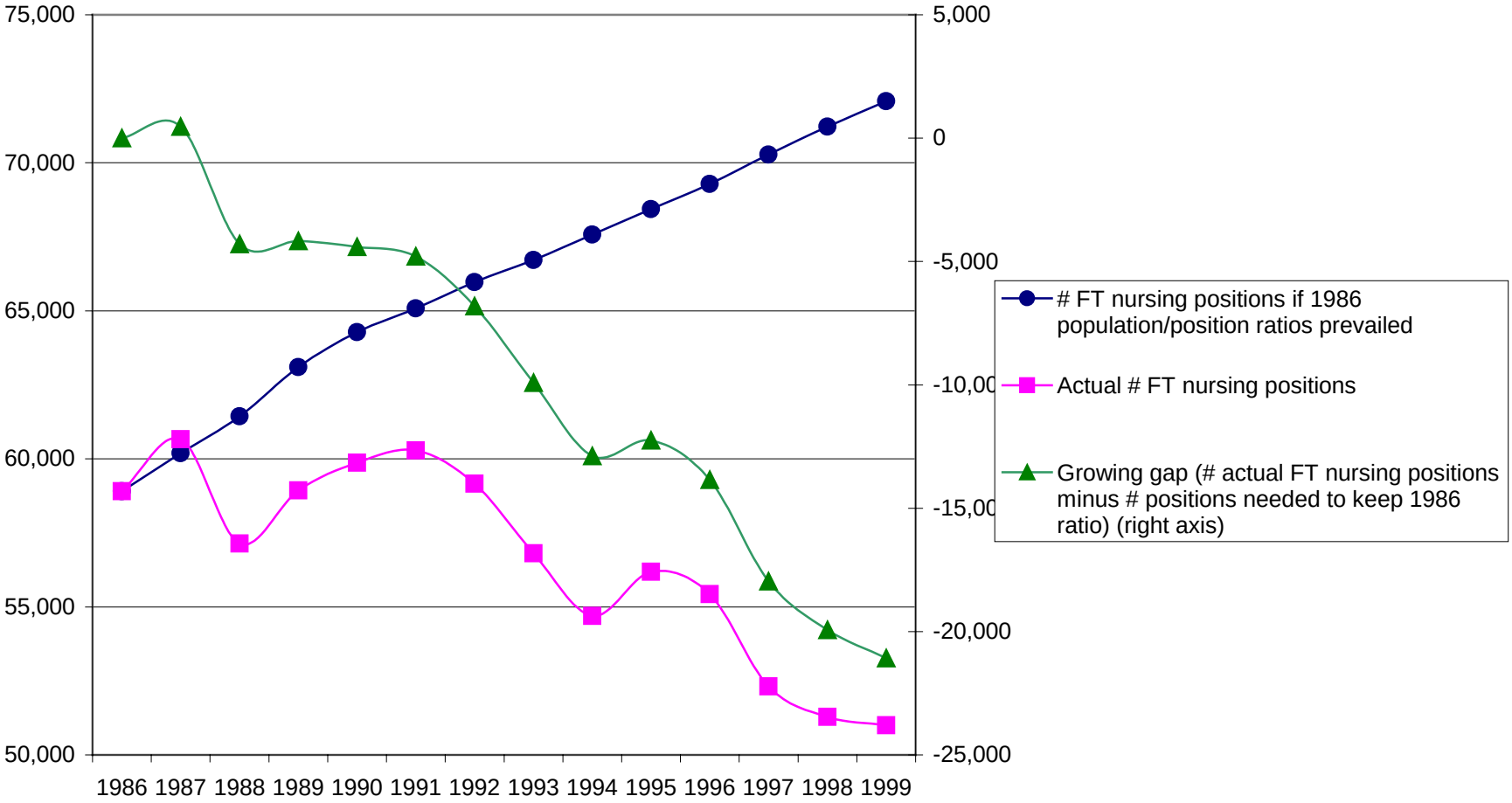
Data source: College of Nurses of Ontario

Figure 19: The Growing Gap between Population and Nursing Employment
Note: Gap on right scale



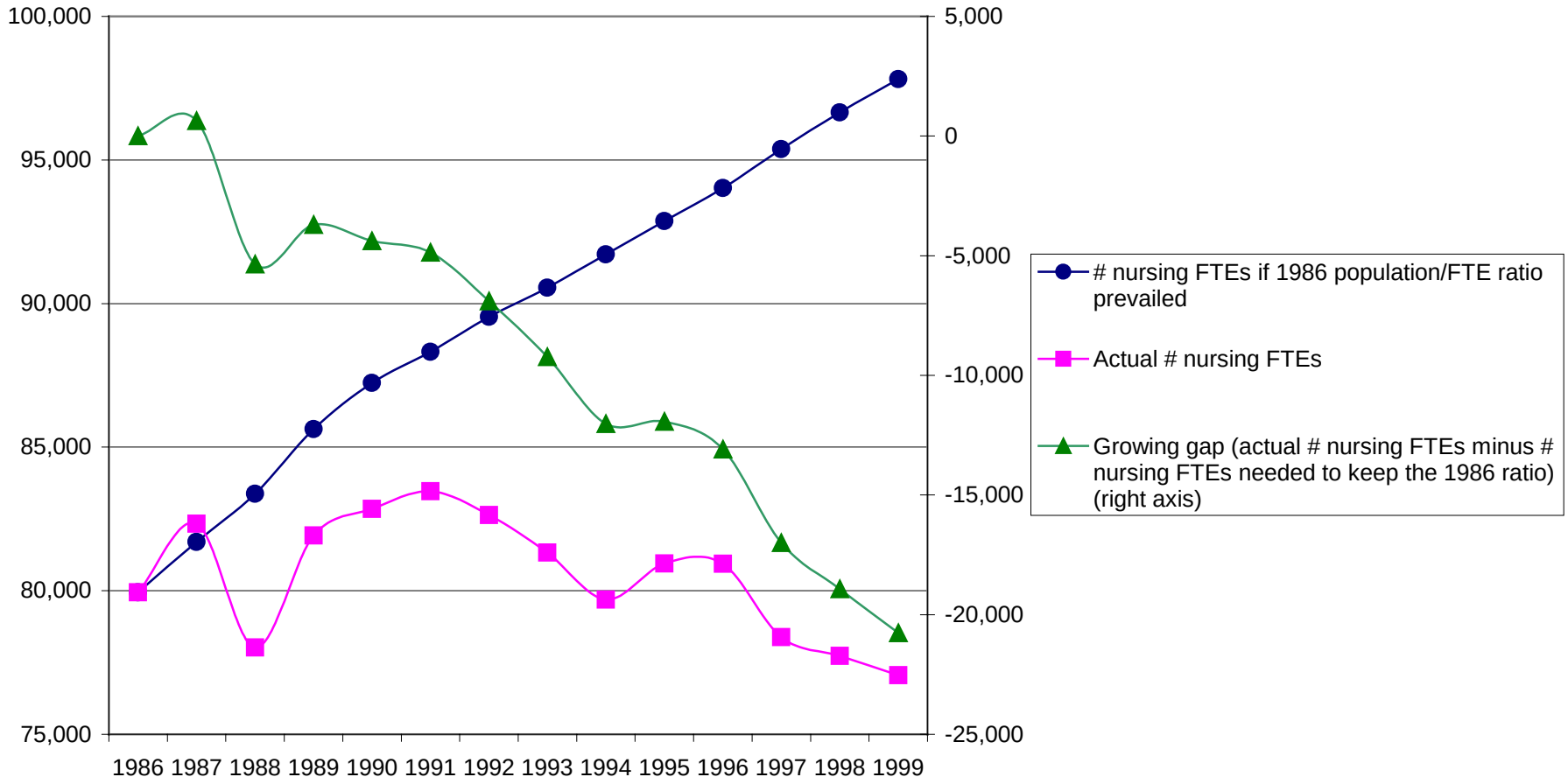
Data source: College of Nurses of Ontario

Figure 20: The Growing Gap between Population and Full-Time Nursing Positions in Ontario
Note: Growing gap on right scale



Data source: College of Nurses of Ontario

Figure 21: The Growing Gap between Population and Nursing FTEs in Ontario
Note: Growing gap on right scale



Data source: College of Nurses of Ontario