Nurses are the largest group of regulated health professionals in Canada. As of 2011, there were 270,724 registered nurses (RNs), 84,587 licensed practical nurses (LPNs) and 5,214 registered psychiatric nurses (RPNs) working as nurses in Canada. (Note: RPNs are regulated as a separate profession in the four western provinces and Yukon only.) In all there are 360,572 regulated nurses working as nurses in Canada. 79.1% of nurses are unionized, while 81.0% are covered by union collective agreements. The Canadian Institute for Health Information (CIHI) study, Regulated Nurses: Canadian Trends, 2007-2011, provides more information on where nurses worked in 2011:

- 61.6% of RNs worked in the hospital sector and 13.3% worked in the community health sector. 10.0% worked in nursing homes and LTC. 89.0% worked in direct patient care.
- 42.9% of all LPNs were employed in hospitals and 9.8% worked in the community health sector. 39.0% were employed in nursing homes and long-term care. 97.6% worked in direct patient care.
- RPNs (Western Canada) worked mostly in the hospital sector (45.6%), while 25.3% were employed in the community health sector and 16.1% in nursing homes. 89.7% worked in direct patient care.
- From 2007 to 2011, the number of employed nurse practitioners more than doubled across the country to 2,777.

The previous edition of Regulated Nurses: Canadian Trends reported that 10.8% of RNs, 17.5% of LPNs and 16.4% of RPNs worked in rural or remote settings or in the North.

Nurses comprise one third of the Canadian health care workforce. The previous edition of Regulated Nurses: Canadian Trends reported that the public sector nursing workforce grew by close to 2% per year since 2006 (8.8% between 2006 and 2010), according to data from CIHI. However, CIHI reports there remain fewer RNS per capita today (785/100,000 population) than there were in the early 1990s (824/100,000 population).

Education

There is a strong trend by nurses to graduate from baccalaureate programs rather than diploma programs in recent years. Until 2003, more RNs graduated from diploma programs. By 2008, this had reversed such that three times as many RNs graduating that year did so with a baccalaureate. 28% of RNs practicing in 2011 had earned a baccalaureate prior to entering practice.

Nurses are also returning to school to upgrade their skills in large numbers. By 2011, 34,042 RNs practicing today who had graduated with a diploma returned to school to obtain a baccalaureate. This brings the total percentage of practicing RNs with a baccalaureate to 38.8% while an additional 3.9% of RNs have either a doctorate or a master’s degree.

Note regarding data referenced in this backgrounder:
The most commonly referenced source for data on nurses in Canada is the CIHI Regulated Nurses Canadian Trends series. Recently there have been changes made to the scope of data that CIHI reports. Therefore in order to provide the most recent data available, more than one year of the CIHI Nursing Trends series is referenced in this backgrounder. Methodological and historical changes to the data make it difficult to compare data across time. In all cases, comparisons should be made with caution and in consideration of the historical and methodological changes made. Please refer to the original documents for more information.
In the report, *Tested Solutions for Eliminating Canada’s Registered Nurse Shortage*, the Canadian Nurses Association recommends increasing enrolment in RN entry-to-practice education programs by 1,000 per year along with steps to reduce the attrition rates in these programs from 28% to 15%. The same report underlines improving the retention of working nurses, which the CFNU believes is the most cost-effective and immediate of the listed solutions.

**Internationally educated nurses**

8.6% of RNs employed in Canada graduated from an international nursing program. British Columbia, Ontario and Alberta had the highest concentrations of internationally trained graduates. Of the LPNs employed in Canada, 97.3% graduated from a practical nursing program in Canada while 2.7% graduated from an international program.

**International perspective**

There is a global shortage of, and therefore a global competition for, health professionals in all disciplines. A World Health Organization/International Council of Nurses discussion paper in 2009 estimated the global shortfall of nurses to have been close to 2 million in 2005 and projected it would rise to 2.8 million by 2015. The shortfall is most acute in South East Asia, Africa and the Eastern Mediterranean but exists in all regions. Lower demand for nurses due to budget restrictions has resulted in high unemployment of nurses in areas where there remain critical shortfalls, and the ICN has received reports of nurses working without pay to maintain their competency levels and to be next in line when a budgeted position opens. The discussion paper notes the distinction between need (number of nurses required to ensure quality services) and demand (number of positions financially supported). The paper notes that the effect of nursing migration on some countries is partly offset by remittances sent home to families.

Employers, particularly from developed countries, are actively recruiting health professionals who are working under less positive working conditions or for lower pay. Much of the world is facing an aging population that is living longer and requiring more care. This is placing further strain on a limited health human resources (HHR) supply. The United States, for example, is expecting a shortage of close to 1 million nurses by 2016.

The International Council of Nurses (ICN) recognizes the right of individual nurses to migrate and promotes ethical nurse recruitment recognizing the adverse effects on “health care quality in countries seriously depleted of their nursing workforce.” Each country must implement sound human resource planning and retention strategies; recruitment practices must not exploit or mislead nurses into accepting job responsibilities and working conditions for which they are unprepared. The ICN also calls for regulation of recruitment practices “based on ethical principles that guide informed decision making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices.” These ethical principles include credible nursing regulation, access to full employment, freedom of movement, good faith contracting, equal pay, a safe working environment, effective orientation/mentoring/supervision among others.

Following its 2011 Workforce Forum, the International Council of Nurses urged world leaders not to adopt economic austerity measures...
that would threaten the health of patients and the integrity of health systems. The ICN continued to urge governments “to develop a nursing workforce capable of consistently meeting established standards of care and the expectations of the public.” The Canadian Federation of Nurses Unions endorses the ICN position.

**Canadian perspective**

Short-sighted decisions with an eye on budget deficits led to restrictions in the numbers of health professionals who graduated in Canada over the last two decades. While some measures to improve the situation have been put in place, we remain well below the number required to sustain the profession. Canada graduated more RNs in 1972 than in 2002 — yet the population increased by some 50% during that time. There is fierce inter-provincial competition for health professionals and significant disparity in terms of shortages from one part of the country to another.

The situation in northern, rural and remote areas and in Aboriginal communities is especially serious. The Aboriginal Nurses Association of Canada (ANAC) advocates for a more “intensive effort” to increase the number of Aboriginal nurses. Few of the nursing schools have Aboriginal-specific access/bridging/transition programs which increase Aboriginal student enrollment. The ANAC believes that “increasing the number of Aboriginal nurses can and will result in increasing the overall health of Aboriginal communities.”

The Canadian Nurses Association is predicting a shortfall of 60,000 full-time equivalent nurses by 2022. There is already a current shortfall of 22,000 nurses which is masked only by delayed retirements and heavy workloads. The Canadian Medical Association (CMA) has said that “delivering on timely access will not be achievable without an adequate supply of doctors, nurses and other health care professionals.” The CFNU Submission to the Standing Committee on Health (2008) put it this way: “If wait times are our greatest concern, addressing our deficit in health human resources must be our first plan of attack.” It is not just nurses that are in short supply. The CMA reports that up to 5 million Canadians are unable to find a family physician.

There are 6,708 RNs and 474 LPNs registered to practice in Canada presently working outside their province or territory of registration. 48% of those RNs and 21.7% of those LPNs were working in the United States.

**An older workforce**

The nursing workforce is aging. In 2011, the average age of an RN was 46.0; the average age of an LPN was 41.6; and the average age of an RPN was 46.9. In Canada in 2011, 28.4% of RNs were over the age of 55 and 13.4% over the age of 60. 16.3% of LPNs were 55 and over, and 6.2% of LPNs were 60 and over.

In 2007, for every nurse under the age of 35 there are two over the age of 50. On average, nurses retire around age 56 compared to the overall Canadian workforce at age 62.

**Working conditions: scheduling**

Only about a third of employers offer flexibility in days and hours worked. Such flexibility is particularly important both to nurses entering the nursing workforce for the first time and to those considering extending their careers after a long service. Therefore flexibility is a policy critical to retention of nurses at both ends of their careers.
Working conditions: overtime
Public sector nurses worked 20,627,800 hours of overtime in 2010, the equivalent of 11,400 jobs costing $891 million/year. The overtime rate was 29% in 2010 compared to 10.5% in 1992. 17.3% of nurses worked paid overtime in 2010 while 14.5% of nurses worked unpaid overtime, up from 12.9% in 2008 and 12.8% in 2005.

Working conditions: access to full-time work
The Canadian Nursing Advisory Committee (CNAC) recommended a 70-30 ratio of full- to part-time as optimum. CIHI reports that 41.3% of RNs and 48.9% of LPNs work in casual or part-time positions. Nurses who work in part-time or casual positions for multiple employers may exceed the number of hours full-time nurses work but are unlikely to receive overtime rates.

• In 2011, 29.2% of RNs and 34.8% of LPNs work in part-time positions; 11.9% of RNs and 16.5% of LPNs work in casual positions.

• The previous edition of Regulated Nurses: Canadian Trends reported that there are 5,203 LPNs and RNs unemployed or working in fields other than nursing, currently seeking employment in nursing.

Working conditions: health and safety
A 2011 study commissioned by the CFNU reported that an average of 19,200 publicly employed nurses were absent from work each week in 2010 due to illness or injury. Nurses had a rate of absence due to illness or disability nearly twice the rate for all other occupations and higher than all other healthcare occupations in 2010. The annual cost of absenteeism due to own illness or disability among nurses was $711 million in 2010. A 2005 survey of nurses reported 37% had experienced pain serious enough to prevent them from carrying out their normal daily activities in the previous twelve months.

According to a 2005 national survey, nearly half of nurses in direct patient care reported having had a needlestick or sharps injury. Almost half of nurses in Canada are concerned about the effectiveness of existing personal protective equipment and about their own risk of contracting a serious disease at the workplace. Almost three in ten nurses who provide direct care said they had been physically assaulted by a patient in the previous year.

A nurse is more likely to be assaulted on the job than a police officer or prison guard.

The Canadian Nurses Association and the Registered Nurses’ Association of Ontario produced a research report, Nurse Fatigue and Patient Safety, which made comprehensive system-level, organization-level and individual-level recommendations to address the unsafe practices that are caused by, and contribute to the rising level of nursing fatigue. This report points to factors such as excessive workloads, staff shortages, inattention to safe labour practices, inadequate rest, scheduling practices and awareness.

Band-aids won’t work
Short-term, stop-gap measures, such as over-utilizing existing nursing staff, are untenable in the long term. These strategies have a negative effect on the health and well-being of nurses and contribute to burnout and attrition. They also deteriorate the quality of patient care. The odds of patient mortality increase by 7% for every additional patient added to an average nursing workload.
WHAT NEEDS TO BE DONE
In September 2010, the CFNU hosted 56 health care experts from across Canada, who met to address the continuous pressures on nurses and the undervaluation of their work. The meeting’s report calls upon Canada’s Health Ministers to appreciate the value of nurses and to improve health care. In particular, it calls on Ministers to improve collaboration between health, education and labour ministries to promote the integration of practice and education and enhance nursing recruitment, retention and quality of care; to support demonstration projects that integrate home, long-term, mental health, and community care into the continuum of primary care with a patient/family focus; to develop an accountability framework that links patient/family needs, provider competencies, and evidence to staffing decisions as well as monitors evidence-based indicators of quality of work life; to develop policies and legislation that support improved work environments and recruitment and retention of nurses; and to support research and evidence-based decision-making to help nurses and other health professionals assist the transformation of health care.

Promote healthy, safe workplaces
Governments, employers and nurses’ unions must develop strategies to advance the implementation of healthy workplace initiatives, workload management systems, innovative staffing initiatives (for example, standardized nurse-patient ratios) and strategies to enhance the productivity of nurses, i.e. relieving nurses of non-nursing duties (e.g. housekeeping, clerical, and porter functions), providing appropriate technologies to improve efficiency, creating ergonomically efficient workplaces, and promoting nurse autonomy in all aspects of nursing practice. The Office of Nursing Policy, Health Canada, should provide a clearing house of best practices.

Governments and employers must implement the precautionary principle to protect health care workers in the face of an outbreak by mandating the use of N95 respirators, at minimum. Governments, employers and unions must implement and enforce workplace policies ensuring nurses and all members of the health care team are safe on the job — while avoiding policies and practices that lead to poor health.

The Canadian Federation of Nurses Unions recently partnered with federal, provincial and territorial governments on pilot projects documenting that changes in the nursing workplace can improve retention and recruitment rates. The projects, collectively referred to as Research to Action: Applied Workplace Solutions for Nurses, resulted in a 10% reduction in overtime, absenteeism and turnover costs and a 147% increase in the number of nurses reporting a high level of leadership and support. Information on these pilot projects can be seen at www.thinknursing.ca/rta. It is essential that such research and partnerships continue.

Value experience
The average nurse has 18 years of experience, which tends to be undervalued. Research has shown that retention of experienced nurses improved with flexibility in scheduling, work practices and arrangements. Unions, governments and employers need to work collaboratively to ensure flexible scheduling options are bargained into collective agreements.
Train more novice nurses and support retention

According to the 2005 Nursing Sector Study, we would need to graduate about 12,000 registered nurses per year to keep up with demand. In 2010 we only graduated 10,074. A 2004 survey report by the Nursing Sector Study Corporation indicated that currently 60% of schools report having insufficient faculty and clinical placements, 70% have inadequate financial support for students, and 40-50% have inadequate space. With increased resources to post-secondary education for nurses, 50% of schools could increase enrollment 10-25%, 40% could manage an increase of 50%, and 30% could double their enrollment. Adding to the challenge, the CNA reported that 34.2% of the faculty in nursing schools in Canada were over 55 years old and 13.7% over 60. Explicit targets for enrolments, funding (and other support), new faculty, the appropriate technology, etc. must be established by governments and educational institutions. Support must be provided to novice nurses, including mentoring and orientation.

A pan-Canadian health human resource strategy

Planning for health human resources must be pan-Canadian, taking into account such mobility and the policy levers that will affect the degree of mobility between provinces. Too often, employers are expending resources, competing for the same nurses and doctors. Moreover, much time and energy is lost in addressing the workplace shortage because the knowledge of successful innovations and planning models is not crossing regional barriers. The First Ministers and the federal government are in a unique position to help rectify these health labour problems.

Canada’s First Ministers agreed in 2003 and 2004 to identify revitalization strategies for Canada’s health workforce and to report to the public on these by the end of 2005. Senior health officials from federal, provincial and territorial governments developed a framework for collaborative pan-Canadian health human resources planning, that is based on population needs. However, turning the agreed framework into a program of action that governments and health organizations can be held accountable for has yet to take place. Much of the proposals and recommendations contained in this backgrounder were laid out in A Renewed Call for Action: A Synthesis Report on the Nursing Shortage in Canada, published by the CFNU in 2008.

Action is needed now

Federal and provincial governments must prioritize strategies to reduce workloads, provide healthy workplaces, retain experienced nurses and stabilize new recruitment with mentoring programs and full-time employment. Canada’s nurses urge government, employers and policy makers to ensure enough health care providers are in place when and where Canadians need them. It is essential that such strategies are included in a new Health Accord to replace the current 10-Year Plan that will expire in 2014. The Canadian Federation of Nurses Unions is calling for early agreement and implementation of a new Accord in order to provide a predictable and stable health care environment.
Sources


29 Ibid.


35 Ibid.


