The Nursing Workforce in Canada and the United States

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Outline

Nurse workforces in Canada and the United States

Comparisons between Canada and the US and contrasts with Europe

Key challenges for nursing and the health systems

Implications of these developments for European hospitals
Regulated Nursing Workers

• Registered (professional) nurses (RN)
  – (2 to 4 years—increasingly 4) formal education, foundational sciences + clinical theory + clinical practice
  – Adult medical-surgical, mental-health, child health, maternal-infant care (a generalist preparation: nurses specialize after graduation)
  – National examinations considered moderately challenging
  – Generally annual renewals +/- continuing education requirement

• Practical nurses (also called vocational nurses) (RPN, LPN/LVN)
  – Minimum 1, increasingly 2 years of postsecondary education
  – “Shrunk down” treatment of generalist content
  – Similar to enrolled nurses in UK/Australia
  – Previously roles set up as “assistant to” registered nurses/physicians; increasing emphasis on independence in all phases of nursing process for patients with predictable, stable, non-complex care needs (controversy!)
  – Examination and licenses/permits renewed annually
Unregulated Workers

- Unregulated care workers (also called unlicensed care providers, aid(e)s)
  - Short-training periods, very limited formal education required
  - Not regulated except where certain acts are restricted to licensed persons
  - Heavy use in long-term care and home health
  - On-the-job training and competency assessment/maintenance emphasized
  - A great deal of variation from employer to employer in roles
  - Potential for delegation of some nursing work from licensed to unlicensed personnel (controversy)
Balance Between Registered and Practical Nurses in a Number of Countries

Approximately 20% LPNs in U.S.
Fast Facts: Canadian RNs in 2006 (N=252 948)

• Mean age 45.0 yrs (20% under 35, 38% 50 and over)
• 5.6% male
• 7.8% internationally educated
• 33% part-time
• 62% hospital employed
• 87% in direct care
• 36% hold baccalaureate or higher degrees

Source: CIHI, 2007
The Changing Distribution of Health Personnel in Canada

Between 1991 and 2003 the share of licensed practical nurses (LPNs) and registered nurses (RNs) decreased, while the share of other health professionals increased.

**Year 1991**
- RNs: 38%
- LPNs: 13%
- M.D. Specialists: 4%
- GPs/FPs: 5%
- Others: 40%

**Year 2003**
- RNs: 36%
- LPNs: 7%
- M.D. Specialists: 4%
- GPs/FPs: 5%
- Others: 48%


51% regulated nurses | 43% regulated nurses
Highest Educational Preparation of Registered Nurses in Canada, 1989 and 2004

1989
- Diploma: 86
- Bacc: 13
- Master's/Doc: 1

2004
- Diploma: 68
- Bacc: 30
- Master's/Doc: 2.5

Source: Canadian Nurses’ Association
Current US Nursing Workforce Statistics

- Nursing is the largest health professions occupation in the United States.
- 3.1 million RNs were licensed in the United States in 2008.
- 2.6 million, or 84.8%, were employed in nursing.
- An aging group: Between 1980 and 2004, the percentage of RNs younger than 40 dropped from 54% to just 27%.
- In 2008, the trend reversed for the first time, and the younger-than-40 proportion rose to 30%.
Employment Settings of RNs in the United States: 2008 National Sample Survey

- 62% hospitals
- 12% government agencies, social assistance agencies, and educational settings
- 11% ambulatory/OPD settings
- 6% home health
- 5% nursing homes
- 4% other
Advanced Practice Nursing

• Roles that draw upon specialized education (usually in graduate programs) and transcend usual responsibilities of the generalist nurse role and/or the legal scope of practice accorded to RNs
• In the U.S. earliest: Nurse anesthesia
• First major wave: Clinical nurse specialists (beginning in the 1960s)
• Current wave: Nurse practitioners (1970s to present)
US Statistics—NSSRN 2008

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<tr>
<th>Category</th>
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<td>Clinical nurse specialists only</td>
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<tr>
<td>Other combinations of advanced practice nurses</td>
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Total: 250,527 RNs (8.2% of registered nurses)

*The totals in each bar may not equal the estimated numbers for RNs in each Survey year due to incomplete information provided by respondents and the effect of rounding. Only those who claimed advanced preparation as a nurse midwife, nurse anesthetist, clinical nurse specialist, and/or nurse practitioner are included in the calculations used for this figure.
Canadian Statistics, 2008

• 1,626 credentialled nurse practitioners
• 2,222 self-identified CNSs
Comparisons Between Canada and the US and Between North America and Europe
A General Statement ...

- Formal credentialing (with degrees) is more prominent in North American than in European nursing historically and more in the U.S. than in Canada

- A feature that’s changing with EU harmonization of education, growth of nursing research, etc. ...
Canada

- A very regionalized country—2\textsuperscript{nd} largest landmass in the world, but 80\% of the population lives within 1-2 hours drive of the southern border, major cities 2 (and often many more) hours apart
- Nature of funding produces much more uniformity, especially within provinces, in management of hospitals: similar staffing practices
- Education is almost exclusively public phenomenon—movement towards higher education in nursing slower than in the U.S.
- More conservatism with respect to advanced practice roles for nurses
… In contrast, in the U.S. …

• Private not-for-profit and for-profit interests dominate in care delivery: Diversity in approaches and in staffing practices
• A very strong role of private colleges and universities in nursing education and diversity/experimentation in nursing education much more common
• Tuition reimbursement is (was) an extremely common employment benefit
• Educational/employment opportunities more evenly spread
Across North America ...

- Most nurses (are geographically bound by personal/family commitments and personal preferences ...
- Enormous variation across regions and institutions in vision of/profile of nursing
- Differences between academic health sciences centers and community hospitals in approach to nursing
- Much emphasis on formal education as a means of advancing the profession for individuals to move up within it AND moving across institutions to take advantage of positions as they open
  - Less and less likely as nurses age
- Relatively little mobility for the great majority of nurses (changing specialties and advanced practice roles are the 2 most common routes)
Key Challenges for Health Care Systems and Nursing
Three Central Problems in Health Policy/Health Systems Design

Also known as the “iron triangle”:

• Cost/expenditures
• Access (economic and practical/geographic)
• Quality of care
  – Incl.: use of safety, evidence-based care, continuity of care, patient-centeredness
• Cost probably first on many minds ...
International Comparison of Spending on Health 1980–2005

Average spending on health per capita ($US PPP*)

Total expenditures on health as percent of GDP

* PPP=Purchasing Power Parity.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008
American Health Care in a Nutshell

• Heavy private sector involvement (both for-profit and not-for-profit) in health care delivery and financing with some public sector payors (e.g. basic coverage for 65 y.o. + and the very poor)

• Lack of coverage for 15-25% of population

• Health care costs comprise a high and escalating proportion of the gross national product, while the system’s outcomes are good/excellent for some (but not all) individuals but are questionable for the society as a whole.
Health Care and Education Reconciliation Act of 2010

- Signed into law by President Obama on March 30, 2010.
- It is a law that will help at least a portion of the millions of Americans who want health care coverage but cannot afford it. The bill is primarily a health insurance reform.
The Central Element of the Reform

- Central provision of the reform: All US citizens and legal residents must purchase minimal essential coverage by 2014
  - Through their employer
  - Through new marketplaces (health insurance exchanges)—online bazaars
  - Tax penalties (by 2016 in full effect--$700/individual or $2,100/family)

- Requiring all to be insured brings healthy younger people into plans

- POTENTIAL PROBLEM: Lots of new clients that service agencies are not used to serving (cf. Massachusetts experience with mandatory health insurance)
And A Few More Provisions ...

- Some attempts to put brakes on runaway Medicare spending
- Some money for health professions education (largely symbolic)
- Investment in comparative effectiveness research

- Where does nursing fit into this?—Directly, perhaps not much ... potential opportunities and risks (hospitals and home health care will experience decreases in revenue at least in short term)
Canadian Health Care System in a Nutshell

• 70% public funds/30% private funds
• For the most part a publicly-funded system in which delivery is carried out by non-governmental/non-profit entities
• Delivery of health care is provincial/territorial responsibility
• Federal government plays an advisory role in many respects and oversees the comparability of programs across the country
• Canada Health Act [1984]
  – “Articulates a social contract that defines health as a basic right.”
  – Lays out conditions of a national framework that covers only hospital care and physician services universally
  – Other services covered by provinces for specific groups in certain circumstances include home care, long-term care and drug treatments
The Enduring Pattern in the Regulated Nursing Workforces in North America

• Cyclical shortages and surpluses:
  – Historically, nursing one of sole careers for women
    • Nursing schools operate at capacity
  – Supply keeps pace with demand
    • Some ongoing losses loss of labor force to marriage/child-rearing ...
      but with compensation from new graduates each year
  – Economic downturns/slowdowns: Nurse unemployment followed by decline in interest in nursing ...
  – Supply and demand raises salaries ... rebound in enrollments several years later
What are we seeing?

• Since 2000, about 10% unfilled positions across both nations
• Experts are convinced that because of demographics we will face national shortages of RNs in the future
  – Perhaps up to 30% of workforce in Canada and the U.S. in the next 15 years (pessimists)
• Due in part to consequences of the Global Financial Crisis (decreased service use, hesitation to hire, delayed retirements), currently many North American nursing school graduates are waiting 6 to 9 months to find their first job
• Still expecting mass retirements and heavy service burden in coming decades, however
Nursing Education in North America: Enduring Challenges

• Multiple entry routes and their consequences (baccalaureate/graduate entry to practice vs. *articulation*)
  More or less resolved in Canada but far from over in U.S. and some other countries

• Recruitment into nursing: fluctuating interest as a general problem; also, a growing imperative to recruit from underrepresented groups

• Historical split between those who teach and those who practice ... Got worse when education shifted to higher education
  -- Practice discipline--relevance to “real world” always an issue

• How will nursing schools and their faculties meet the challenges of scholarship in the modern university while meeting the other imperatives?: Role strain in faculty
Where Does Nursing Fit in All of This?

- In many countries, the majority of nurses work in hospitals—the “big ticket” item in health services
  - Human resources (and nursing human resources) account for a big chunk of budget
- Stability of health care service financing influences nurses’ job security
RNs in Management Positions in Canada

![Graph showing RNs in Management Positions in Canada from 1992 to 2002. The graph displays data for CNO, Director, Manager, and Total positions.]
Staffing Patterns

• Typically, in long-term care registered nurses not used
• In acute care in academic medical centres—RNs dominate, in community hospitals also, but less so (up to 50-50 blend with practical nurses in some regions)
• Typical nurse-patient ratios in acute care areas on day shifts: 4-6 to 1
• Intensive care units: 1-2 to 1
• Efforts to:
  – Regulate staffing levels (especially in US)
  – Ongoing efforts to measure workload to justify/manage staffing
  – Benchmark staffing levels and outcomes potentially sensitive to staffing (in both countries)
  – Reduce staffing levels (or decrease skill mix (more practical nurses, fewer RNs)) to save costs
Nursing Practice in North America

- Length of stay in hospitals/service duration in other settings is very short—care is intense and complex
- Emphasis on basic elements of nursing care is uneven across hospitals/sectors and remains so
- Working in teams within nursing and across health care disciplines is a continuing challenge
- Fundamental debates within the profession and across sectors whether we’re investing in the right places: health promotion vs. other areas of practice
- Increasing attention to problems with safety and quality of care (thoroughness, handover, etc.)
- Working conditions and salaries have improved, job security also—long-term prospects unclear
The Major Trends

Cost control is a central preoccupation in the U.S. and in Canada.
Shift away from acute care to community—has increased acuity/intensity of service in both sectors.
In Canada (and perhaps in the US), nursing personnel losing dominance among health workers.
Workforce stability is questionable.
The centrality of nurses and nursing leadership to hospital management is slipping.
The importance of strong nurse managers and executives in developing and defending strong practice environments is clear ... but interest in these roles diminishing.
Safety/Quality Challenges

• Knowledge base, safety issues
  – Entry to practice and continuing practice
• Evidence base for practice
• Workload issues and their implications for quality and safety
• Lack of focus on basics of care?
• Initiative overload—too much change at once?
Implications for European Hospitals

• Need for/perils of healthcare workforce projections—the need to think through demand side
• Defining boundaries at the lower end (Unregulated vs. Professional vs. Practical nurses): If abundant supply of RNs/no cost constraints, not an issue ... But otherwise ...
• Defining boundaries at interface with medicine (promise of advanced practice nursing)
• Support needs of direct care generalist clinicians: managers/executives and advanced practice
• Safety and quality issues: Dealing with tensions and positioning nursing as leverage in resolving dilemmas of the “iron triangle”
The Future

• Benchmark and understand unfolding picture of forces influencing supply (results may surprise)
  – For instance, studies like RN4CAST
• Patient outcomes focus must be a stronger force within the profession (probably overdue)
• Change is coming ... Goals of care/models of care, maybe both
  – Adequate planning
  – Prepare for resistance
  – Evaluation of impacts of change is essential