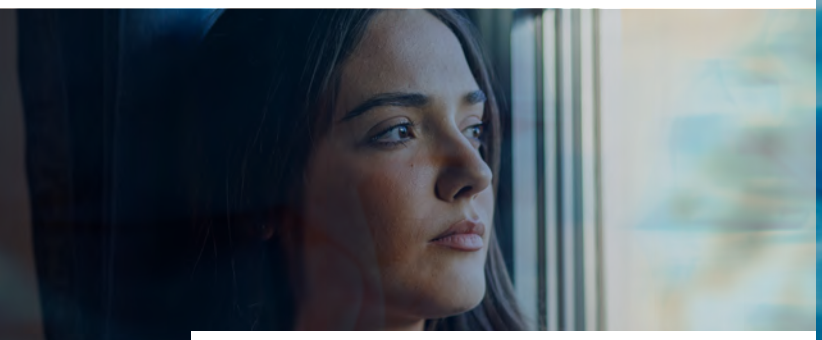
WHY ONTARIO NEEDS SAFE NURSE STAFFING LEVELS

"I have anxiety and feelings of guilt that I should have done more, but I can't. I can only do so much."

Nurse-Patient Ratios: Saving lives and rebuilding nurses' morale



Report prepared by James T. Brophy, PhD
and Margaret M. Keith, PhD

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OCHU

ONTARIO COUNCIL OF HOSPITAL UNIONS

CUPE

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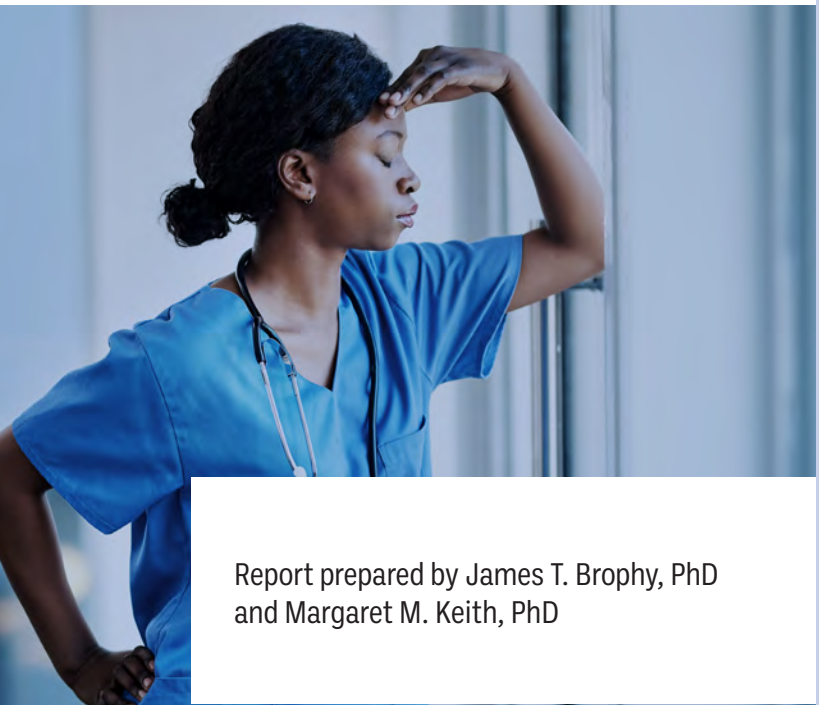
“I DREAD GOING INTO WORK”

Why Ontario needs safe nurse staffing levels



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Executive Summary

"The public needs to know that without better working conditions and more nurses, the system is never going to recover." – *Oncology nurse*

Ontario needs more nurses.

There is a well-documented shortage of nurses, personal support workers (PSWs), family physicians, and other health care staff in the Ontario health care system and in many jurisdictions worldwide. Chronic government underfunding and the prioritizing of budgetary efficiencies by health care administrations are primarily to blame.

This research was undertaken on behalf of the Ontario Council of Hospital Unions-Canadian Union of Public Employees (OCHU-CUPE). It focuses primarily on the nursing shortage; it explores the issue of understaffing and related heavy workloads and their impacts on nurses in Ontario, their patients, and the health care system as a whole; it focuses particularly on the benefits that would be experienced by staff and patients with the implementation of minimum staffing levels for nurses, such as mandated minimum *nurse-to-patient ratios* (mNPRs). The data upon which the findings are based include published research and interviews with Ontario nurses.

The research shows that growing nurse staffing shortages have resulted in increased workloads, poorer patient outcomes and a loss of public confidence. They also cause significant negative impacts on staff including a deepening sense of moral injury, depression, anxiety, despair, increasing workplace harassment and violence, and on attrition.

There is strong evidence, particularly from jurisdictions such as California and Australia, which have long-standing mandated safe nurse staffing policies, that they produce positive results. They have been shown to: improve job satisfaction; decrease occupational health and safety hazards; decrease stress and burnout; decrease nurse attrition, thereby alleviating staff shortages; decrease patient mortality rates; decrease patients' length of stay (LOS); decrease likelihood of patient readmission to hospital; decrease medical errors; decrease hospital-acquired infections; improve patient satisfaction; and provide cost-savings to the health care system. It is important to note that safe staffing levels regulating the complement of registered professionals, both registered nurses (RNs) and registered practical nurses (RPNs) or equivalents, are minimum standards, in other words, the baseline. They must be flexible to respond to conditions such as outbreaks, increased acuity, or local population needs. Exceptions are to be determined by a steering committee or similar body that includes nurses as equal participants.

The evidence is clear that there is a significant need for more nurses and for improved working conditions, both of which improve patient outcomes and the well-being of the health care system. It is, therefore, strongly recommended that mNPRs be mandated in Ontario as they are in British Columbia or that a model be adopted similar to the contractually negotiated Nova Scotia *Nursing Hours Per Patient Day (NHPPD) Framework*. Note that Manitoba has also agreed to implementing nurse staffing ratios.

Introduction

Health care in Ontario is in a precarious state. There is a significant shortage of nurses in hospitals, long-term care, and community care. Many of those who are working are suffering from burnout. The public is also suffering from long wait times and reduced care. One solution to this problem is to increase the nursing workforce. To this end, several jurisdictions have successfully implemented mandated minimum nurse staffing levels, such as minimum nurse-patient ratios (mNPRs). Precedents for mNPRs, for example, have been set in California, British Columbia, Australia, and Oregon. These models include RNs as well as RPNs or equivalent in their ratios. Minimum staffing levels, in some form, have also been established in other jurisdictions, such as Nova Scotia and several US states.

Research

This study examines the existing literature regarding minimum nurse staffing levels. It also includes data regarding health care workers' knowledge and experience. The research seeks to answer the following questions:

1) **The precedents:** Where have mandated minimum nurse staffing levels or mNPRs been implemented?
2) **The evidence:** What are the documented implications of nurse staffing levels?
    - **a)** How do nurse staffing levels affect **nurses' well-being?**
    - **b)** How do nurse staffing levels affect **patients' well-being?**
    - **c)** How do nurse staffing levels affect the **health care system?**
3) **The state of the health care system:** Why does Ontario need mandated minimum nurse staffing levels?

Data Sources

The quantitative and qualitative data upon which this report is based are derived from multiple sources:

- The transcripts of in-depth individual and group interviews with OCHU-CUPE members, 61 of whom were RPNs, from hospitals and long-term care facilities across Ontario who were consulted between 2016 and 2023 about such issues as violence, impacts of the COVID-19 pandemic, workload, and mental health. Thematic analysis was used to explore the responses provided by interviewees to the semi-structured interview questions, providing insight into individual experiences and the contextual environment. ***Note:*** *These interviews were undertaken for university ethics committee-approved qualitative peer-reviewed and published research. The interviewees' voices have been integrated into the evidence as they provide an important first-hand perspective of the conditions within Ontario's health care facilities. The excerpts have been marginally edited for brevity, clarity, and confidentiality.*
- Results from surveys and polls carried out across Canada and within Ontario showing that nurses' well-being and their capacity to provide patient-centred care are suffering from chronic overwork and understaffing. ***Note:*** *Pertinent examples of survey/poll results are included along with links to the complete reports, which can be found in the RESOURCES section.*
- Published literature: scientific research articles, gray literature, government and organizational reports, and media reports. ***Note:*** *Pertinent examples of research outcomes are provided in this report as well as links to several comprehensive literature reviews, which can be found in the RESOURCES section.*

Findings

1) The precedents: Where have mandated minimum nurse staffing levels or nurse-to-patient ratios (mNPRs) been implemented?

The following precedents are based on a review of published academic literature, and reports from governments, health care organizations, and nurses' unions and associations.

Researchers who have been studying the issue of nurse staffing levels, along with unions, the public, and government representatives, have made it clear that mandated minimum nurse staffing levels are needed to begin to deal with the widespread hospital staffing crisis. Evidence continues to grow that better hospital nurse staffing is associated with improved patient outcomes, including fewer hospital acquired infections, shorter length of stay (LOS), fewer readmissions, higher patient satisfaction, and lower nurse burnout (Lasater et al., 2021a; McHugh et al., 2021; Schlak et al., 2021). For example, after the mNPR legislation was implemented, "the average medical or surgical unit nurse workload in California hospitals was one patient lower than in other states. Having fewer patients per nurse was associated with significantly lower patient mortality and nurse emotional exhaustion and job dissatisfaction, as well as better nurse-reported quality of care" (McHugh et al., 2020).

According to McHugh et al. (2021) we need:

. . . public policy interventions to establish minimum safe staffing standards in hospitals. In 2018, the International Council of Nurses, representing national nursing associations worldwide, issued their Position Statement on Evidence-Based Nurse Staffing, concluding that plenty of evidence supports taking action now to improve hospital nurse staffing, echoing Nightingale's call to action over 150 years ago, that if we have evidence and fail to act, we are going backwards.

Numerous jurisdictions across the globe have either mandated nurse staffing levels or mNPRs. For a full accounting and description for each jurisdiction, see the comprehensive report prepared by the Canadian Federation of Nurses Unions (CFNU) (Hamill & Hiltz, 2024).

In the US, nurse staffing levels have been extensively examined and, in some jurisdictions, mandated in some form. A study was conducted, "to provide a comprehensive updated review of hospital nurse staffing requirements across all fifty US states" (Krishnamurthy et al., 2024). It covers both mNPRs and other safe nurse staffing requirements. The study found:

> As of January 2024, seven states had laws pertaining to staffing ratios for at least one hospital unit, including California and Oregon, which had ratios pertaining to multiple units. Eight states required nurse staffing committees, of which six specified a percentage of committee members who must be registered nurses. Eleven states required nurse staffing plans. Five states had pending legislation, and one state, Idaho, had passed legislation banning minimum nurse staffing requirements.

A law was passed in 2021 in New York State, for example, that requires safe nurse staffing levels (New York State Nurses Association, 2022). The NY Safe Staffing for Quality Care Act "requires ICUs to comply with a 1:2 nurse-to-patient staffing ratio. The bill also requires every nursing home to maintain daily staffing hours equal to 3.5 hours per care facility resident" (Trusted Managed Services, 2024). As of January 2024, five US states had pending mNPRs: Illinois, Georgia, Maine, New Jersey, and Pennsylvania (Trusted Managed Services, 2024).

Jurisdictions with minimum nurse-to-patient ratios (mNPRs)

Several jurisdictions have legislated minimum nurse-to-patient ratios (McHugh et al., 2020). The following is a brief review of four locations with mNPRs, one of which is in Canada.

California

Legislation mandating mNPRs was passed in California in 1999 and was implemented in 2004 (Mark et al., 2013). It was the first North American jurisdiction to do so (Aiken et al., 2010). The legislation covers all RNs, which include both those with a university nursing degree, such as a BScN or MScN, and those with a community-college based Associate Degree in Nursing (ADNs) -- as well as Licensed Vocational Nurses (LVNs) (National Nurses United, 2025a). Hospitals that violate the mNPR requirements in California are subject to fines (Morse, 2023).

Australia

There are two states in Australia out of its six states and two territories that have legislated mNPRs -- Victoria and Queensland.

> Victoria became the first state in Australia to set minimum nurse-to-patient ratios in public hospitals via the Safe Patient Care Act 2015. These ratios mean that the number of nurses required on a ward will depend on the number of patients (occupied beds). The Safe Patient Care Act specifies different ratios depending on the level of care those patients may require (Royal Melbourne Hospital, 2024).

In 2016, Queensland Health in Australia "established minimum nurse-to-patient ratios for acute adult medical-surgical wards in 27 prescribed public hospitals across the state. The legislation requires that the average nurse-to-patient ratio on morning/afternoon shifts must be no less than 1:4 and on night shifts no less than 1:7" (McHugh et al., 2020). According to the Queensland Government (2018a), "Excellent care across the public health system is paramount. Legislated ratios set the minimum number of nursing staff that a public Hospital and Health Service must provide on a prescribed ward during each morning, afternoon and night shift." Nursing staff can be made up of RNs and enrolled nurses, which are roughly equivalent to Ontario's RPNs.

In Queensland, the legislated ratios are implemented under "the industrially mandated Queensland Health Business Planning Framework: a tool for nursing and midwifery workload management" (Queensland Government, 2018b).

British Columbia

British Columbia (BC) is the first Canadian province or territory to have succeeded in establishing mNPRs. It was implemented after sustained campaigning by the BC Nurses Union (BCNU) and negotiations with the provincial government by the Nurses' Bargaining Association (NBA) (BC Nurses Union, 2024b). The NBA represents the BCNU and the Health Sciences Association (HSA). The mandate took the form of a memorandum of understanding with the BC Ministry of Health. It covers nurses "in hospitals, long-term care and assisted living, and health authority community and non-hospital care settings" (BC Government, 2024a).

The BCNU has made a strong case for mNPRs. It lays out the conditions under which nurses have been working and the problems with the increasing reliance on private nursing agencies.

For years, BC's nurses have struggled to provide safe patient care while facing a reality that sees them running from patient-to-patient, working short-staffed and juggling multiple duties on every shift. These untenable working conditions are leading to high levels of nurse burnout and significant moral distress, forcing many nurses to leave the profession altogether. BC now has an unprecedented number of nurse vacancies – more than 5,000 according to Statistics Canada. This severe staffing shortage has also resulted in a growing frequency of temporary emergency room closures and service disruptions in the health-care system. Health employers have responded by spending tens of millions of dollars on expensive for-profit staffing agencies to bring nurses to the bedside and fill the staffing gap. This costly and unsustainable health human resources strategy has resulted in a 24-fold increase in spending on agencies between 2016 and 2024. Research has linked the use of agency nurses to increased staff turnover, deterioration of the quality of care, inequities in working conditions and salaries, and destabilization of health-care teams (BC Nurses Union, 2024b).

The BC Government (2024b) explains the ratios, which cover both RNs and licensed practical nurses (LPNs), as follows:

> mNPRs are a critical policy solution aimed at addressing the severe nurse staffing shortage in BC's health-care system. mNPRs represent the m inimum number of nurses deemed necessary to care for a maximum number of patients on a given unit, and provides a simple, clear formula that transparently indicates staffing requirements for licensed practical nurses, registered psychiatric nurses and registered nurses throughout the province.

An executive steering committee was established in 2023 to introduce the implementation of the new model. It was "comprised of members of the Ministry, NBA, Health Employers Association of BC (HEABC) and health authority leaders" (BC Government, 2024a).

The following table shows the agreed-upon ratios to be implemented in acute care settings (hospital-based) in BC beginning in fall 2024. They are similar to those in other jurisdictions. *See Table 1 below.*

Table 1: British Columbia nurse-patient ratios

SETTING	RATIO
General Medical / Surgical Inpatient	1:4 24/7
Rehabilitation	1:5 Day/Evening 1:7 Night
Palliative	1:3
Focused (Special) Care	1:3
High Acuity / Step Down	1:2
Intensive Care	1:1
Pediatric Medical / Surgical	1:4
Pediatric Focused (Special)	1:3
Pediatric Intensive Care Units	1:1
Pediatric High Acuity Units	1:2
Neonatal Intensive Care Unit (NICU)	1:1 to 1:3
Post-Anesthesia Care Unit (PACU)	2:1 to 1:2
Maternity Care – Antepartum	1:3
Maternity Care - Labour & Delivery	1:1 during active labour; 2:1 at birth
Maternity Care – Postpartum	1:3 for dyad care (nurse for both parent and newborn); 1:4 for birth parent only
Maternity Care - Newborn Care Nursery	1:3
Operating Room (OR)	2.5:1
Alternative Level of Care	1:7
Emergency Department - General Emergency	1:3
Emergency Department - Short Stay Observation	1:4
Emergency Department - Medical/Surgical Short Stay	1:4
Emergency Department - Trauma	1:1
Emergency Department - Critical Care	1:1
Emergency Department - Fast Track	1:4
Emergency Department - Waiting/Triage	Visits per year

Source: BC Nurses Union, 2024a

Oregon

Oregon is the second US state to have enacted mNPRs (Oregon Health Authority, 2024). A coalition of unions—the Oregon Nurses Association (ONA), Oregon Federation of Nurses and Health Professionals (OFNHP), Service Employees International Union Local 49 (SEIU 49), and the Oregon American Federation of State, County, and Municipal Employees (AFSCME)—worked together with a member of the Oregon legislature over many months to negotiate its terms.

These ratios are "minimum" because it is the minimum staffing allowed under the law. Facilities can't increase patient load from the ratios in the law without facing consequences... It's also important to remember this law is a floor not a ceiling, staffing committees can create staffing plans with even higher standards with their facilities' needs in mind (Oregon Nurses Association, 2024a).

The law initially covers only acute care hospitals; rural hospitals were given an additional two years in which to implement mNPRs; although the ratio specifies the number of patients per RN, the nurse staffing committee can approve a deviation within a unit from the mNPRs by adding up to 50% "clinical staff" (including LPNs) with the stipulation that the staffing committee must re-approve of the model every two years (Oregon Nurses Association, 2024a).

Its notable that allied employees are also covered under the new law and will have their own mandated staffing committees, "One for service workers (like environmental and food services), and the other is for technical providers (such as radiology technicians and ultrasound technicians) and professional providers (like physical therapists and occupational therapists)" (Oregon Nurses Association, 2024a).

Jurisdictions with other minimum nurse staffing levels

Many countries, states or other jurisdictions have some form of legislated or negotiated minimum nurse staffing levels. Some are at a national level; others are at a provincial or state level. A significant report by McTavish & Blain commissioned by the CFNU in 2024 explains:

> Mandated nurse staffing acts and programs often involve initiatives to ensure adequate staffing levels, enhance nurse training and improve working conditions. Examples include Connecticut and Ohio's engagement of frontline care providers in staffing decisions, Washington and Nevada's legislative adaptability to regional needs, and New Jersey and Illinois's transparency and accountability measures, which require public reporting of staffing levels and adherence to staffing standards. In Wales, there is a legal duty placed on health boards and NHS trusts to maintain sufficient nurse staffing levels for safe and effective patient care. Meanwhile, Scotland mandates the development and application of a common staffing method for health and care services, which uses professional judgment, evidence-based workload, workforce planning tools and local context to determine appropriate staffing levels.

Nova Scotia

In Nova Scotia, a safe staffing framework for nurses has been put into place via the collective agreement between the Nova Scotia Health Authority and the Nova Scotia Council of Nursing Unions, which represents 10,000 LPNs, RNs, and Nurse Practitioners (NPs) who are members of the Nova Scotia Nurses Union (NSNU), Nova Scotia Government and General Employees Union (NSGEU), CUPE, and Unifor.

In Nova Scotia, acute care health employers are now contractually required to staff units with a minimum number of nursing hours per patient day, fulfilled by a specific number of registered nurses and licensed practical nurses according to the number of patients and their specific needs, which is being referred to as "ratios plus" (Hamill & Hiltz, 2024).

Rather than explicitly using the mNPR model, Nova Scotia has adopted the Nursing Hours Per Patient Day (NHPPD) Framework. This approach has been successfully utilized in Western Australia since 2002 and was found to lead to improved hospital patient safety and outcomes, including reducing length of stay (Twigg et al., 2011).

The approach is methodical and patient-centric, designed to ensure that staffing reflects the specific needs and circumstances of each unit. This structured framework promises not only to uphold current staffing levels but also sets the stage for potential negotiations for additional staff based on thorough assessments of each unit's unique clinical capacity and workload. (McTavish & Blain, 2024a)

A *Joint Nurse Staffing Steering Committee (JNSSC)* has been established to maintain the Nurse Staffing and Skill Mix Framework, and it will be implemented by *Nurse Staffing Advisory Committees (NSAC).*

Beyond the staffing issue, in 2023, the government promised to allocate 7 million dollars to address violence against staff (Nova Scotia Nurses Union, 2023).

Manitoba

A letter of intent has been signed in Manitoba to develop staffing ratios. A subcommittee will explore the best approach for the province and provide recommendations by January 2026. "This initiative aims to establish nurse-patient ratios that consider the skills mix, complexity and acuity of care, ultimately providing tailored staffing strategies" (McTavish & Blain, 2024a).

2) The evidence: What are the documented implications of nurse staffing levels?

The following evidence is based on a review of published academic literature, reports from governments, health care organizations, and nurses' unions and associations, and on interviews with Ontario nurses.

"It didn't used to be like this about ten years ago but it's getting more and more complex. We're supposed to have five RPNs and one RN that's supposed to take on the most complex of these patients and the admissions, but half the time we don't even have an RN so we're doing the admissions. It's just evolved; we're getting more and more responsibilities." *– Complex care nurse*

a) How do nurse staffing levels affect nurses' well-being?

Ontario nurses are suffering burnout from a myriad of factors: heavy workload, hectic pace of work and long hours, largely due to understaffing (Govasli & Solvoll, 2020; Suran, 2023; Duong & Vogel, 2023), moral distress, physical injuries, workplace violence, a sense of powerlessness and demoralization (Brophy et al., 2024). In an atmosphere where nurses feel their voices and concerns are not being heard or addressed, it follows that many are leaving their profession (Statistics Canada, 2023; Ménard et al., 2022).

"I can't even find a blood pressure machine to take blood pressures on my seven patients instead of four patients – because we're short that day. And it's like you don't have the resources to perform the tasks they expect you to do. … The amount of time spent trying to make things work is crazy." *– Dialysis unit nurse*

Hospitals and long-term care facilities seem to be operating under industrial models of management. Time management, budgetary interests, and efficiency practices seem to supersede the principle of patient-centred care as the concept of "Medical Taylorism" becomes the dominant mode of operation (Hartzband & Groopman, 2016).

"I feel like time is our biggest enemy. We understand the behaviours. You cannot rush a person with advanced dementia. They don't understand. You can't just go in and start getting them dressed because they'll be scared. So, you need time to introduce yourself, smile, talk slow, help them do what they can. So maybe they can still pick out their clothes and they'll agree with you more if you give them choices, but we don't have the luxury of time. There's not enough time to do the job so that everyone is safe." *– Long-term care nurse*

Just-in-time production is becoming a guiding health care management principle in terms of material costs, scheduling and staffing (Gupta, 2012).

"I couldn't leave for my break because I had an IV that needed to be started and up the hall I had an IV and a tube feed and vitals to do and then on the other side of the room, I had to wait for orders to be done, for clarification because it had been written wrong, so now I'm 45 minutes already behind. I'm thinking God, I'm not going to get my break. I'm not going to be able to go to the bathroom because there's no time for that. And it's dinner time, so now all my patients have to be fed – so get those roller skates on because there's work to be done." *– Complex care nurse*

The notion that nurses are tantamount to machinery expected to perform tasks at a sustained breakneck speed misses the essential understanding that they are biological, emotional, and intelligent beings. Nurses require rest time, or slower and lighter work intervals, to offset the hectic, high-demand periods, both mentally and physically in order to continue to function as effective caregivers. Instead, efficiency is prioritized over the quality of relational and patient-centred care and the well-being of health care workers. In other words, both the patients and the providers of care suffer when nurses are overworked.

"Nursing is about body, mind and soul…we work with a heavy workload, and the hardest part for all of us is that our patients aren't getting their needs met, and they're not getting taken care of the way a person should be, especially at the end of their life." *– Palliative care nurse*

Research has repeatedly shown that rest is an essential counterforce to the heavy demands and fast pace of work. A 2023 review of related literature conducted by Stutting found:

> Professional burnout is a well-studied phenomenon marked by feelings of depersonalization, emotional exhaustion, and decreased accomplishment. Affecting nearly half of all nurses, burnout presents a threat to health outcomes of the nurse, patient, organization, and society... Rest breaks are effective in decreasing professional burnout...

"You walk in and you're two staff down…So, my anxiety goes up because I won't get a break. No one cares…you're working short and there's so much stress." *– Post-surgical rehabilitation nurse*

In a meta-narrative review of 121 studies regarding the nature of effective nursing care, Jackson, Anderson & Maben (2021) explore the diversity of nursing tasks and responsibilities and conclude, "Nursing work is complex and includes physical, emotional, cognitive, and organisational labour. Staffing needs to take all nursing labour into account."

"It's gotten progressively worse. . . every year they're taking away more staff and putting that workload on top of you. It's gotten to a point where we're doing the jobs of four different people. There's no time in the day to do the amount of work that we're doing. It's become so unsafe; it's become so unrealistic. It's a disgrace, an absolute disgrace to our profession." *– Operating Room (OR) nurse*

OCHU-CUPE has carried out numerous research studies and surveys in recent years that clearly indicate health care workers in Ontario are in the midst of an unprecedented crisis. (OCHU-CUPE various; Brophy et al, 2017, 2018, 2020, 2024; Keith and Brophy, 2022; McArthur et al, 2020; McArthur, 2020)

"A number of my co-workers are on medication, a lot of the younger nurses. I had to go on stress leave. A couple of my nursing friends have been on stress leaves. A lot of us have thought about quitting. . . You come into work – you might have four patients, you might have seven patients. You might have one patient crashing and then you have six other patients screaming at you for something and the family members. It's unpredictable. And it's more stressful when you don't have the tools and staff to do your job." *– Medical-surgical nurse*

A Nanos Research (2023) poll was commissioned by OCHU/CUPE. There were 750 health care worker respondents overall. Of the 219 respondents who were nurses:

- 60.7 per cent reported trouble sleeping
- 36 per cent suffer depression
- 64.9 per cent have anxiety
- 75.4 per cent experience high stress
- 55.9 per cent dread going to work
- 43.6 per cent said violence had increased or somewhat increased since the beginning of the pandemic

"Staff are having daily breakdowns on certain floors because they can't handle the patient ratios…The nurses are crying and not being able to finish their day because they just feel so overwhelmed with the amount of patients they have and looking at what they have to do in the day and they can't get that done. And afraid of being in trouble for not getting certain things done." *– Dialysis unit nurse*

In 2024, the Registered Practical Nurses Association of Ontario (WeRPN) surveyed over 1,300 members. It found that:

- 78 per cent have been directly impacted by the nursing shortage
- 84 per cent report an increase in their workload over the past year
- 49 per cent say that the quality of patient care worsened over the past year
- 93 per cent indicate having seen firsthand patient care being compromised because there are not enough nurses to meet patient needs
- 58 per cent say they still do not have the time or resources needed to provide adequate care to patients, residents or clients

"I used to come to work on this floor and at the end of a 12 hour shift I'd never feel like I do now. The workload has increased; the sick calls increased because my co-workers took stress leave because they could not cope. The patients have changed – the complexity of the patients … they're so sick. You're juggling IVs. You're getting thrown up on. Your patient is spiking a fever. . . Meanwhile the patient in the next bed is yelling and cussing you out because you won't go get them a spoonful of peanut butter, or go get them hot tea, or drop what you're doing and go get a cold water. You can only do so much, and I try to do my best." *– Orthopedic rehab nurse*

A collaborative study conducted by OCHU-CUPE and academic researchers found that Ontario's nurses and other health care workers are experiencing "anxiety, sadness, a dread of going to work, and a sense of hopelessness" that conditions will ever improve (Brophy et al., 2024).

"It makes you feel insignificant. You hear that from nurses all the time. 'Why bother? Why complain? Nothing's going to change." *– Psychiatric nurse*

Workload and long hours

"Something's got to give. The thing about being a nurse is all that stress. I have a loved one in the medical field and they came in to drop me off coffee one day and said I would never be able to do your job. Well, the thing is, you can't react as a nurse, as stressed as you are and despite that migraine from all those bells and the anxiety. You are constantly go, go, go; you haven't peed in about four hours; you haven't had anything to drink or eat."
– Medical-surgical nurse

Heavy workloads have been shown to have serious consequences for the health and morale of nurses.

"My colleagues are crying, they're burnt out, we're calling in sick. We can't do all this care because care involves five to six patients, total care for personal care, washing them, dressing them. They are incontinent, they have catheters; you have to do all that care, plus you have to talk to the patients' families. We're on a special floor where they need a lot of counselling, so that's also incorporated in my job. I have to deal with these patients and their families." *– Palliative care nurse*

For example, a 2023 review of the evidence by Ben-Ahmed and Bourgault demonstrated that nurses in Canada are in short supply and revealed that, as a result, they are in severe distress. The authors of the review made a disturbing assertion:

> Inadequate staffing, excessive workloads, endemic violence and unhealthy workplaces are some of the challenges facing Canadian nurses. Leaving these issues unaddressed has had pernicious impacts on the nursing workforce: thousands of nurses across Canada have been suffering from extreme stress, anxiety and burnout, leading many of
> them to leave their current jobs and, for some,
> the profession of nursing altogether.

The CFNU commissioned a research report on the effects of hours of work on the health and well-being of nurses. In the discussion section of the report, Dr. Heather Scott-Marshall (2023) stated:

> As we have seen, the body of evidence regarding the adverse occupational health and safety impacts of excessive work hours is both clear and compelling. . . The individual health-related effects of excessive work hours range from disorders of sleep and mood to serious chronic illness, including a heightened risk of cardiovascular disease, metabolic disorders and cancer.

The stress of a heavy workload and excessive work hours is exacerbated by the complexity of much of the care now being demanded of the nursing staff.

"I do total care for patients; I have to dress them. If they can't eat I have to feed them. I have to do all their medications, injections, PO medications, treatments, nebulizers, oxygen. Most often they're on IVs now because things have changed. We're getting patients that are needing more treatment. It's getting more complex as a teaching unit so they're offering more and more treatment with their blood transfusions, IV insertions, taking blood."
– Palliative care nurse

Moral distress and injury

Significant contributors to burnout among nurses are moral distress and moral injury. Moral distress can result: "When one knows the right thing to do, but constraints, conflict, dilemmas or uncertainty make it nearly impossible to pursue the right course of action" (American Association of Critical-Care Nurses, 2020). Moral injury refers to "the damage done to one's conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical codes of conduct" (Syracuse University, 2025).

A prominent journalist, Ed Yong, has conducted extensive interviews with health care workers. He said he prefers not to use the word burnout which gives the impression that they are simply exhausted from doing their jobs. Instead, he believes, "that they couldn't handle not being able to do their job... For them, it was more about this idea of moral injury, this massive gulf between what you want the world to be and what you see happening around you" (Marchese, 2025)

"It's family getting angry or patients getting angry and you know what? They have a right to be angry. They feel that, 'Well, my loved one is in the hospital or I'm in the hospital and I should be getting cared for and I haven't seen my nurse in three hours.' Well, they haven't seen the nurse because she's got eight patients to look after and

she's got IVs and catheters and dressings and medications and all of that to do. The patient in the next room is in a crisis and, as a nurse, in the back of your head, you're thinking of that poor patient you haven't seen in three hours and that's the truth. It's not that you have forgotten about the patient you saw three hours ago and haven't gotten back to and you know might need their diaper changed or pain medication, it's just that you're doing the best you can and you're trying to prioritize your work. And you don't go home feeling like you've done a good job. Every nurse will tell you that." *– Medical-surgical nurse*

Many nurses are plagued by ethical dilemmas arising from their working conditions and the weakening of the culture of care.

"I am completely burnt out. Every shift we're short staffed…It's embarrassing to say I don't have the compassion I used to have…I am exhausted, mentally, physically, emotionally and I dread going into work…I'm not at all the nurse I wanted to be…We all recognize it's hard for patients too. This is not the kind of health care they deserve. But as nurses, we are all at a loss; we don't know what more to do." *– Medical-surgical nurse*

According to Danish researchers, "Working within time limits and heavy workload leads to burnout and ethical insensitivity among nurses, and may challenge nurses' options to act on the basis of ethical and moral grounds in the individual care situation" (Haahr et al., 2020).

"I have insomnia because I'm thinking about patients and work and feeling guilty and sad, so I can't sleep at night. I have to take sleeping pills, which I never had to do before."
– Complex care nurse

Extended stress can cause burnout, as can moral injury. According to the US Office of the Surgeon General, burnout results from "…inadequate support, escalating workloads and administrative burdens, chronic underinvestment in public health infrastructure, and moral injury from being unable to provide the care patients need" (Murthy, 2022).

"There's just no time to spend with my patients. With all the charting we have to do, there's all of that, plus having seven or eight on a dayshift, with all their meds, and their ADLs [dressing, bathing, mobility, etc.]." *– Medical-surgical nurse*

The gender and racial composition of the nursing profession arguably puts them at an increased risk.

"We don't report sexual violence because it happens so frequently…I have been grabbed many times. Sexual harassment is definitely a problem for women workers. A patient referred to the nurses as whores and bitches…You feel disgusted with yourself after someone makes an inappropriate pass. It makes you feel violated." *– Psychiatric nurse*

In 2024, the College of Nurses of Ontario (CNO) conducted a Workforce Census; 90.8 per cent of respondents identified as women and 32.3 per cent as "First Nations, Inuk/Inuit, Métis or racialized, including mixed race."

"I've had to remove residents, bring them to the office and report them to management because they've had my coworkers in tears because they were racialized. And nobody should have to come to work and be humiliated like that." *– Long-term care nurse*

Social inequalities put gendered and racialized groups at a distinct disadvantage. Katherine Lippel (2018) identified this phenomenon as "structural violence," a term used "to identify the heavy workloads, low levels of decision-making autonomy, low status, rigid work routines and insufficient relational care as forms of violence."

"I think nurses feel helpless in fixing any of it because when you complain about it and we do complain about it, nothing happens or you're told that, 'Well, this is the way it is. We've got to cut corners. And you just have to live with it.' I believe that the health care workers now just feel victimized like there's nothing we can do. We just have to keep going with it – like a bad marriage." *– Psychiatric nurse*

As Katherine Lippel (2018) explains, "Not only are these poor working conditions experienced as sources of suffering, but they prevent care workers from providing the kind of care they know they are capable of."

"They've cut me up into pieces. They spread me so thin I don't have the time to provide the level of care I would love to provide. I have anxiety and feelings of guilt that I should have done more, but I can't. I can only do so much…Palliative care is hard enough. I'm concerned about patient neglect and the physical part of the job is killing me." *– Palliative care nurse*

And then with the issues we have at work and the concern about patient neglect and the physical part of the job is so draining; my job is killing me." *– Palliative care nurse*

Violence

Violence against health care workers is epidemic. According to the New England Journal of Medicine, "Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored" (Phillips, 2016).

"On our floor, if we're working short and a patient rang maybe five times and the ward clerk's answering and saying, 'okay someone's going to be coming shortly, they're trying,' technically we're not supposed to tell them that we're working short so then they think that we're just ignoring them. And we're running around trying to get to all the bells and by the time somebody actually gets to them they might have waited 20 minutes, and they had to go to the bathroom, or they want a pain pill or whatever. And now they've gone from being a little bit mad to now they're agitated." *– Medical-surgical nurse*

Besides physical injuries, violence has been shown to increase anxiety, depression or post-traumatic stress, burnout, and attrition (Blomquist, 2025).

Despite years of research, awareness-raising campaigns, and lobbying of the government by unions and associations representing health care workers in Ontario, violence continues to plague nurses. It contributes to physical injuries and emotional ill-health – and ultimately to attrition. Verbal abuse, including racist and sexist remarks, along with physical assaults, adds to stress. Even the anticipation and fear of abuse are stressful (Brophy, Keith, & Hurley, 2017; 2019).

Inadequate staffing levels have been identified as a risk factor. Statistics Canada, in partnership with the Canadian Institute for Health Information (CIHI) and Health Canada, conducted a large survey involving 18,676 RNs, RPNs, and LPNs from across the country. The results found that "inadequate" staffing levels or resources were "associated with both physical and emotional abuse" (Shields & Wilkins, 2009).

"We do not have enough staff. It's hard on us; it's hard on the patients. In the last two years, I've seen a lot more aggression from patients. I've been hit at least three times in the last six months. The families seem to be a lot more aggressive as well." *– Medical-surgical nurse*

Yvette Coffey, president of the Newfoundland and Labrador Nurses' Union (NLNU), has asserted that legislated nurse-to-patient ratios are urgently needed in Newfoundland and Labrador to address the growing crisis in health care, including increasing violent incidents against staff. She stated, "We need to ensure the safety of nurses if we're going to ensure the safety of our patients...This is not just about staffing. It's about survival" (Mercer, 2025).

In 2019, Linda Silas, President of the CFNU, testified in a submission to the House of Commons Standing Committee on Health. She stated that:

> Workplace violence is a growing epidemic among health care workers as staffing levels heavily decline, patient acuity increases and weak security protocols fail to offer adequate protection. From a Canada-wide survey, 61% of nurses reported abuse, harassment and assault on the job during the last year. A recent survey here in Ontario said that 68% of nurses and personal support workers experienced violence on the job. We know that these numbers are unacceptable.

There are many contributors to violence, including wait times. According to Erin Ariss, President of Ontario Nurses Association (ONA), in terms of understaffed rural hospitals, "As ER wait times grow, staff are too often subjected to violent behaviour and the resulting stress has led to widespread burnout" (Ireton & Ouellet, 2024).

"A lot of the issues are because we're short staffed. There's still going to be aggression, no matter what, but the majority of why and how poorly it is handled and why it escalates is because there's not enough staff. And you're not going to be able to retain staff if you're busy burning them out; giving them mental issues because they're so stressed and what they see at work is messing them up, physically and mentally." *– Complex care nurse*

A study in 2020 of 528 nurses working in medical-surgical settings in BC found that heavy workloads, which are directly related to inadequate staffing levels, increased the risk of physical and/or emotional violence. The nurses attributed the violent incidents to "compromised standards," "interruptions," and "higher patient acuity" (Havaei and Macphee, 2020).

"As we're running up the hall, we could see a patient punching a nurse. He had her on the floor and he kept punching her and punching her. I felt like I was running in slow motion. I just felt like I wasn't getting there and there were other people running behind me. And all I could hear was the sound of the punches. And even now today, if I'm in a grocery store and someone runs behind me, I feel that all over again. It brings me right back there. She ended up badly bruised and had PTSD from it... My neighbours will say, 'Wow, I never really thought of that happening in the hospital. That's crazy. That really happens?' The public doesn't realize, they really don't." *– Psychiatric nurse*

Karen Lasater, Heather Brom, Linda Aiken, and Matthew McHugh (2025), recognized authorities on the implications of nurse staffing levels, conducted a study of 58 hospitals in British Columbia. It was intended to serve as a baseline as the newly legislated mNPRs were being rolled out. The study found that staffing had a direct effect on the risk of violence. The data showed that "one additional patient per nurse was associated with a 3 percentage-point increase in emotional abuse of nurses, a 4 percentage-point increase in physical violence directed at nurses" (Aiken, 2025).

Job dissatisfaction

"I'm not even proud to be a nurse anymore... If I had any other skill, I would quit...it's just like I'm a robot. I go there. I do my job. And I go home now. It's not that I don't care, but I used to be excited about the outcome and wanted to see their care through...Now I just want to do my job and go home."
– Medical-surgical nurse

There are many international studies showing the link between low nurse staffing and effects on emotional and mental health and increasing job dissatisfaction. For example, a study was carried out by McHugh et al. (2020) in Australia, where mNPRs have been enacted; it included "4372 medical-surgical nurses and 146,456 patients in 68 public hospitals." The study concluded:

> Before ratios were implemented, nurse staffing varied considerably across Queensland hospital medical-surgical wards and higher nurse workloads were associated with ...nurse emotional exhaustion and job dissatisfaction. The considerable variation across hospitals and the link with outcomes suggests that taking action to improve staffing levels was prudent.

"You think it can't get any worse - and it just got worse. I was going through increasing panic attacks before work, crying before I got out of the car. I loved going to work when I first started. Now I dread it." *– Trauma department nurse*

A study conducted in the UK by Rafferty et al. (2010) on the impact of nurse staffing levels noted similar findings; nurses in hospitals "with the highest patient to nurse ratios [fewer nurses]...were approximately twice as likely to be dissatisfied with their jobs" and "to show "high burnout levels."

Physical injuries and illnesses

The US Occupational Safety and Health Administration (OSHA) reported that, "health care workers are seven times more likely than others to develop injuries that affect muscles, tendons, ligaments, nerves, discs and blood vessels." They cite understaffing as a contributing factor: "When a health care facility is short on staffing, that puts a heavy burden on front-line workers. Added workload, less assistance from others and pressure to work at an accelerated pace can up the chances of accidents and injuries" (MultiCare Occupational Medicine, 2021).

There was a rise in documented injuries for health care workers in Ontario between 2020 and 2022. Besides the COVID-19 infections during the pandemic, when workload rose dramatically, overexertion injuries increased by 19%. Jean-Daniel Jacob, the director of the School of Nursing at the University of Ottawa, attributed much of the increase to "strains from excessive lifting of patients and other medical equipment" (Shaw and Edwards, 2024).

"I was working in neurology, and right after a procedure, I had to help a male patient off the table. He was about 250 pounds. . . He basically passed out on my side of the table. I had just put metal stairs on wheels right in front of him. By passing out, he was going to smash his face on the stairs and maybe roll and hit a wall that wasn't even three feet away from those stairs. He would have really injured himself. I just had time to grab him by his gown and with all the strength that I had, I was able to safely put him down. He scraped his leg a little bit, that's the only injury he had – but I tore my shoulder." *– Neurology nurse*

According to Linda Aiken (2025), the Lasater et al. (2025) baseline study in BC found, "Regarding nurse safety, one additional patient per nurse was associated with ... a 4 percentage-point increase in work-related physical injuries to nurses."

"We were working short. I had a very troubled patient who had mental health issues and it led to me getting a needle stick injury. You're only one person and you're rushing and you're trying to get things done and you're trying to keep all your patients happy and you can't." *– Medical-surgical nurse*

A study was conducted on injuries and illnesses among nurses after implementing mNPRs in California. The law was found to have been "associated with 55.57 fewer occupational injuries and illnesses per 10,000 RNs per year, a value 31.6% lower than the expected rate without the law. The most probable reduction for LPNs [licensed practical nurses] was 38.2%" (Leigh et al., 2024).

Staff attrition

Poor working conditions, violence, lack of support, inadequate wages, overwork, and burnout lead to attrition. The greater the attrition, the fewer nurses there are to do the work. Staff shortages and related problems then further increase, and more nurses leave.

"I know many [nurses] have just left their career...I wouldn't be here myself either if it wasn't that I have a family to support." *– Oncology nurse*

A Statistics Canada Labour Force Survey of health care workers that was published in 2023 found that only 55.6% of nurses agreed that their positions were "strongly aligned with their values...Examples of these values include the importance of job autonomy, salary and benefits, recognition, career advancement, and the relationship with coworkers" (Blackwell, 2023). Workplace health and safety was also a high priority for 89.4% of nurses. Overwork was the primary reason nurses intended to leave their jobs.

"I have to do all of this, and it's just getting so much more, and more, and more. I'm going to be retiring soon, as soon as possible at 55. I'm going to get out of there because it's killing my back. I have sprained my neck doing patient care. I was only on modified duties for three days because of that injury a few years ago. When I'm feeling really stressed and overworked, my neck hurts a lot. It's ongoing." *– Palliative care nurse*

The evidence goes a long way in explaining why nurses are leaving, many very early in their careers. It is a nationwide problem.

"Why can't the government see it? It's just so obvious, it makes me tear up. I love my job but I can't wait until I retire and I'm only in my forties…There are so many nurses that did retire – seasoned, experienced nurses that are invaluable. All gone." *– Palliative care nurse*

The Registered Nurses Association of Ontario (RNAO) reports that, "nurses are experiencing depression, anxiety and stress as never before," leading to increasing attrition in the public system. The report states that they are: "migrating to nursing agencies for fairer compensation and more control over their lives;" attrition is especially pronounced among younger, early-career nurses, who are more likely to leave their positions (Registered Nurses Association of Ontario, 2023).

"Younger new grads are unwilling to stay in the profession. Because when you have people's lives on the line and you feel like you're the reason that something got missed or something bad happened, it doesn't matter how much they're willing to pay you if you feel like you're sacrificing somebody's wellbeing, you can't continue doing that." *– Dialysis unit nurse*

A recent Montreal Economic Institute (MEI) study found that, "In 2013, Ontario only lost 19 young nurses for every 100 that joined the profession. By 2022, this ratio had increased to 35 in 100, an increase of 83%" (Faubert, 2024).

"I literally think every day how can I get out of this? I don't want to be here anymore. We have all these new young nurses coming in but, as fast as they come in, is as fast as they leave. My next door neighbour finished her RPN and then realized you make such little money and you do so much work.

So, she went back to do an RN. She's currently in the middle of finishing up but she now doesn't think she wants to do nursing anymore." *– OR nurse*

A survey conducted by the Registered Practical Nurses Association of Ontario (WeRPN) found:

> In 2024, nearly half of Ontario RPNs surveyed (48 per cent) say they are considering leaving the profession. While this is an improvement from last year's figure of 62 per cent, the impact of a further loss of RPNs at this time would be devastating for patients across the province. According to the survey, 7 in 10 respondents (69 per cent) say they have witnessed an increase in experienced nurses (RNs and RPNs) leaving their workplace in the past year, and concerningly, 1 in 2 (50 per cent) do not feel as though their workplace has enough experienced nurses to consult with on more complex cases.

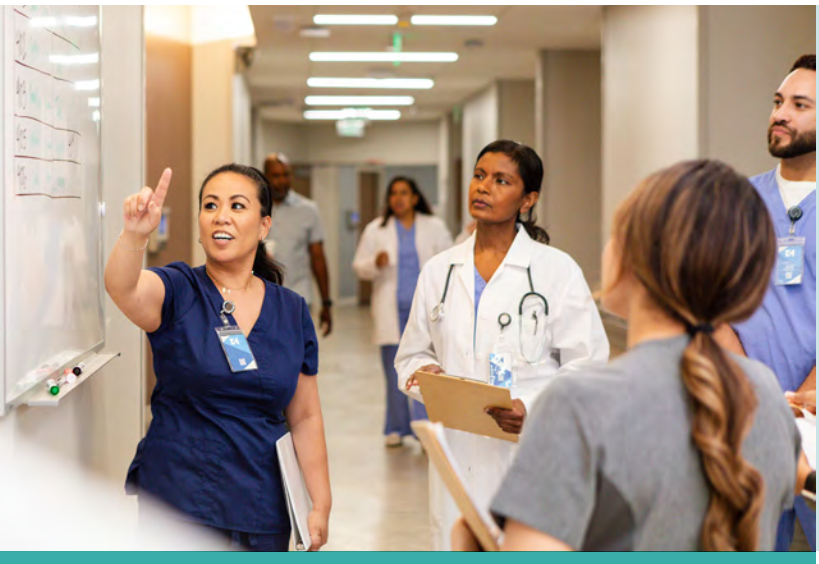
According to Erin Ariss, president of ONA, "Nurses are leaving the profession. Nurses aren't entering the profession. They're not staying in the profession, and I don't think anyone can blame them when there's not much to keep us here" (Ireton & Ouellet, 2024).

"Staff's emotional health is not good. We have had a lot of our long-time nurses – the ones you go to when you want to talk about something that's happened or just to collaborate with – they've all left because they just were exhausted, burnt out." *– Palliative care nurse*

The staff attrition crisis is exacerbated by nurse burnout and job dissatisfaction, which are "associated with costly turnover" (McHugh et al., 2020). In addition, nurses are experiencing a decrease in their "real" wage. As a result, many feel undervalued and exploited. Wage increases have not kept up with inflation (Macdonald, 2022).

According to the BC Nurses Union (2024a), when working conditions improve, attrition declines: "When we retain experienced nurses, we keep valuable knowledge, skills, and real-life experience in our health-care systems – a win-win for nurses and patients."

This was, in fact, the case in Australia. The establishment of mNPRs in Victoria has significantly addressed the shortage of nurses that existed prior to its implementation. "After the policy was implemented, Victoria saw a 24 per cent uptick in employed nurses, with more than 7,000 inactive nurses — those who either left the profession or retired — rejoining the workforce" (Globe Content Studio, 2024).



Impact of the COVID-19 pandemic

"We have lots of senior nurses quitting. And a lot of people crying… People are still overwhelmed with what we've been through." *– Obstetrical nurse*

There is no question that the COVID-19 pandemic put additional strain on the health care system and its nurses, and many are still suffering its effects (McArthur, Brophy & Keith, 2020; Voth et al., 2022).

"COVID brought out the worst. I was always a strong person and I'm a leader, and I take on extra responsibilities but I couldn't handle COVID. I had to go on antidepressants. Now I depend on the antidepressants because of the new normal at work and all the increased duties and the stress. I can't cope. I was getting anxiety attacks getting off the elevator coming into my floor to do the work. It just caused me to be really, really resentful of health care." *– Palliative care nurse*

Governments and funding decision makers have tended to blame the pandemic for today's failing system, but the evidence shows that many of the burdens of stress and overwork experienced by nurses today preceded the pandemic (Twigg et al., 2015; Lasater et al., 2021b).

According to Canadian researchers, the pandemic "exposed the grim underbelly of a fragmented, regionalized, costly, and inefficient approach to health service that is an engine for health workforce burnout" (Affleck & Wagner, 2022).

A 2020 poll sponsored by OCHU-CUPE found that 91 per cent of health care workers felt "abandoned by the provincial government" (Business Wire, 2020).

In a survey on the effects of the pandemic on health care workers, the Mental Health Commission of Canada (MHCC) found that 37 percent were experiencing burnout. They noted increasing demands and diminishing support and that the "COVID-19 pandemic has worsened these poor working conditions, negatively impacting mental health and exacerbating feelings of moral distress" (Grady et al., 2022).

"The rest of the world is just back to business as usual. But it's not for us in the hospital. It's not business as usual. We are still experiencing the trauma from COVID on a daily basis. We're still trying to catch up. We're still living horrors that we went through, and there's just nobody there to help. You literally just kind of feel alone." *– Trauma unit nurse*

A large Canadian study published in 2021 found the majority of nurses (63.2%) were experiencing some symptoms of "burnout and mental disorders (i.e., Posttraumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Panic Disorder)" and 29.3% have clinically significant serious indications (Stelnicki et al., 2021).

A study by Singh et al. (2024) also showed a very high prevalence of burnout among the Canadian public health workforce from the added pressures of COVID, along with other work-related factors.

The Registered Nurses Association of Ontario (RNAO) (2022) reported that 75.3% of Canadian nurses were suffering burnout, being "both exhausted and disengaged."

There were similar findings from an extensive survey of over 151,335 hospital nurses in New York and Illinois pre- and during the pandemic (Aiken et al., 2023), which are reflective of the Ontario experience as well. The data revealed that:

> ...high nurse burnout, job dissatisfaction, intent to leave hospital employer, and lack of confidence in hospital management predated the pandemic... The high rates of nurse burnout during the pandemic appear to be largely a consequence of high burnout prior to the pandemic... Importantly, our results show that hospital nurse understaffing and poor work environments prior to the COVID-19 emergency were associated with unfavorable outcomes during the pandemic.

b) How do nurse staffing levels affect patients' well-being?

"We work short-staffed pretty much every day. . . we work with a heavy workload and I would say that the hardest part for all of us is that our patients aren't getting their needs met; they're not getting taken care of the way a person should be, especially at the end of their life. Their family members are having to take up a lot of the slack and having to accept that there's a problem in our health care system that is not allowing their family member to be cared for like they need to be cared for." *– Palliative care nurse*

Nurse staffing levels affect patients in terms of wait times, sense of being valued, level of care, readmissions, medical errors, hospital-acquired infections, and mortality.

Many studies have provided persuasive evidence of poorer patient outcomes when nurse staffing levels are lower (McHugh et al., 2020). In the last two decades, over 100 research studies have established the link between inadequate nurse staffing levels and negative impacts on patients (Levins, 2023).

"We're always working short-staffed. We have a backlog of over two years. We hardly have time to take breaks or go to the washroom...I don't think patients are getting the care they need." *– Outpatient clinic nurse*

A substantive evaluation of the relationship between the degree to which nurses feel able to do their jobs and patients' sense that they are being adequately cared for found, "Patient satisfaction levels are lower in hospitals with more nurses who are dissatisfied or burned out." (McHugh et al., 2011)

"The staffing levels are hugely down, during daytime and evening and night shifts; they keep cutting, we'll cut one nurse here and we'll cut one nurse here. We have three vacant lines that have never been filled. When they take away the frontline worker, patients get neglected. Patients don't get the care they need, the immediate attention they need. That causes stress, whether you're a psychiatric patient, a medical patient, a physiotherapy patient, or coming into an emergency room." *– Psychiatric nurse*

A UK study by Rafferty et al. (2010) found that poor nurse-to-patient ratios resulted in "low or deteriorating quality of care on their wards and hospitals."

"We don't have enough staff members to be able to sit down and talk with your parents for at least five minutes to get to know them. Literally all we're doing is running in the room, giving them water, giving them pills and telling them to choke it down. It's sad. It's so sad to see." – *Medical-surgical nurse*

In their review of Canada's nurse staffing problem, Ben-Ahmed and Bourgault (2023) stated that, "there is a substantial relationship between nurses' burnout and poor patient outcomes, e.g., high level of patient mortality, failure to rescue, and longer length of stay."

Patient mortality

There is substantial evidence that the level of nursing care has a direct effect on a patient's likelihood of dying. For example, according to the researchers of the baseline study carried out by Lasater et al. (2025), "We documented very similar findings in BC regarding the impact of nurse variation in staffing on patient mortality as previous research has documented in the US (Aiken et al., 2002) and in Europe (Aiken et al., 2014) —every 1 patient increase in the workload of inpatient hospital nurses is associated with a 7% increase in mortality."

When Aiken et al. (2010) compared outcomes from California, where nurse-to-patient ratios were mandated, to two other states without such a mandate, they found, "Hospital nurse staffing ratios mandated in California are associated with lower mortality."

Silber et al. (2016) explored the relationship between nurse staffing levels and surgical patient outcomes in 3 different states in the US. They concluded, "Hospitals with better nursing environments and above-average staffing levels were associated with better value (lower mortality with similar costs) compared with hospitals without nursing environment recognition and with below-average staffing, especially for higher-risk patients."

A study by Rafferty et al. (2010) conducted in the UK on the impact of nurse staffing levels found, "Patients and nurses in the quartile of hospitals with the most favourable staffing levels (the lowest patient-to-nurse ratios) had consistently better outcomes than those in hospitals with less favourable staffing. Patients in the hospitals with the highest patient to nurse ratios [fewer nurses] had 26% higher mortality."

In another UK study, Griffiths et al. (2019) examined the hours of nursing care per patient per day and found an increased risk for mortality among those receiving less nursing care.

Ball et al. (2018) examined the effects of "missed nursing care" on patient outcomes. The study included "422,730 surgical patients from 300 general acute hospitals" in nine European countries. The study found that:

> Missed nursing care, which is highly related to nurse staffing, is associated with increased odds of patients dying in hospital following common surgical procedures. The analyses support the hypothesis that missed nursing care mediates the relationship between registered nurse staffing and risk of patient mortality. Measuring missed care may provide an 'early warning' indicator of higher risk for poor patient outcomes.

A study of mortality among patients in seven Belgian hospitals by Haegdorens et al. (2019) found an "association between higher nurse staffing levels and lower patient mortality."

Needleman et al. (2011) examined the outcomes of 197,961 patient admissions in 43 US hospital units in relation to nurse staffing levels. They found that a lower level of nursing care "was associated with increased mortality, which reinforces the need to match staffing with patients' needs for nursing care."

Medical errors and hospital-acquired infections

"I believe understaffing is contributing to medical errors. It happens all the time, not only because of the short staffing, but because, even if you do have staffing you don't have continuity. You don't have people there regularly who know the system, know the patient, know the ins and outs…things just don't get done or get missed, following up on blood work that was critical being missed." *– Dialysis unit nurse*

According to the Canadian Institute for Health Information (CIHI) the rate of hospital-acquired infections (HAIs) has increased. "1 in 17 hospital stays in 2021–2022 involved patients experiencing at least one harmful event, up from 1 in 18 reported in 2014–2015" (2024b).

A study conducted in 19 teaching hospitals in Ontario found that, "a higher proportion of professional nurses in the staff mix (RNs/RPNs) on medical and surgical units in Ontario teaching hospitals are associated with lower rates of medication errors and wound infections." (Hall et al., 2004).

"We can't get the proper equipment most of the time. We can't even get our equipment properly sterilized most of the time. They're not training the individuals to do the sterilizations properly. They can't even find individuals to do the jobs properly." *– OR nurse*

Cimiotti et al. (2021) examined the effects of nurse staffing and burnout on the rates of urinary tract and post-surgical infections among patients in Pennsylvania hospitals. They found, "Hospitals in which burnout was reduced by 30% had a total of 6,239 fewer infections, for an annual cost saving of up to $68 million."

An Australian study that explored the causes of pressure injuries found they are "considered a nursing-sensitive patient outcome and are commonly used as an indicator of the quality of nursing care . . . Higher levels of missed care can result from inadequate staffing levels and workplace culture; both are known to impact patient safety" (Alanazi et al., 2023).

"Half of our staff are off on stress leave or whatever. In the operating room it takes two years to get a nurse up and running. And that's a good nurse that comes from a surgical background. Now they're taking individuals straight out of school and expecting them to be up and running in six months. How unrealistic is that?" *– OR nurse*

Duffield et al. (2011) examined the effects of low nurse staffing levels in New South Wales Australia, and found they "were linked to negative patient outcomes including falls and medication errors on medical/surgical units."

"I know I never want to go to a hospital. That's for sure. We have a lot of patients come to us from acute care that have not had a shower or a bath in however long they've been there…They come with their hair matted, their hair is filthy, their skin is very dry, nails are filthy dirty and really long. Their oral care is just atrocious." *– Palliative care nurse*

Brooks et al. (2011) surveyed nurses in 4 different states and found, "Nurses in poorly staffed hospitals were 6% more likely to report that important information about patients "fell through the cracks" when transferring patients across units... Interventions to improve nurse engagement and adequate staffing serve as strategies to improve patient safety."

"We'll see individuals that come from the floors who have been sitting in their beds for a day or two, sometimes three or four, because the operating rooms get so clogged that you can't get spaces. And when that individual gets to us they're so filthy, the bed is so dirty, the individuals are so dirty. You can tell the beds haven't been changed or the individual has not been properly turned and positioned. They're starting to get pressure ulcers, which a patient should never get in the hospital. Every patient should be turned and positioned every four hours so they never acquire a pressure ulcer. Especially when they have a broken hip, a broken leg." *– OR nurse*

Readmissions

Jurisdictions with fewer nurses per patient have been shown to have higher rates of readmissions. The baseline study in BC carried out by Lasater et al. (2025) found "Avoidable readmissions were the most frequently reported adverse event, with 58.1% of nurses, on average, reporting that avoidable readmissions occur at least monthly ... Nearly 10% of patients in the average hospital were readmitted within 30-days of discharge."

A US study found, "Each additional patient per nurse increased the odds of readmission by 3% ... Patients cared for in hospitals with better nurse work environments had lower odds of readmission." The study concluded: "Better nurse staffing and work environment were significantly associated with 30-day readmission, and can be considered as system-level interventions to reduce readmissions and associated financial penalties" (Ma et al., 2015).

Lasater and McHugh (2016) studied the prevalence of readmission of patients in 4 states, including California, who had undergone total knee or hip replacement. They found, "Adjusted for patient and hospital characteristics, patients had 8% higher odds of 30-day readmission and 12% higher odds of 10-day readmission, for each additional patient per nurse. Patients cared for in the best work environments had 12% lower odds of 30-day readmission."

"It doesn't matter if the patient is ready or not, they have to go-go-go. You have to discharge, discharge, discharge, because if you don't, then you're not efficient. And they're not going to bring more staff. So now it's like a conveyor. We're supposed to treat people like a piece of hardware on a conveyor." *– ER nurse*

c) How do nurse levels affect the health care system?

Nurse staffing levels have been shown to affect the bottom line of health care systems. Readmissions to hospital, for example, not only affect patients, according to the Canadian Institute for Health Information (CIHI) (2025b) they cost the Canadian health care system 2.6 billion dollars a year; in 2023-24 overall 9.3% of patients in Canada were readmitted to hospital within 30 days of discharge; Ontario's readmission rate was higher at 9.5%.

The BC Nurses Union has estimated tremendous cost savings to the province just in terms of compensation for nurses. They state: "In California, the implementation of nurse-to-patient ratios decreased nurse occupational injuries and illnesses by 32%. If we see a similar reduction here in BC, WorkSafeBC data suggests we'd save over $195 million in injury and illness claims over the next decade" (BC Nurses Union, 2024a).

A multi-country study of the financial costs to the health care system related to inadequate nurse staffing levels found:

> The preponderance of the evidence suggests that increasing the proportion of registered nurses is associated with improved outcomes and, potentially, reduced net cost. Conversely, policies that lead to a reduction in the proportion of registered nurses in nursing teams could give worse outcomes at increased costs and there is no evidence that such approaches are cost-effective. (Griffiths et al., 2023)

A study was carried out in Illinois by Lasater et al. (2021a) to "determine whether higher nurse workloads are associated with mortality and length of stay for patients, and cost outcomes for hospitals." It looked at outcomes of staffing in 87 acute care hospitals and included over 200,000 older Medicare patients. The study found that if the hospitals had been "staffed at a 4:1 ratio during the 1-year study period, more than 1595 deaths would have been avoided and hospitals would have collectively saved over $117 million."

A similar study in New York hospitals by Lasater et al. (2021c) found that, "Were hospitals staffed at the 4:1 P/N [patient-nurse] ratio proposed in the legislation, we conservatively estimated 4370 lives saved and $720 million saved over the 2-year study period in shorter lengths of stay and avoided readmissions."

A study by McHugh et al. of over 200,000 hospital patients in Queensland, Australia (2021) found that improving staffing by one patient per nurse would reduce mortality, readmissions, and LOS [length of stay]. "In addition to producing better outcomes, the costs avoided due to fewer readmissions and shorter LOS were more than twice the cost of the additional nurse staffing." They concluded, "Minimum nurse-to-patient ratio policies are a feasible approach to improve nurse staffing and patient outcomes with good return on investment."

Not only do inadequate staffing levels impact financial cost, but they also erode the public trust. A survey conducted in 2023 found that over one-third of Canadian respondents "believe a shortage of doctors and nurses is the biggest problem facing the health care system right now." (Canseco, 2023). The president of the public opinion research firm that conducted the survey reported, "You have essentially a third of Canadians who say, 'I don't want to get sick because I don't think the system is going to be there for me'" (Jiang, 2023).

In summary, establishing mNPRs can improve staff morale and health, thereby reducing related sick days that require hiring temporary replacements, increasingly from expensive private nursing agencies. They can also improve staff retention, which eliminates the need for the costly training of replacements. mNPRs have also been shown to generate better patient care and outcomes, thereby reducing costly LOS and readmissions.

3) The state of the health care system: Why does Ontario need mandated minimum nurse staffing levels?

"The system is crumbling. The new graduates are not getting trained properly because the nurses who are training them are just so burnt out. It's just not adding up. Too many responsibilities are put on us for not enough wage." *– Complex care nurse*

Canada's once esteemed public health care system is in steep decline. Decades of austerity-driven policy decisions, underfunding, understaffing, deregulation and increased privatization have left it in critical condition (Armstrong & Armstrong, 2023). There are fewer beds, longer wait times, more costs to patients, and arguably poorer care. These government policies have also had a profoundly deleterious impact on the well-being of health care workers. In 1976, Canada had about seven hospital beds per 1,000 people (World Bank, 2024); in 2024, the number had dropped to 2.6 (Organization for Economic Cooperation and Development (OECD), 2018). In 2004, Canada held 4th place out of eleven high-income countries in terms of health care performance (Shoo et al., 2021) but fell to 10th place in 2021; Canada ranked above the US in terms of performance when compared to the other OECD countries, but both are at the bottom of the list (Commonwealth Fund, 2021).

Canada is facing increasingly complex health care challenges, many related to heightened demand due to population growth as well as aging and its related morbidity (Arsenych, 2023; Naik, 2024).

"I believe the health care system is in big crisis… There's a large turnover. We can't seem to keep any staff, whether it's nursing or health care aides. I have noticed even a change with some of my old colleagues. Their personality has changed; they went from loving their job to just being so unhappy on every shift. It's so hard to see because I know that's not who they are – or – that's not who they were." *– Outpatient clinic nurse*

Ontario health care under-resourced

Health care is an issue that is important to the Ontario population, which is becoming increasingly dismayed by its erosion. A CTV/Nanos Research poll leading up to the 2025 provincial election revealed that health care ranked as the number one priority for voters.

The Financial Accountability Office (FAO) of Ontario issued a report comparing Ontario government spending with other Canadian provinces. It found, "Ontario's health care spending was the lowest in Canada per capita and below the average of other provinces in the 2022-2023 fiscal year" (Draaisma, 2024).

Ontario prides itself on its health care cost efficiency. A 2024 report from the Ontario Hospital Association (OHA) (2024) states:

> Ontario hospital budgets reflect the lowest hospital expenditure per capita by a provincial government. If Ontario were to fund hospitals at the average rate per capita for all other provinces, it would cost the province an additional $3.7 billion; under Alberta's funding model, $4.5 billion. Ontario hospitals contribute to: The lowest health care expenditure per capita by a province; The lowest provincial program expenditure per capita by a province.

Staffing and beds

It's not surprising, considering its low level of expenditures, that Ontario's health care system is among the most strained of the Canadian provinces and territories. Ontario has fewer hospital staff per capita than the rest of Canada, and those who are employed are putting in the highest number of overtime hours in a decade (Canadian Institute for Health Information, 2022).

"The particular [inpatient] unit that I was on, I really loved. I was on there for many, many years, and the team itself is really good. But they started to not replace any sick calls so we were always short three nurses, four nurses. On the type of unit that I was working on, the ratio should be about one to four or one to five, but then it was not unheard of to be one to six, one to seven. And then they took away a nursing line altogether, permanently, so it just added to the stress." *– Outpatient clinic nurse*

According to researcher Doug Allan (2023), "Less and less of hospital spending in Ontario is on staffing. Employee compensation as a share of hospital expenditures has consistently shrunk in Ontario...Hospitals in provinces other than Ontario now have 18 percent more staff per capita than hospitals in Ontario."

The number of hospital beds is directly related to the level of staffing. According to the Canadian Institute for Health Information (CIHI) data, in 2022-23, Ontario had fewer staffed hospital beds than any other province or territory in Canada. A calculation based on 2023 hospital bed and population data from Statistics Canada shows there were 2.23 beds per 1,000 people; the average for the rest of Canada was 2.59. "Internationally Ontario is an outlier – only Sweden has fewer hospital beds per capita. The median among rich nations is 4.1 hospital beds per 1,000 population. That is 84% more than Ontario" (Hurley & Allan, 2025).

"Every single day that I was going into work there would be 20 to 40 no-bed admits. Twenty to 40! That's individuals lying on a stretcher. Individuals between the age of 60 and 90 years old with whatever ailment they had, in emerge, in whatever corner closet, whatever they could find, they would stuff them." *– OR nurse*

Nurse staffing vacancies in Ontario are the worst in the country "with a 43% increase in nursing job listings throughout the 2022 to 2024 period" (Lagace, 2024). Staffing shortages are projected to increase substantially over the next few years. A report by the Financial Accountability Office of Ontario (FAO) (2023) states that by 2027-28 there will be a projected "shortfall of 33,000 nurses and PSWs [personal support workers]...These nurse and PSW shortages will jeopardize Ontario's ability to sustain current programs and meet program expansion commitments."

The public is well aware of and concerned about the staff shortages. A survey conducted by Nanos in 2025 reported that, "Over four in five Ontarians (84%) believe there is currently not enough staff in hospitals."

Wait times

Depending on their location, patients in Ontario can experience long wait times for specialist consults, surgeries, diagnostic imaging, emergency room (ER) care, inpatient beds, long-term care – even family doctor appointments.

"The emergency department is overwhelmed; they're spread so thin that when that patient does come in, are they getting the proper treatment? No, because there's no beds, so the patients are being sent home and they should have been admitted." *– Medical-surgical nurse*

The ER departments in many locations are apocalyptic-looking scenes of overcrowding and human suffering. According to the Office of the Auditor General of Ontario (2023), while patients requiring urgent life-saving care are usually seen in a timely manner, many others suffer long hours of waiting. Admission from the ER to an inpatient bed can take 24 hours or longer, depending on location. A Toronto Star investigative article cited "an internal provincial report... prepared by Ontario Health but not made public," that revealed, "patients visiting EDs in the past three years waited longer than they did in the previous 13 years" (Wallace and Ogilvie, 2025).

There are human and financial costs for such delays. Research has shown that delays in admission from the ER can increase the likelihood of death (Jones et al., 2022). "Strains in the system and long wait times have resulted in delayed or missed diagnoses, leading to patients returning to the emergency department in worse health" (Office of the Auditor General of Ontario, 2023).

A news report from CBC revealed that in 2024 there were record numbers of ER closures: "1 out of every 5 hospitals with an ER or urgent care centre had unplanned shutdowns" (Ireton & Ouellet, 2024). According to data obtained by the CBC, "the primary cause of ER closures has been a shortage of nurses, accounting for more than 85 per cent of all closure hours."

Such closures, particularly in rural and remote areas, were very rare prior to 2019-20 (Office of the Auditor General of Ontario, 2023). Furthermore, there is "no comprehensive province-wide and centralized strategy to help hospitals maintain nurse staffing levels to avoid closures or to reduce the duration of the closure."

Moreover, "internal government data" reveals that hallway medicine in Ontario is "worse than ever" (Chamandy, 2024). It essentially doubled between 2017 and 2024. "In January 2024, nearly 2,000 patients per day on average were kept in unconventional spaces in hospitals across the province," such as corridors, break rooms and storage areas.

Hospital capacity is further strained by the shortage of family doctors in the province, which leaves patients with no recourse but to use the ER services. In many cases, the delays leave them sicker. "Far too many Ontarians, a staggering 2.3 million people, are already without a family doctor and that number is expected to nearly double in only two years" (Ontario Medical Association, 2024). According to the Office of the Auditor General of Ontario, "one in five patients go to the hospital because they don't have a family doctor — and many of these cases were for non-urgent care" (Chamandy, 2024).

The lack of adequate home care is another contributor to ER congestion.

"There are no nurses in the home care system, no funding in the home care system, so now they're coming into emerge. They're not spending their days at home; they're spending them lying in hospital beds with a nurse that has seven patients. So, you can just imagine – more bedsores, a lot of medications being prescribed." *– Medical-surgical nurse*

Another factor is the shortage of long-term care beds. According to the Ontario Long-Term Care Association (OLTCA, 2025), there is a severe shortage of nurses and personal support workers (PSWs), and the need is expected to increase dramatically. "Nearly 48,000 people are currently waiting for long-term care... More than half of seniors wait 126 days or more to access long-term care, with some waiting up to 2.5 years."

Depending on their location within the province, patients can wait months or even years for non-urgent surgeries (de Jager et al., 2024). The nursing shortage is a factor in many of the waits. For example, nurse staffing has contributed to long waits for OR time at Hamilton Health Sciences, where, in 2023, there was a shortage of 731 nurses (Ontario Health Coalition, 2023).

"A lot of our nurses left. Now our ICU is super short. There are fewer nurses to care for the patients coming from the OR and we are now backed up in surgeries." *– Trauma department nurse*

According to a report by the Canadian Center for Policy Alternatives (CCPA), "Ontario does not lack the physical space and equipment to improve wait times for surgeries and medical imaging; what is missing is the health care workforce necessary to do the work" (Longhurst, 2023).

Privatization

The privatization of health care is steadily growing. It threatens the public system and the very principles of equity and accessibility upon which it was proudly founded. The public is not in agreement with this trend. For example, a 2025 Nanos survey revealed, "Ontarians [73 per cent] prefer the government prioritize spending on public hospitals than private clinics." Several different types of privatization are taking place.

Many services, such as hospital laundry and food services, are now privately operated. Numerous other essential services, such as medical labs, are private. "In Ontario there are currently about eight hundred (800) Independent Health Facilities [IHF] that primarily provide diagnostic services such as x-rays, ultrasounds and sleeping studies. About 25 IHFs provide other services including surgeries such as cataract and plastic surgery, and dialysis" (Canadian Office and Professional Employees Union (COPE), 2024).

Many long-term care facilities and home care services are in private hands. According to COPE, "Expanding the privatization of health care leads to increases in staffing shortages driving skilled health care workers from public hospitals to private clinics."

"Privatization is going to do one thing only. It will suck every single good nurse out of public

health care…They will be very well paid, get the best hours, the best doctors…And that will leave you with a public system that is even worse off than it is now. *– OR nurse*

It has also become common for new hospitals to be established as public-private partnerships (P3s) in which they are constructed and owned by the corporate sector but leased by the government for a period of time. However, according to the Canadian Centre for Policy Alternatives (CCPA), "Unfortunately, the P3 model invariably costs more than traditional procurement" (Robinson, 2019).

"They built us a new facility, but the amount of beds that we have was lower than what we had, and in our old facilities we had individuals in the hallways already. So, you knew you were going to have a problem. They had estimated that we were going to have 75,000 individuals a year for emergency visits. We were averaging 55,000 to 65,000 at that time. We're averaging right now 95,000 to 115,000 visits a year. We don't have staff. We can't even come close to having it. They don't even have the budget for it." *– OR nurse*

Another manifestation of for-profit corporatization is the growth of private equity (PE) ownership of health care facilities. Raza and Palmer (2024), two Canadian health care researchers who have studied the growth of PEs have commented, "Around the world, private equity firms have become more active in owning health-care companies. In Canada, they own long-term care facilities and an increasing number of for-profit surgical centres." They go on to explain: "The largest national network of independent surgical centres – made up of 53 operating rooms spread across 14 cities in Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and BC – are owned by a single private equity firm, nearly a monopoly." There is concern regarding the quality of care provided under PE ownership. Studies have indicated that they are "associated with higher costs to payers and patients along with mixed or worse patient outcomes." One of the reasons for this may be related to staffing levels. A systematic review by Borsa et al. (2023) of published studies examining the consequences of private equity ownership of health care found: "PE ownership was associated with reduced nurse staffing levels or a shift towards lower nursing skill mix. No consistently beneficial impacts of PE ownership were identified."

In 2023, Ontario enacted Bill 60, "Your Health Act," which permits an expansion of privatization (Legislative Assembly of Ontario, 2023). It is touted as a way to reduce wait times and hallway medicine, but, in fact, according to the CCPA, "expanding the for-profit sector is unlikely to do either; capacity depends on the availability of qualified staff, which is unchanged by the addition of profit" (Longhurst, 2023). It also increases surgical wait times. The CCPA report warns: "Expanded outsourcing is likely to worsen public hospital staffing shortages that cause longer waits. For-profit surgical and diagnostic delivery comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long term."

As Canadian researchers Pat and Hugh Armstrong (2023) explain:

> [Privatization] will simply provide quicker access for those with the economic means to pay extra fees. It also draws staff out of the public system, thereby further increasing wait times and eroding care. This steady privatization has had serious consequences for access to and support for the public health care system while embedding profit and for-profit managerial techniques in health care services.

Another form of privatization is the private nursing agencies, which have been shown to be detrimental to care in the public system in several ways. They are overall more costly, as they are intended to generate profit. According to the Office of the Auditor General of Ontario (2023), the use of private agency nurses is increasing, and there is "no legislation that caps the amount for-profit staffing agencies can charge to hospitals. We noted that these agency nurses were paid significantly more than hospitals' full-time permanent nurses."

It can also be disruptive and inefficient to bring in outside staff. The Canadian Federation of Nurses Unions (CFNU) (2024) conducted extensive research on the use of such agencies across the country; it concluded that the "transient nature of agency contracts" destabilizes the health care teams.

"You don't have continuity. You don't have consistency. You don't have people there regularly that know the system, know the patient population, know the ins and outs of things." *– Dialysis unit nurse*

The CFNU also found that using agency nurses increases the "workload for permanent nurses" and adds to management's administrative burdens.

"They are trying to make this system look like it cannot sustain itself, and we can fix this by privatizing. But that doesn't work. I've seen it. I used to work at a nursing resource office. I basically staffed units that were short. We had a pool of nurses that were hired within our hospital, so that we didn't have to use agency nurses, because we were paying agency nurses three times the amount of money per hour that a regular RN or RPN would be making."
– Inpatient coordinator

It has been suggested that the continuing erosion of the public system and the ensuing frustration, suffering, fear, and anger it generates were introduced to pave the way for the emerging two-tiered system. As Noam Chomsky stated in a lecture at the University of Toronto in 2011, "That's the standard technique of privatization: defund, make sure things don't work, people get angry, you hand it over to private capital."

This is a worrying prospect. It has been well established that publicly funded and administered health care improves the overall health of the population and significantly increases longevity – by as much as 10 years (Galvani-Townsend, 2022). Although numerous social determinants of health can affect longevity, it is interesting to note that in the US, where health care is private, life expectancy for women in 2022 was 79 years compared to Canada's 84 and life expectancy for men in the US was 73 years compared to Canada's 80 (Statista, 2025).

"We already have a health care system. Why not just invest all that money you want to invest in the private system and put it back into the public system? Where is the staffing going to come from? We can barely keep our hospital staff in the public system now – and then in a private system? It doesn't make sense." *– Outpatient clinic nurse*

Canada already spends more on private health care than most other OECD countries, except the US. According to the Canadian Institute for Health Information (CIHI) (2024):

> In 2022, Canada's share of health care spending from private sources was 28.8%, exceeding the OECD average of 25.3% and placing Canada in the top quarter of OECD countries. Private-sector spending is composed mainly of out-of-pocket spending and private, voluntary health insurance payments. Compared with similar OECD countries, Canada ranks higher than Germany (13.3%), France (15.3%) and New Zealand (19.2%).

Discussion

The interviews conducted with health care workers that were used in this analysis and the results of polls and surveys have painted a picture of increasingly demanding work, dwindling support, a growing sense of powerlessness and hopelessness, a deepening demoralization, increased rates of injury, exhaustion, burnout and despair. Many of the nurses we spoke with felt disrespected by their employers and abandoned by the government, particularly during the pandemic. Whether the issue was violence against staff, the pandemic stressors, or mental health, understaffing sprang to the top of the list of factors they saw as contributors.

Many expressed anguish over their inability to consistently provide the care to their patients that they knew they needed. Some feared they were at risk of discipline from their employer and even the College of Nurses for being unable to fulfill their mandate. Many, particularly in the most recent interviews, spoke of the growing number of sick leaves they and their colleagues have had to take. They spoke of their need for antidepressants and sleeping pills, and the impacts their stress and exhaustion are having on their families and other relationships and activities outside of work. Many said they just wanted to quit, but were staying almost exclusively for economic reasons. They spoke of how their love for nursing and compassion for patients have been eroded. They said they were concerned that the well-being of the public system is being sacrificed to augment the growth of for-profit health care services. Their recommendations included: increased funding for the public system, increased staffing, increased hospital capacity, reduced patient wait times in the ER, for surgeries, and other care, mental health supports, fair wages, fair workers compensation for injuries and illnesses, including PTSD, predictable scheduling, greater respect, acknowledgment and engagement, strong protection from abuse, violence, and other health and safety hazards, education incentives, such as waiving tuition, and a range of supports. They universally contended that the public system needs more nurses.

The findings from extensive academic research demonstrate that minimum nurse staffing levels, such as mNPRs, improve patient safety, including risk of infections, injuries, and mortality, shorten length of hospital stay and reduce the risk of readmission, prevent staff burnout, illness, and injuries (including from violence) and attenuate attrition. They also improve staff and public confidence and save the health care system money. In jurisdictions where mNPRs have been in place for several years, such as California and Australia, studies show conclusively that they have positively impacted patient outcomes and nurses' well-being. They have also resulted in nurses returning to the profession they left due to overwork, and they improve recruitment, thereby alleviating understaffing. Studies also show that improving other working conditions besides staffing levels has a positive effect on nurses' job satisfaction levels and on retention.

Each of the examples of mNPRs provided – California, Queensland, Victoria, Oregon and BC – includes RNs and RPNs or equivalent in their ratios, has a steering committee to plan and evaluate, and includes flexibility for exceptional circumstances. Some levy penalties, while others leave it to the steering committees to manage. Some provide exemptions or permit delays for rural hospitals, etc. Some cover only acute care hospitals, while others include long-term and community care. Other staffing models, such as the Nova Scotia Nurse Staffing and Skill Mix Framework, have similar characteristics.

The health care crisis can be fixed. Chronic nurse understaffing can be remedied. There are solutions. Nursing shortages are directly related to decades of austerity-driven economic decisions, inadequate government funding and work restructuring. There is ample literature establishing this causal phenomenon. It is having a profound impact on patient care. After examining data from 300 hospitals in 9 European countries, Aiken et al. (2014) stated, "Austerity measures and health-system redesign to minimise hospital expenditures risk [is] adversely affecting patient outcomes."

Respect and support for nurses are imperative in order to prevent attrition. The BC Nurses Union (2024a) states:

> When nurses feel supported in their work, fewer of them leave the profession due to burnout and distress. Research shows that two-thirds of working nurses say they're more likely to stay in their jobs if minimum nurse-to-patient ratios are implemented. Shortly after implementing nurse-to-patient ratios in California, many hospitals saw nurse vacancies drop below 5%, well below the national average. In the state capital of Sacramento, vacancies decreased by 69% in four years. Similarly, within a few years of the implementation of nurse-to-patient ratios in Australia, nurse vacancies were almost entirely eliminated, with more than 7,000 inactive nurses returning to the profession.

Photo credit: BC Nurses' Union.

Photo credit: Australian Nursing Federation (Victorian Branch) 'Respect our Work' rally to save ratios, November 2011. Photo: Mark Munro.

Unions in other jurisdictions have sucessfully campaigned for nurse-to-patient ratios

"I don't think my manager ever told me I did a good job and I don't think I ever had a patient say thank you…And that's fine, but eventually, after you feel you've given 110% to these people, and love them and care for them, and be their family when their families are not there, at the end of the day, it wears you down…And you're watching your patients fall through your fingertips and be so sick." *– Orthopedic rehab nurse*

The comprehensive CFNU report on nurse staffing (Scott-Marshall, 2023a) points out numerous occupations in Canada where hours of work, which are directly related to staffing levels, are restricted for public safety reasons.

While the known occupational health and safety risks of long work hours and occupational fatigue are cited as evidence for governmental restrictions on work hours in safety-critical industries such as transport, aviation and nuclear, to date health care remains for the most part unregulated. . . federal regulations on work hours require that operators in safety-critical industries have in place specific protocols for fatigue risk management in employees.

Participant interviews presented in the CFNU report (Scott-Marshall, 2023) included nurses and stakeholders, and it summarized their ideas for improvements:

> There was consensus across participants that excessive work hours in nursing stems from a broader systemic problem of too few nurses working in the public system. In turn, it was generally understood that ensuring safe work hours requires long-term planning around resolving staffing shortages. . . In addition to the implementation of work hours protections, near-term remedies that participants said would help to mitigate the impacts of rising workloads and unsafe work hours, while forestalling attrition in nurses,were: regulation of agency nurses; mandated nurse-to-patient ratios; and workplace-level efforts to promote healthy working conditions and nurse well-being.

In their 2023 review of Canada's nursing shortage, Ben-Ahmed and Bourgault stated that the number one strategy for retaining nurses was to reduce existing workloads. After reviewing the results of participant surveys, they concluded that one of the key recommendations was the establishment of a legislated "minimum nurse-to-patient ratio policy or minimum care standard." The creation of safe work environments was a close second. This would involve tackling the epidemic of incivility and violence against nursing staff.

Ontario currently has no mandated or legislated minimum nurse staffing levels. Ontario opposition NDP Health Critic, France Gélinas MPP, introduced Bill 192, *Patient-to-Nurse Ratios for Hospitals Act*, in May 2024, calling for mNPRs, saying it would be "a solution that could do a lot to end nurse burnout today." Unfortunately, the bill was defeated on second reading the following month (Legislative Assembly of Ontario, 2024).

The Ontario Hospital Association (OHA) (2025) has publicly denied the merits of mNPRs, arguing that they restrict the *"Real-Time Staffing Decisions"* model they claim to be following. The OHA states:

> In our view, fixed nurse-to-patient ratios limit the hospital's ability to calibrate staffing based on a multitude of factors (i.e., the dynamic needs of patients, RNs and other health care workers, and environmental factors) to balance workload and meet patient needs. The rigidity of a fixed RN staffing model is antiquated 20th century thinking, at a time when Ontario's hospitals are innovating to respond to the demands and complexities of the 21st century.

The OHA contends that technology is an increasingly important and cost-efficient mechanism for dealing with the growing demand for health care. They propose an acceleration in the development and use of AI and other technological tools as a mechanism for functioning with limited health care personnel, claiming, "we can't be locked into old thinking that we can hire our way out of our problems." While technology has a role, it does not negate the need for optimizing front-line nursing staff. The personal care crucial to patient outcomes cannot be delivered by technology. As researchers Pepito et al. (2023) have stated, "Technological developments will continue to increase rapidly in the coming years, but good health care practice continues to be firmly rooted in person-centred care. . . The nurses' touch will always be an irreplaceable component of caring in nursing."

Moreover, the OHA does not accurately reflect the nature of mNPRs as they have been implemented in other jurisdictions. These are minimum standards and are not as rigid as they claim but are to be considered baseline. They must be flexible to respond to conditions such as outbreaks, increased acuity, and local population needs. Such eventualities must be taken into account in the employment of the workforce. According to the BC government (2024), reasonable flexibility is built into their mNPR policy directive to address changes in circumstances. It states:

> Ratios are absolute at the unit level and prescribe the total number of nurses to be scheduled per shift. The implementation of mNPRs will strive to ensure that patient assignments are always regularized and in ratio. At times patient assignments will not be in ratio due to unforeseen changes in patient acuity and/or intensity requiring nursing teams to work together to ensure safe patient care while immediate efforts are undertaken to secure additional workload to bring patient assignments on the unit into ratio. The charge nurse plays a key role in coordinating patient assignments.

Similar flexibility exists in California. As Sara Oakman (2023), Senior Fellow and Director of Health Equity and Reform at the US Century Foundation, explains:

> Hospitals that do not follow the ratio requirements are penalized with a fine, but there are exemptions to these repercussions and limitations to enforcement. Hospitals are excused from the penalty if staffing fluctuations are unpredictable and uncontrollable, and efforts are made to address them. Rural hospitals have the opportunity to request an exemption.

The recently enacted mNPR laws in Oregon also permit hospitals to temporarily deviate from mNPRs, within limits, during exceptional or emergency situations, such as a disease outbreak or mass casualty (Oregon Nurses Association, 2024).

As discussed, Nova Scotia is the second Canadian province to have the language to address nurse staffing shortages, and in this case, it is a negotiated policy. It also has flexibility. Staffing levels are to be determined by a *Nurse Staffing Advisory Committee*. As the Nova Scotia Nurses Union (2024) explains:

> A nurse's workload will be determined by the ratio of Nursing Hours of Care per Patient Day (patient ratios). Nova Scotia Health and the IWK will provide a profile of all units and the current number of nurses working on each shift as an agreed upon starting point. The Employers and Union will then develop a framework that determines the appropriate number of nurses for each unit across the province. This approach recognizes that not all units are the same, and that different patient populations require different levels of nursing care provided by specific skill mixes while also providing a guaranteed level of nursing staff. When those numbers are not met nurses will be able to formally report staffing deficiencies which will be brought to the newly established Nurse Staffing Advisory Committee. The joint committee will then determine the appropriate number of nurses for the unit.

The OHA management plan also fails to adequately consider nurses' well-being. A significant body of scientific literature has exhaustively demonstrated a widespread crisis of burnout, exhaustion, and attrition among Ontario nurses. The proposed technocratic approach, arising from austerity-driven under-resourcing, can only exacerbate the current crisis.

"I know that their hands are tied with the budget but it's hard not feeling supported ever, especially when you raise your concerns and it's just dusted off, like it's nothing, like those aren't real issues when they are. When you go home it is affecting you. You're tired; you're sore; you're covered in bruises; you can't even wear a dress when you go in public because your legs are so mangled because, God forbid, you've tripped over a walker because you're rushing or a patient has kicked you or hit you or ran into you with their wheelchair. It trails into your home life; it affects how you're interacting with your loved ones; it affects your negativity. My boyfriend has told me I'm a shell of myself at times." *– Medical-surgical nurse*

Besides establishing nurse staffing levels, other working conditions must be optimized. As McHugh et al., (2020) have stated, "The benefits of better nurse staffing are conditional on having a good work environment; thus, investing in more staff without considering the environment in which those staff work may fall short of expected improvements."

For example, a large study in Pennsylvania determined, "Improvements in nurse work environments over time are associated with lower rates of nurse burnout, intention to leave current position, and job dissatisfaction" (Kutney-Lee et al., 2023).

Nurses need to be able to work to their scope, be respected, have time for relational patient care, be adequately paid, and have protection from violence and other occupational hazards. They should have access to professional development and education without personal cost as this enhances their value to their employer and patients. As researchers, McHugh et al. (2020) explain:

> Nurse staffing is necessary but not sufficient to ensure good outcomes. Research suggests that hospitals with good work environments—where nurses have autonomy, opportunities for advancement, support and trust of management, excellent relationships built on professional respect with physician colleagues and active engagement in organisational decision-making— have better outcomes for nurses and patients.

As discussed, mNPRs can potentially bring back nurses who have left their jobs due to burnout and frustration into the system. The BC Nurses Union (2024b) states:

> Many of the nurses needed to staff our health-care system are in our midst but have left the current system because they are unwilling or unable to tolerate the dire working conditions and demands of their work environment. Fixing the staffing shortage is key to addressing those problems.

"A mass exodus of nurses is going to happen. Everyone's going to be retiring. Or they're going to be leaving acute care and hospitals to do less stressful physical nursing. When that happens, there's going to be no one to watch the floor. When you get sick and you go in the hospital there's going to be no one to give you proper care. There's going to be increased death rates, infection rates, people aren't going to be getting looked after properly and it's going to spiral out of control. It's already happening … I would change the nurse-patient ratio. I would change the wage, especially lessen that gap between RPN and RN, so RPNs want to stay and feel valued. I would provide more support, mental health support for the nursing profession… and more staff to do the job." *– Palliative care nurse*

As Linda Aiken (2025) concludes in her report on Ontario's need for nurses, the implementation of mNPRs in California did much to alleviate the nurse shortage and could do the same in Ontario.

California had and still has one of the lower nurse-to-population ratios among US states. California passed legislation like that being considered in Ontario over 20 years ago. Considerable evidence shows the mandated patient-to nurse staffing legislation was effective in attracting inactive nurses within California back into hospital practice and for part time nurses to work more hours. So, there is precedent for a jurisdiction with similar nurse workforce conditions to Ontario to successfully implement and sustain over time a policy requiring safe nurse staffing without having unintended adverse consequences for closure of services that would affect access to care.

Effective strategies, such as legislation requiring a sufficient complement of all health care staff and specifically nurse-to-patient ratios, are urgently needed to address the root causes of overwork and turnover among health care workers, ensuring the sustainability of Ontario's health care system and the well-being of its workforce.

The way forward

Proponents who have succeeded in securing mandated safe staffing levels have had to overcome pushback, including baseless economic arguments, threats of job loss, and the creation of divisions among nurse classifications. While the evidence has established that such mandates make economic sense, the true incentive should be about more people-centred, compassionate values. To that end, evidence also shows that appropriate staffing levels are good for patients, staff, and health care.

Mandated minimum nurse staffing levels are part of a broader need. There are many challenges right now in Ontario's health care system. There is a need for more family doctors who could provide care that might keep patients from needing hospital care. There is a need for adequate community and home care. Hospital patients need to be treated and cared for in beds that are in treatment and patient rooms, not hallways. Nurses and other health care staff must have adequate mental health supports. The support they receive from their Employee Assistance Programs (EAP) may be too minimal for some, especially considering that the stress and anxiety are pervasive and ongoing.

A nurse working with COVID-19 patients told us that she hoped the realization of how poor working conditions and understaffing have become would finally turn things around for a health care system that was foundering before the pandemic even began. She said:

"At the end of the day, the silver lining of this pandemic is that it has brought to light the dismal condition that health care is actually in. It has shone a light on it, not only for the government, but also the public to actually see what is happening in hospitals and long-term care. Hopefully after this pandemic is over, the government, along with the employers, will fix what is broken." *– Medical-surgical nurse*

Health care workers and the public share the heartfelt hope expressed by this dedicated but overwhelmed nurse across the province.

Nurses and their representatives are asking whether there is the political will to do what needs to be done, or are governments intentionally moving health care into a private, profit-generating industry rather than a high-quality public health care system that prioritizes the well-being of patients and staff?

Conclusion

Ontario's health care system is in crisis. Nurses and patients are suffering the consequences of underfunding and the administrative focus on efficiencies. The already problematic nurse staffing shortage is projected to increase as attrition continues and the demand for health care grows. A broad ranging revamping of priorities is called for. The academic research and the experience and insights of nurses themselves clearly show that mandated minimum nurse staffing levels, such as mNPRs, can effect positive outcomes for staff, patients and the health care system as a whole.

Resources

There are numerous excellent resources to assist governments, health care employers and unions or associations in developing legislation or policies regarding mNPRs or other safe staffing policies:

- The CFNU has created two detailed reports that provide information on the issue of nurse staffing levels: "Nurse-Patient Ratios" (see McTavish & Blain, 2024a) and "Safe Hours Save Lives" (see Scott-Marshall, 2023).
- The CFNU has also outlined the legislation and other regulations regarding staffing requirements, including mNPRs, in diverse jurisdictions worldwide. They have also gathered, reviewed, and summarized the literature demonstrating the value of safe staffing for nurses and patients (see McTavish & Blain, 2024a).
- The BCNU in British Columbia, the first province in Canada to implement mNPRs, makes ample information available on its website: www.bcnu.org (see BC Nurses Union, 2024a, 2024b; McTavish & Blain, 2024a, 2024b)
- The Ontario Nurses Association (ONA) commissioned a policy brief titled "Staffing Ratios and their Impact on the Health and Safety of Nurses." It provides a comprehensive review authored by Linda Aiken (2025).
- The California legislation regarding nurse-patient ratios can be accessed online (State of California, 1999).
- National Nurses United (NNU) (2025b) provides several links regarding the California nurse-patient ratios.
- An overview of the Oregon legislation regarding safe staffing levels is provided by the Oregon Nurses Association (ONA) (2024) and "Frequently Asked Questions (FAQ)" by the Oregon Health Authority (2024).
- Legislation on mNPRs in Victoria, Australia, entitled *Safe Patient Care [Nurse to Patient and Midwife to Patient Ratios] Act 2015*, is available from the State Government of Victoria (2015).
- The Queensland Government (2018 b) provides information on mNPRs in Queensland, Australia, and links to additional resources.

Several surveys and polls have been conducted that provide evidence of the need for mandated safe staffing levels.

- Nanos Research conducted a poll in 2023 of OCHU-CUPE members. The results can be accessed at: https://nanos.co/wp-content/uploads/2024/01/2023-2465-CUPE-OCHU-Members-survey-Populated-report-with-tabs.pdf
- WeRPN produced The State of Nursing in Ontario: A 2024 Review based on member survey results. It can be accessed at: https://www.werpn.com/wp-content/uploads/2024/05/StateOfNursing2024_Report_Final.pdf
- Statistics Canada carried out a survey in 2023 titled, "Quality of employment and labour market dynamics of health care workers during the COVID-19 pandemic." It can be accessed at: https://www150.statcan.gc.ca/n1/pub/75-006-x/2023001/article/00007-eng.htm

AUTHORS

James T. Brophy, PhD and Margaret M. Keith, PhD, are occupational and environmental health researchers. They are both adjunct faculty members of the Sociology Department at the University of Windsor in Ontario. James is a tutor in the Sociology Department at Athabasca University in Alberta. This work is a continuation of research they have been conducting over the past decade regarding working conditions within Ontario's strained health care system.

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