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Nursing Workforce Issues: Policy Reactions and Strategic Approaches

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Abstract
Canadian nursing labour market is experiencing a major crisis of shortage in supply of the labour force, high incidences of burnout and high turnover. The presence of this situation alongside the COVID-19 pandemic has unveiled the systemic problems that workforce planning, retention strategies and policymaking have. In this paper, the Canadian policies to address the nursing shortage issue are discussed and their effectiveness upon the issues of labour supply and demand imbalances, geographical differences, and professional satisfaction are evaluated. It is stressed that the harmonization of federal and provincial plans, international human resources, changes to education and workplace needs to be coordinated in order to have a sustainable and resilient nursing labor force.

Keywords: ***Nursing shortage, Canadian healthcare policy, workforce planning, nurse retention, healthcare crisis, labour market, nursing workforce, health policy reform, burnout, nurse migration*.**

1.Introduction
The healthcare system experienced a worsening shortage of nursing human resource in Canada. It is not sudden and unanticipated but a question of years, of failure to invest and of a fragmented policy approach and changing demographic and service requirements. Nurses are the biggest sector of healthcare workforce in the world since they are the core of healthcare delivery. The World Health Organization estimates that there will be a demand of 13 million more nurses in a decade to fill the growing demand. The supply and demand difference in the nursing care requirements in Canada has been increasing over the years. An estimate in the pre-pandemic times predicted that there would be a nursing shortage of over 117,000 nurses by the year 2030. The beginning of the pandemic, however, has played a massive role in increasing this deficit with stressors brought about by rampant burnout, greater absenteeism, and smaller payrolls(1).

This paper explores the systemic causative factors underlying the nursing workforce crisis of Canada. It surveys the national nursing workforce, charts how its trends have changed over time and in recent years, assesses national and international supply methods and strategies, and thoughtfully considers the implications of task shifting and COVID-era policy responses. Lastly, it also reveals future paths to encourage stability, resilience, and sustainability in nursing labour force in Canada.

Canadian Nursing Landscapes of Healthcare

Nursing professionals in Canada work in a variety of settings including long-term care facilities, hospitals, community-based services and others. Hospitals continue to remain the biggest employee, consuming much healthcare expenditure especially in staffing. According to the information provided by the Canadian Institute for Health Information (CIHI), there were more than 445,000 licensed nurses in 2021. But there are national differences in terms of employment terms, including the existence of full-time jobs and specialty classification.

The regulation of nursing is a provincial requirement, and the registration, the standards of competence and licensure are under the governance of various regulatory organizations. Such jurisdiction differences may become a bottleneck to nurse mobility and supply. Although regulatory bodies are set to protect the interest of people, the responsibilities tend to overlap with other interests including transparency, autonomy of the professionals and flexibility of the system. The pandemic highlighted the instability of this regulatory framework and kick-started work on improving the efficiency and broadening access to the profession(2).

Historic Nurse Supply

The last 30 years have acted as a catalyst of various socio-economic and public health incidents on the level of nursing supply in Canada. The casualization of healthcare workforces in the nursing sector was caused by economic crises and structural reforms in the healthcare sector in the 1990s. There was a reduction in full-time jobs, many nurses went on part-time and precarious jobs or moved to the United States.

Systemic weaknesses were even more revealed in the crises in public health like the outbreak of SARS in 2003 and in the pandemic COVID-19 in 2020. Casualization and the agency nurse reliance generated serious surge capacity and continuity of care voids. Task forces and expert panels identified these problems and over and over, urged the need to stabilize the full time employment and create a permanent, well integrated work force.

Ontario reacted by establishing full-time nursing vacancies and changing part-time jobs around the time of the early 2000s. The momentum fell by the wayside however and the pressure began emerging in the form of the 2008 recession. Though the field of healthcare was somewhat sheltered by the layoff process, healthcare policies started targeting more on potential new staffing and retention to accommodate the projected flow of aging and complicated health requirements.

Data-Bases Workforce Planning

A strong evidence base of data collection and analysis is central to strategic workforce planning. In Canada, the process of annual registration with the provincial organizations obliges the nurses to report data on demographics, educational degrees, and jobs. CIHI collects, aggregates, and standardizes this information, which means that national and international comparisons can be made.

Supply crisis had already been brewing since even pre-pandemic. Take the example of Ontario where membership of non-practicing nurses rose by 60 percent in the same period of 2014 to 2019. Staffing shortages intensified further because during COVID-19, nurses had to be redeployed to understaffed areas such as long-term care and vaccination clinics. There was also absenteeism and the resignations that compounded the system.

Even prior to the pandemic, surveys of the Ontario employers showed that recruitment was getting more challenging(3). The number of available postings of registered nurses almost doubled between 2019 and 2021. However, even such postings did not completely cover unmet needs because of turnover within the organization and undocumented vacancies. Developments in computer intelligence are now being used to scrape real-time job postings thus providing a more dynamic perspective to system-wide demand.

International Recruitment as a Qualified Measure

Due to increased shortages, provinces have pressured more into the recruitment process with internationally educated nurses (IENs). Canada has historically accepted IENs as immigrants especially the under skilled worker programs and family reunification. Nonetheless, as a result of their qualifications, IENs may encounter licensure obstacles, and may be requested to take assessments, exams and bridging programs.

Even though the International Council of Nurses is against the recruitment of professionals in the countries that have weak health care system, a number of provinces, especially shortage areas have embarked on international recruitment. Between 2021 and 2022, Ontario only had an 8 percent increase in domestic nurse graduates, unlike the 40 percent increase in IEN registrations, highlighting the increasing use of international labour in filling staffing shortages in Ontario.

Task Shifting, and the Emergence of Unregulated Roles

In order to fill in nursing shortages, a lot of provinces have encouraged hiring and training unregulated care staffs like personal support workers (PSWs), or healthcare aides. Depending on the basic care tasks of the patients such as feeding, bathing, and equipment maintenance, they are usually attended by those who hold these roles and enable the regulated nurses to concentrate on more complex clinical abilities.

Policy interventions comprise of bursaries, wage supplement, and work guaranteed incentive. The critics, however, claim that too much exploitation of unregulated workers has the potenital to diminish quality of professional care. In the context of task shifting, although the practice is suitable in the short run, it should be reconciled with policies to strengthen professional nursing roles.

Repositioning Supply: Canadian Positioning

Having more graduating nurses to satisfy the nursing demands of Canada is not only important but also their incorporation in the workforce. Integration encompasses employments with punctuality, career assistance and full time jobs. In the past, there have been few full-time positions of new nurses. Prior to pandemic, less than 30 percent of new nurses were in full-time jobs in Ontario.

Incentive Programs such as the Nursing Graduate Guarantee provides incentive to an employer to hire a new graduate and mentor them. These have been demonstrating positive outcomes towards transition and retention. However, this has proceeded in fits and starts and additional policy effort is required to enshrine newly graduated nurses into the system.

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2.Structure, Distribution, and Regulatory Complexities

Healthcare in Canada cannot exist without nursing, as it is a significant component of frontline clinical workers in the nation. Nurses are no exception given they constitute more than 445,000 licensed professionals as of 2021, taking into consideration their significance to the continuity, safety, and efficiency of health provision in various care settings. These are the high intensity acute care hospitals, long-term residential, community clinics, home care agencies and the public health units. Nevertheless, the vast size notwithstanding, the workforce is marked by high intra-province and inter-province disparity in employment opportunities, occupation, as well as control administration. The reading of the realities of the Canadian nursing structure and operations necessitates the discussion of how the workforce is distributed in terms of employment, distribution of the sectors within the industry, and the regulation of the workforce in terms of regulating their practice(4).

Most hurdles faced by nurses in Canada occur in the hospitals or hospital-based jobs where the nurses form a major portion of the clinical work. Even so, when considering the remuneration of employees particularly those in nursing personnel, a huge percentage of the hospital expenses is used here-commonly a two-thirds proportion. This is the expenditure in financial terms that show the core function of nurses in the provision of direct and indirect patient care, coordination, and system navigation. However, the situation at the job market is not homogeneous in the country. The Canadian nurse in the province of Ontario and QuEbec are more likely to be full time employed as compared to those employed in part time capacities or on casual basis as it happens to those in other provinces or states in Canada. Such discrepancies in contract types do not simply fall into the administrative sphere but instead directly relate to workforce stability, job satisfaction, and continuity of care as well as retention results.

FIGURE 1 Canadian Nursing Workforce Challenges

The regulation of the nursing workforce is a huge source of complexity in the Canadian workforce. The nursing profession is deemed as one of 30 regulated health professions in Canada and their licensure and supervision is controlled by the provincial and territorial regulatory authorities. These organizations play important roles in keeping the people and the population at large safe by implementing entry- to practice examinations, scrutinizing educational qualifications, developing code of ethics, and building lists of the active practitioners. Additionally, they have responsibility to oversee the ongoing competence by administering regular examinations and including disciplinary actions under the situations where the standards are violated. This federal system portrays the federal nature of Canada that gives the provinces a large portion of independence in the running of healthcare.

Whereas this jurisdictional freedom permits the regulating body to draw policies that fit the local conditions, it creates a loophole through which differences may arise that can be of influence to the labour mobility and national workforce consolidation. As an example, there might be varying standards that each province has towards the objective of recognizing an international educated nurse (IEN), and there might be wide variations in terms of timeline towards licensure(5). The limited practice contexts reveal that these inconsistencies negatively affect efficient redistribution of nursing personnel during crisis or to meet the changing demographic pressures. Moreover, differences in scope of practice among provinces, i.e. what Registered Nurses (RNs), Licensed Practical Nurses (LPNs) or Nurse Practitioners (NPs) are allowed to do may confound national planning.

Most recent scholarly and policy articles have noticed the contradictions, implicit in this system of regulation. Regulators face a common dilemma of conflicting obligations, and this pertains to the need to act in the best interest of the people and need to maintain professional autonomy; the need to be accountable, and the need to be

flexible; the demands of obligation to publish information, and the need to protect confidentiality of a person. These tensions become worse in times of health crises e.g. pandemic where it is essential to make prompt licensure approvals, quickly deploy more workers, and share information in real time. Some provincial regulators have put in place fast-tracked registration processes, revived expired licenses and sought inter-jurisdictional recognition measures during COVID-19 to alleviate workforce shortages. Though these are welcome steps, they were mostly fire brigade and they reflect lack of an effective proactive regulatory contingency process.

The other complexity in the nursing ecosystem in Canada is an increase in the specialization of nursing. Nurses working in specialty areas e.g. intensive care, emergency services, neonatal care have greater clinically complex caseloads and exposure to increased levels of occupational stress and burnout. By comparison, long-term care or community health nurses may acquire managerial and supervisory roles, supervising groups of unregulated health professionals and communicating with family members and community agencies. Such profile roles entail uniquely designed training, assistance, and compensation models but the majorities of policy strategies tend to oversimplify the profession as a unit. Such lack of acknowledgement of the intra-professional diversity does not support attempts to maximize the deployment of nurses, their satisfaction, and retention.

The issues of equity also appear in the nursing labour force. The provision with full-time work opportunities, which is a defining factor in economic stability, growth of the career ladder, and professional activity, is not evenly divided. As stated above, Ontario and Québec present a higher rate of full-time employment, whereas where the rest of the jurisdictions experience underemployment systematically. The part-time nurses tend to work under an irregular schedule, have lesser stability of income as well as access to benefits like a pension or they are required to take leave(6). This form of precarity can precipitate attrition and cultivate disillusionment and diminish the appeal of the profession to future entrants, especially to healthcare professionals considering areas where staffing is already low in health care, e.g., the rural or remote setting.

Schooling infrastructure is a second major factor that determines nursing workforce vitality. Publicly funded universities and community colleges are the major contributors to the nursing pipeline in Canada as they regard primarily individual and diploma programs. Although there are some increment in educational seats experienced over the past few years, it is still not enough to accommodate the surging demand. Shortages of clinical placements, numbers of trained faculty, and the budgetary limits have all effectively stifled the ability to increase nurse production domestically. Moreover, the transition into virtual learning induced by the pandemic spotlighted the digital inequalities and barriers and established further obstacles among students, especially those within rural settings or presenting disadvantaged backgrounds.

Moreover, new graduate nurses tend to find it difficult transitioning out of academic life to the real life. Misalignment between education and practice along with short orientation and an extreme world of acuity may cause early career burnout or attrition. The Ontario Nurses Graduate Guarantee program has attempted to answer this need by developing some form of orientation and mentorship supports, but again, this requires mixed results in the different regions of the province.

In short the Canadian nursing workforce is strong but not resistant it is effective yet vulnerable and that is not proportional as it is made up in size but undermined by structural inefficiencies, regulatory inconsistency and inconsistent employment patterns. Policymakers need to abandon short-term crisis response and look into lasting reform to make sure the system remains sustainable. This involves harmonization of regulatory standards between provinces, improvement of fair access to fulltime employment, enhancement of specialization and clinical excellence and investment on educational and leadership pathways. In a turbulent healthcare landscape of fast ageing demographics, technology upheaval and international health risks, the nursing workforce has potential to be seen as a strategic strand of national health security, rather than being a source of costs.

3.Historical Challenges in Canada’s Nursing Supply

To fully comprehend the current crisis engulfing Canada’s nursing labour market, it is critical to evaluate the historical workforce dynamics, systemic inefficiencies, and policy missteps that have contributed to the chronic instability in nursing supply. The Canadian nursing profession has consistently been shaped and strained by macroeconomic fluctuations, repeated healthcare system restructuring, population aging, and sudden public health emergencies. The convergence of these pressures has undermined long-term workforce sustainability. Contrary to the misconception that nursing shortages are recent or rare events, evidence demonstrates that these shortfalls have long been foreseeable and largely preventable. They are, in effect, systemic failures failures of planning, policy,

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investment, and responsiveness to workforce realities. This review assesses the historical causes of volatility in the nursing sector and critically evaluates the key moments where governmental actions either mitigated or, more often, failed to alleviate the pressures on the nursing labour force.

Impact of the 1990s Economic Restructuring:

During the 1990s, an economic recession combined with a wave of healthcare restructuring radically altered the employment landscape for nurses. Facing budgetary constraints, provincial governments enacted aggressive cost-cutting measures, leading to the downsizing of hospital staff, closure of acute care beds, and the transfer of services from institutional to community-based models(7). Nurses were disproportionately affected by these changes. Secure full-time positions were eliminated in favour of part-time or casual contracts, eroding job stability. This casualization of employment not only diminished professional security but also led to a sharp decline in morale across the profession. Many nurses, faced with uncertain income and degraded work conditions, left the workforce entirely or migrated to more stable environments particularly to the United States. The resulting exodus contributed to a workforce drain that exacerbated service delivery gaps and weakened the system's ability to respond to future demand.

Policy Response and the Role of Nursing Task Forces:

In response to these structural shifts, nursing task forces were established, notably in Ontario in the late 1990s, to assess the impact of healthcare reforms on the profession and patient care. These bodies identified the excessive reliance on part-time contracts as a significant threat to workforce integrity and healthcare quality. Their findings emphasized the urgent need to generate more full-time employment opportunities and to restore professional confidence in nursing. Stable employment was recognized not merely as a matter of economic fairness but as a cornerstone of high-quality, consistent patient care and healthcare system efficiency. These insights led to a series of policy proposals aimed at rebuilding workforce stability, though long-term implementation remained inconsistent.

SARS Outbreak and Exposure of Workforce Vulnerabilities:

The 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) marked another critical turning point. The crisis exposed severe deficiencies in Canada's healthcare surge capacity and highlighted the detrimental effects of the earlier casualization of the workforce. Due to fragmented staffing arrangements, many nurses were working across multiple sites, facilitating viral transmission and undermining infection control efforts. Public health authorities, policymakers, and expert panels unanimously agreed that the transient nature of the workforce had become a systemic liability. Reports from the National Advisory Committee on SARS and the Ontario Expert Panel on Infectious Disease Control recommended a decisive pivot toward a stable, full-time nursing workforce. These groups urged governments to reduce reliance on agency staff and to implement long-term, sustainable staffing strategies grounded in surge preparedness and workforce resilience.

Proactive Reforms Post-SARS:

Between 2003 and 2006, the Government of Ontario initiated a series of corrective measures designed to reverse the damage. These included the creation of more full-time nursing roles in hospitals and long-term care facilities, along with the conversion of casual and part-time jobs into full-time equivalents. These reforms marked a proactive shift in health human resources policy, underpinned by the understanding that retaining experienced nurses is just as critical as training new ones. However, these gains proved to be fragile. The 2008 global financial crisis introduced a new layer of economic stress, and although healthcare budgets were somewhat protected, the resulting financial strain caused many nurses to become the primary earners in their households further intensifying job-related stress and professional fatigue.

Failure to Act on Forecasting Data:

As economic conditions stabilized, policy attention returned to recruitment and retention. Empirical models had already predicted a growing imbalance between nursing supply and demand due to two interrelated trends: the aging of the Canadian population and the aging of the nursing workforce itself. Rising rates of chronic illness and increased care complexity led to a sharp uptick in service demand. Unfortunately, these trends were not matched by proportional investments in education, employment integration, or retention supports. The failure to act on these forecasts laid the groundwork for the acute workforce crisis that emerged in the 2020s.

The COVID-19 Effect:

The COVID-19 pandemic served both as a trigger and an accelerant of existing labour force pressures. Nurses found themselves at the frontlines of a global emergency that dramatically increased the physical and emotional

intensity of their work. Burnout became widespread, staffing levels fell to dangerous lows, and moral distress was pervasive. Many nurses retired early, took extended sick leave, or resigned, further shrinking the active workforce. These stressors rippled across all healthcare sectors, from hospitals to long-term care, revealing the interdependency of different segments of the healthcare system and how shortages in one area can destabilize the entire network.

Inadequacy of Crisis-Driven Policy Responses:

Governments responded with a patchwork of crisis-driven initiatives many of which were too reactive and too late. A persistent limitation was the lack of real-time, integrated workforce data. Without the ability to accurately track vacancies, migration patterns, or employment trends, provincial planners were handicapped in their ability to respond strategically. The pandemic reinforced the urgent need for continuous workforce monitoring systems that support predictive analytics and evidence-based policymaking. Workforce planning should not be episodic or emergency-triggered; it must be a standard, well-resourced, and ongoing national function.

Education Pipeline and International Integration Challenges:

Meanwhile, domestic educational institutions were unable to scale up training fast enough to meet projected retirements and growing service demands. At the same time, internationally educated nurses (IENs) who account for approximately 13% of Canada's nursing workforce remained underutilized due to barriers such as credentialing delays, inconsistent standards, and limited access to bridging programs. These systemic inefficiencies hindered Canada's ability to use all available labour resources during a critical time.

4. Building Evidence for Policy Action

The core business of any successful strategy of managing and maintaining national nursing workforce is to have reliable, standardized, and actionable data. In Canada, problematic workforce have long been exacerbated with disarrayed data collection procedures and ad hoc execution of workforce intelligence in the policy development process. Although frequently, the health human resource decisions could be followed by the occurrence of the crisis, such reactive planning of a gustatory nature will not reflect the changing demands of the healthcare system and the nursing workforce. In this section, the necessity of having complete workforce data in order to know of supply dynamism, keeping tabs on trends and anticipating future requirements and formulating responsive policies is stressed. It also brings to fore the roles of regulatory forces, the evolving data tools as well as the demographic changes in the profession that lead to a change in interpretation and subsequent reaction of the decision-makers to the workforce pressure.

Registration with a provincial or territorial regulatory body is a compulsory requirement when undertaking nursing in Canada. The information that nurses must provide their regulators on an annual basis is demographic data, educational history, geographical location, employment status and clinical role. The Canadian Institute for Health Information (CIHI) compiles these data and then standardizes them so it can compare between the regions, and also report nationally. Although such a system allows obtaining a certain background picture of the workforce, the current limited scope and application of the collected data do not lend themselves to directly applying them to real-time decision-making. There is need of more granular, dynamic and disaggregated data to know the intricate movements and variations in the labour market of nursing.

This case study needs to be considered along with the data in Ontario, as it provides an excellent opportunity to see how the workforce data can be utilized to monitor the emergent trends and indicate the necessity of the intervention further. The data on the nursing workforce in the province of Ontario in the years preceding the COVID-19 pandemic showed the warning signs of critical importance. The most significant of these seems to have been the drastic increase in the registered non-practising nurses. The number of non-practicing nurse registrations exceeded 60 per cent during 2014-2019 with the growth rising to 13,500. This implied an alarming gap between certification and in-service membership. It is possible that at least some nurses continued to be registered during their time away on leave, or between jobs, but the sharp increase strongly suggested systemic constraints to retention--due to work environment, staff burnout, or a lack of full-time opportunities--that were driving nurses out of active practice(8).

These red flags were more exaggerated in the case of the COVID-19 pandemic. The nursing workforces were moved in large numbers amid one care facility to another, primarily because the health system was stressed to the other limits, with the most definite circulations occurring between acute care hospital facilities and the long-term purchase facilities. The driving force behind these reassignment was the dire necessity to address staffing shortages

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in long-term care where issues relating to workforce had historically existed in sharp relief. Meanwhile, the nurses were mobilized as well in the activities of COVID-19 testing sites and vaccine rollouts. This kind of fast movement resulted in the dislocation of other areas, as well as the vulnerability of the system to even slight change in the nursing provision. Overworked and undermanned, most nurses started complaining and citing more stress, burnout, and the plans to abandon the profession completely.

Measuring such changes during the process was cumbersome as a result of the time it took to collect and report data. Although traditional registration information is worthwhile to long-term trend analysis, daily or weekly variations in the employment status, quitting or redeployment is not reflected in this data. Identifying this absence, other organizations and researchers have resorted to the emerging technologies and ways in which they can come up in real-time labour market intelligence such as artificial intelligence (AI) and web scraping. As such an example of using algorithms, job posting websites are increasingly analyzed so that postings of nursing jobs in various sectors, regions, and job types are tracked. These scraped data are crude but valuable estimate of unmet demand and enable stakeholders to track changes in vacancy rates with flexibility that would otherwise never be possible in a conventional way.

Reflectively, a review of the job advertisements of RNs (Registered Nurses) and RPNs (Registered Practical Nurses) in the Ontario province in the three years of 2019, 2020, and 2021 reports an alarming trend that shows a rise in a vertical tendency. Approximately, there were 5,518 nursing job postings within three months, according to the data of 2019. In 2020, this figure was 8,709 and hit 10,974 in 2021, i.e., the increase of 100 percent in two years. This dramatic increase in the number of jobs advertised is indicative of not only the rising demand in the nursing services, but also of the incapabilities of the current workforce to handle these necessities. Among the most impressive growths, one may note the postings offering RNs employment which seems to be a group that will have the most significant clinical responsibilities(9).

Such vacancy patterns highlight an underlying issue the inconsistency between the overall adult licensure and the real, available nursing supply. Although it might look on paper that the nursing supply is stable- or even increasing, what is really important is the number of nurses able and actively working, the number of nurses working full-time and the number of nurses to be reallocated in the case of a crisis. In this respect, workforce planning would have to distinguish between headcount and the full time equivalent (FTE) staffing, the holding of multiple jobs, and absenteeism, sick leaves and early retirements.

Another very critical segment in the nursing supply for the country (Canada) is the Internationally Educated Nurses (IENs), which takes about 13 percent of the workforce in the country. Their incorporation in the system is not immediate; they usually meet a considerable time lag because of the credentials verification procedures, language proficiency tests, and bridging course prescriptions. Therefore, although they add to the number of licensure, a greater number of IENs lack capacity to fill the vacancies at once. Advanced data systems are necessitated to monitor the progress of the IENs in the pipeline process to know when they could be ready to hire and implement policies that assist in stabilizing them in the workforce.

It is also important to pay attention to the demographics of age within the nursing workforce. According to the data presented by the College of Nurses of Ontario (CNO), a change in the demographics of nurses occurred between 2014 and 2021; i.e., younger nurses under 35 became the most numerous group in the workforce. The younger generation is energetic and skilled at the digital platform yet the probability of high turnover is also high unless they are mentored and supported properly. This coincides with the fact that a substantial number of nurses of the senior age group (55 years and above) are soon approaching retirement age, which brings about the possibility of even more knowledge losses and staff vacancies in near future. These two pressures also require policies that would assist early career development and late career retention.

Furthermore, the complexity of professional decisions of nurses is hardly ever recorded in traditional workforce data sets. As an example, why would licensed nurses give up and quit the field? Why do they prefer part-time over full time employment? What role does the culture of the workplace, the quality of the leadership teams, and the team dynamics play regarding retention? These are big questions that cannot be observed with just administratively data. They rather need to bring a combination of qualitative research studies, surveys, exit interviews, and engagement studies into workforce oversight approaches.

5.Conclusion

On a long-standing and deep-seated nursing labour market shortage, Canada finds itself in a crucial stage of dealing with the issue. As demonstrated in this discussion, the healthcare system in the country has gone through decades of staffing shortages, disparate employment policies, and responsive policies. Although the COVID-19 pandemic exacerbated these pressures and raised workforce challenges facing nursing professionals to the highest level of concern not only in the public sphere but also the political one, neither of them was introduced. Instead, it acted as a microscope, revealing a frail system that lacked systemic strength and had a persistent tendency not to invest in the nursing profession as a foundational element of the nation guaranteeing security in health matters. A systems-based, data-driven, and futuristic approach to nursing workforce planning is needed in Canada to shift away crisis management to a more sustainable, equitable, and steady nursing workforce planning model.

Among the most pressing insights of this examination is the fact that nursing shortages are not isolated and do not occur overnight. They normally arise due to years, maybe even decades of underinvestment, uncoordinated regulation, poor retention and lack of national workforce planning structures. Retrospective data that have been properly documented, such as the post-SARS period and the start of COVID-19, revealed clearly that the indicators of the problematic situation in the nursing labour force appear before the crisis hits its climax. Such red flags as increasing rates of part-time employment, casualization of contracts, demographic changes, and more non-practicing license holders are the issues which would have been the symptomatic arguments forcing earlier intervention. Rather, limited and tardy responses have frequently come in the form of policy responses, small-scale and short-term reactions to symptoms instead of structural causes.

One of the valuable lessons that can be learnt out of this history is the necessity of monitoring the workforce data in real-time and in a continuous process of validation and collection. An annual statistics or episodic review are no longer acceptable in a labour market where demand can fluctuate so quickly be it a pandemic, aging population, or a change in care model. Regulatory and government organizations should develop the integrated data systems in which the active nurses, full-time equivalents availability, differences by region, and retirement prospects can be tracked in real-time. Such systems also need to embrace more intricate variables, including job fulfillment levels, burn-out levels, the likelihood of migration, and attrition causes. Based on such insights alone, workforce planning could instead be considered a completely ad-hoc affair and could result in a continued cycle of failed matches between supply and demand.

Along the same lines, it is imperative to consider that a healthy nursing workforce cannot be characterized by the mere number sufficiency but must anticipate quality employment conditions, career recognition, and open channels to development and improvement. There is no reason to expect that the nurses will stay in a system that provides them with unstable work, little financial assistance with their further education, poor remunerations and great job stress. Any attempts to increase the workforce either through education endeavours or external hiring will not be effective where the retention rates are poor. As such, retention policies should be aimed at establishing permanent positions, mental health services, mobility to other careers and mentorship of new graduates as well as the professional autonomy to implement their full scope of practice.

New graduates have been brought on board into the system but the process is unstable and underutilized. Statistics indicate that a good percentage of nurses who are newly licensed in Canada fail to engage in full time employment at that time and usually take a long time with part-time or casual employment. This makes them slower in developing clinically, makes them more likely to be attrited before they reach clinical development and wastefully consumes human and educational capital. Programs like the Ontario Nursing Graduate Guarantee have demonstrated positive changes in easing the transition to practice but similar initiatives need to be increased and customized at the provincial level to achieve fair and equitable access. Also, these efforts cannot be short-term or crisis-related only; they should be institutionalized as national nursing workforce strategy of any country.

The other critical area that needs to be sustained is domestic education pipeline. Canada needs to increase capacity in its nursing schools and meet the limitations like the shortage of faculty and clinical placement, and outmoded infrastructure. The present nursing programs are overloaded already and can easily undermine quality of education during expansions of student enrolment. Also, the programmes will have to change to capture current health systems demands such as gerontology, mental health, community-based care, and digital health skills. It is imperative to ensure nursing education is not only available but also current and progressive so as to generate an effective workforce that can address the challenge of future health needs.

With these needs, it cannot only depend on the domestic education in the short-to-medium terms. Internationally educated nurses (IENs) integration is an important part of workforce strategy. Nevertheless, the licensure, credential recognition and workforce integration of IENs has been ineffective, cumbersome, and full of obstacles.

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Although the recent increased IEN recruitment has implied some improvement, it has to be accompanied by fair, transparent, and efficient regulatory activities. Provinces should progress to national standardization of practices and provide a wider access to the bridging programs, mentorship, and orientation supports. Immigration strategy must also be more responsive to the health workforce planning whereby competent nurses are directed to the provinces and areas where there is dire need.

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The authors have no conflicts of interest to declare

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