BCRHN Position Statement: The Use of Agency Nurses in Rural BC

It is well known that Registered Nurses (RNs), Nurse Practitioners and Licenced Practical Nurses (LPNs) play an essential role in both contributing to optimal population health outcomes through public health roles and as members of health care teams;[1] there is also emerging evidence that reflects the challenges to sustainability they have faced in British Columbia[2], Canada-wide[3] and internationally. This may be more pronounced in rural settings due to the lack of redundancy in health human resources, leading to pressure on individuals to work additional shifts to avoid temporary hospital closures and service reductions. These stressors, in addition to the inherent challenges of working in lower resourced rural environments, have made nursing sustainability a focal concern for rural health planners[4].

One stop-gap solution in British Columbia since 2017 has been the use of *Agency Nurses*. These fully trained and qualified RNs have the same role as other nursing professionals; however, they work mostly for private agencies that contract their services to Regional Health Authorities to fill human resource staffing gaps, often mitigating burnout of the staff RNs or preventing service diversion. Originally a solution to the precariousness of rural services, Agency Nurses are now employed pan-provincially. This essential stabilizing intervention, however, has moved from being a temporary system safety-net to being integrated into service planning in many communities across the province, at significant costs. There was a precipitous jump in health care spending dedicated towards agency nurses between 2018/2019 and

[1] National Academies of Sciences, Engineering, and Medicine; National Academy of Medicine; Committee on the Future of Nursing 2020–2030; Flaubert JL, Le Menestrel S, Williams DR, et al., editors. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. Washington (DC): National Academies Press (US); 2021 May 11. 4, The Role of Nurses in Improving Health Care Access and Quality. Available from: https://www.ncbi.nlm.nih.gov/books/NBK573910/

[2] British Columbia Nurses Union. The Future of Nursing in BC. FALL 2021 (https://www.bcnu.org/News-Events/CampaignsInitiatives/Documents/Future_of_Nursing_in_BC.pdf)

[3] Baumann, Andrea, and Mary Crea-Arsenio. "The Crisis in the Nursing Labour Market: Canadian Policy Perspectives." *Healthcare (Basel, Switzerland)* vol. 11,13 1954. 6 Jul. 2023, doi:10.3390/healthcare11131954

[4] Angharad Jones, Rachel J. Rahman, Jiaqing O,. A crisis in the countryside - Barriers to nurse recruitment and retention in rural areas of high-income countries: A qualitative meta-analysis, Journal of Rural Studies, Volume 72, 2019, Pages 153-163, https://doi.org/10.1016/j.jrurstud.2019.10.007.

2021/2022, from approximately $8.7 million to $64 million[5]. This shift in expenditure is beyond what would be anticipated for Health Authority nursing costs, with significant overhead going to the agencies that organize and deliver the nursing staffing.

Although the reasons for RNs choosing agency work are varied, they generally reflect the desire for increased flexibility, potentially higher rates of pay and increased independence. Additionally for some, subsidized and available accommodation is an incentive. The flexibility afforded by agencies include choice in shifts and schedules, including location and duration of assignments allowing for time-off between assignments. This may facilitate better work-life balance for some. In addition, Agency Nurses have the potential to negotiate higher wages, although they do not usually receive benefits[6]. From a practice perspective, lack of pressure for overtime and redeployment are also highly valued. Ultimately, the draw of agency nursing includes increased autonomy and control over practice.

The increasing drain of Health Authority-contracted nurses to supplement Agency Nursing – and the subsequent staff shortages this precipitates – is concerning at a systems level as it impacts the availability of Registered Nurses for more permanent, health authority-funded positions. But it also provides an opportunity to understand the antecedents to the attrition and work towards solutions to retain the nursing workforce. Although there are nuanced reasons contributing to nursing human resource outflow, they can be broadly classified as being due to challenging work environments as a result of understaffing and the attendant disruption of work-life balance when additional shifts are expected[7]. This in turn can exacerbate negative workplace culture and further entrench feelings of lack of support and lead to feelings of undervaluation (compounded for some by low wages and inadequate benefits). Demographic data also reveals that in Canada, like other jurisdictions, the nursing workforce is aging, which leads to many either retiring or transitioning into non-clinical roles. This well-documented nursing shortage leads to both further attrition but also the potential for compromised patient care.

Some of the challenges facing nursing in British Columbia are *systems level challenges.* For example, although nursing is housed under 'clinical operations' in health authorities, Chief Nursing Officers do not fall under this structure legislatively, which means they are devoid of clinical oversite for nursing practice. Instead, clinical oversite usually falls to physicians. This lack of operational accountability through systematic dismantling of nursing leadership has weakened the efficacy of professional advocacy.

Currently, agency nurses occupy as much as 60% (with some outliers relying on agency nurses for 100%) of the workforce in rural British Columbia[8]. They are staffed by those who have the desire for flexibility in practice location and scheduling. Although the health system implications of this reliance are significant in terms of costs (due to substantive overhead costs for the private agencies that contract the positions) and drain from the public system, they currently occupy a crucial role in stabilizing rural

[5] https://bc.ctvnews.ca/a-disaster-64m-in-a-single-year-to-for-profit-b-c-nursing-companies-amid-7-fold-increase-1.6043113 August 25, 2022; Cited June 17, 2024
[6] Drost, Alyssa et al. "The Trajectory of Agency-Employed Nurses in Ontario, Canada: A Longitudinal Analysis (2011-2021)." *Policy, politics & nursing practice* vol. 25,2 (2024): 70-82. doi:10.1177/15271544241240489
[7] Fukuzaki, Toshiki et al. "The Effect of Nurses' Work-Life Balance on Work Engagement: The Adjustment Effect of Affective Commitment." *Yonago acta medica* vol. 64,3 269-281. 29 Jul. 2021, doi:10.33160/yam.2021.08.005
[8] https://bc.ctvnews.ca/a-disaster-64m-in-a-single-year-to-for-profit-b-c-nursing-companies-amid-7-fold-increase-1.6043113. Cited on June 17, 2024.

communities and preventing more frequent diversions and closures. In response to the dual priorities of developing a temporary nursing force and providing the flexibility desired by RNs, Northern and Island Health Authority have developed a hybrid model, *GoHealth BC*. Unlike privatized agencies, *GoHealth BC* is Health Authority-supported but also allows the flexibility afforded by private nursing agencies. They offer permanent part-time and casual positions for RNs, RPNs and LPNs with the promise of maintaining work-life balance due to self-scheduling. Employees are part of the BC Nurses Union and receive medical and dental benefits, accrue sick time and paid vacation leave and hours worked contribute to the Municipal Pension Plan[9] [ref]. Although this initiative is a promising start, the suitability of nurses assigned to local needs must be continually monitored and evaluated. Likewise, contraction of local staff due to preferences to work in the GoHealth model should also be monitored and policy adjusted if required.

Regardless, working to temper our reliance on out-sourced nursing necessarily begins with a clear understand of the motivations to leave the current health authority practice setting. This has been done at a national level through Health Canada's *Nursing Retention Toolkit* [ref] which takes a nuanced approach by targeting *phases of nursing careers* and nursing roles, spans the continuum of care (from acute hospital care to public health) to provide a framework that addresses core work-place issues to promote retention.

Based on the reality of the challenges of nursing coverage across rural BC, the BC Rural Health Network, the Nurse and Nurse Practitioners of British Columbia [BCNU and CFNU] contend:

> *The over-reliance on agency nurses is part of a broader healthcare system problem, which has evolved over several decades. Addressing this issue, at the core, is contingent on addressing systemic challenges in rural healthcare, such as resource allocation and access to care. Equity is needed within the entire healthcare team and creating enhanced working conditions for nurses needs to also be applied to the entire rural healthcare team.*

The following statements further explicate this position.

1) The BC Rural Health Network and the Nurse and Nurse Practitioners of British Columbia [+ other partners] acknowledge the critical role of agency nurses in supporting rural healthcare services. **However, the reliance on out-sourced nursing poses significant challenges that must be addressed.**
2) Nursing shortages are not only affecting rural and remote communities but increasingly, urban sites as well. This points to the urgency of considering these issues through a whole systems lens.
3) Agency nurses are currently hired and screened through privately run agencies within a for-profit framework. This has implications on both public-sector employees occupying permanent positions and on fiscal accountability.[10] We must prioritize a fair and equal distribution of resources within our publicly-funded health care system.

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[9] https://gohealthbc.ca/?gad_source=1&gbraid=0AAAAA-AUhRtjrTzlVhXW5nv6oMW4seqCa&gclid=CjwKCAjwqf20BhBwEiwAt7dtdQ8sqOmDZBs-2fB3hZQyXz9peTT9Tigzm-oZzL6fXAT37V10FDy5zRoCTVMQAvD_BwE

[10] Although Agency Nurses may not have a higher income than Health Authority nurses, overhead is paid to the private agencies that contract the nurses.

4) Long-term staffing solutions, including initiatives to attract and retain permanent nursing staff in rural areas, need to be prioritized. This includes investment in rural recruitment programs, direct engagement with student nurses, better incentives, and improved working conditions.

5) Partnerships must be fostered between educational institutions, government bodies, unions and healthcare organizations to develop innovative staffing solutions, like the *GoHealth BC* model.

BACKGROUND Agency Nurse Costs – 2022-23 FISCAL YEAR

In the 2022-23 fiscal year, the overall cost to health authorities ballooned to $162 million, up from just $73.7 million in the previous year, and $8.7 million in 2018-19.

Breakdown per Health Authority:

1) Vancouver Coastal Health: in 2021-22, agency nursing represented 0.84 per cent of nursing costs and 3.17 per cent in 2022-23. 1. This represented $6.1 million in 2021-22 and $24.05 million in 2022-23.

2) Fraser Health: in 2021-22, agency nursing represented 0.95 per cent of nursing costs and 1.11 per cent in 2022-23. 1. This represented $11.84 million in 2021-22 and $14.73 million in 2022-23.

3) Interior Health: in 2021-22, agency nursing represents 1.12 per cent of nursing costs and 4.38 per cent in 2022-23. 1. This represented $8.46 million in 2021-22 and $34.4 million in 2022-23.

4) Island Health: in 2021-22, agency nursing represents 2.52 per cent of nursing costs and 4.69 per cent in 2022-23. 1. This represented $20.08 million in 2021-22 and $37.46 million in 2022-23.

5) Northern Health: in 2021-22, agency nursing represents 8.83 per cent of nursing costs and 15.86 per cent in 2022-23. 1. This represented $27.24 million in 2021-22 and $52.03 million in 2022-23.

6) PHSA: in 2021-22, agency nursing represents 0.01 per cent of nursing costs and 0.03 per cent in 2022-23. 1. This represented $50,000 in 2021-22 and $120,000 in 2022-23.

Recommendations

Urgent attention is needed to address the over-reliance on for-profit agencies supplying temporary and transient nursing human resources to buttress hospital operations in rural communities. This involves recognition of the following:

1) That the current nursing work-force model is outdated and does not reflect shifting work-life balance expectations, specifically due to lack of flexibility and pressure for extended hours. To this end, **we recommend the provincial *Nursing Policy Secretariat* convene a task force of nursing and health authority leaders to determine alternative professional models for nurses**

that align with current priorities, including increased flexibility. Once established, this model requires regional adaptation and pan-provincial evaluation.

2) **That the system-embedded flexible, nursing-responsive model of *GoHealthBC* be expanded** with Northern Health Authority and across other RHAs while at the same time implementing safeguards to ensure the stabilization of the permanent nursing workforce.

3) In response to professional competency concerns, that **redeployment of nurses between ward designations be limited** and compensation be offered in instances where it is inevitable.

4) That our system currently lacks mentorship and clinical coaching frameworks for nurses that are new-to-practice, new to the practice setting, adopting new skills or in an unfamiliar environment. **We recommend provincial funding to establish a mentorship and clinical coaching program available in real-time to all nurses. Depending on the needs and context, this may be in person or virtual.**

5) Front-line health care providers have insight into ways to improve quality of care, patient safety, provider sustainability and reduced costs. Currently, there is no formalized mechanism for nurses to test hypothesis or use locally-collected evidence to determine alternative modes of practice. **We recommend funding for an infrastructure to support nurse-involved, local quality improvement projects, working in synergy with physician-led CQI projects.**

6) The importance of interprofessional teams in optimizing health outcomes and supporting sustainability has been well established through recent research [ref]. However, team cohesion and function are not a necessary by-product of proximal work, but instead rely on intentional development. To the end, we recognize the importance of system supports for health care team development and **recommend a funding stream to enhance teamwork including funding for interprofessional education.**

British Columbia has recently introduced several positive steps to support nursing sustainability, including but not limited to system-embedded model for flexible work (*GoHealth BC)* and a PHSA-led strategy to stabilize rural Emergency Departments at risk through virtual supports. In addition, the BC Nurses Union in collaboration with the BC Ministry of Health (https://www.bcnu.org/media/8971) recently announced the Nurse Recruitment and Retention Initiatives (April 2024) which included funding for amending nurse staffing ratios, rural retention initiatives, and recruitment incentives. However, without stabilizing the nursing workforce in our publicly-funded system, we are at risk of not meeting these objectives. To this end, we further recommend a series of **pan-provincial deliberative dialogues with rural nursing leaders, regional and provincial policy and decision-makers, nurses working in a variety of practice settings, researchers and evaluators and rural patients.** Inclusive discussion will be the foundation from which the other recommendations can be achieved.